Chair: Jon Towler
Enquiries to: ncccg.notts-committees@nhs.net

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Agenda (Open Session)

Governing Body
Wednesday 05 August 2020 (9:00 – 11:15)
Virtual meeting via Zoom

Time	Item		Presenter	Reference
09.00	**Introductory Items**			
	1.	Welcome, introductions and apologies	Jon Towler	GB/20/050 – Verbal
	2.	Confirmation of quoracy	Jon Towler	GB/20/051 – Verbal
	3.	Declarations of interest for any item on the agenda	Jon Towler	GB/20/052
	4.	Management of any real or perceived conflicts of interest	Jon Towler	GB/20/053
	5.	Questions from the public	Jon Towler	GB/20/054 – Verbal
	6.	Minutes from the meeting held on 3 June 2020	Jon Towler	GB/20/055
	7.	Minutes from the extra ordinary meeting held on 21 July 2020	Jon Towler	GB/20/056
	8.	Action log from the meetings held on 3 June and 21 July 2020	Jon Towler	GB/20/057
	9.	Governing Body Work Programme	Lucy Branson	GB/20/058
09:20	**Strategy and Leadership**			
	10.	Accountable Officer and Joint Clinical Leaders' Report	Amanda Sullivan	GB/20/059
	11.	Equality, Diversity and Inclusion Policy	Rosa Waddingham	GB/20/060
09:45	**Commissioning Developments**			
	12.	Patient and Public Engagement Committee Highlight Report – 23 June and 28 July 2020	Sue Clague	GB/20/061
	13.	Primary Care Commissioning Committee Highlight Report – 17 June and 15 July 2020	Eleri de Gilbert	GB/20/062
09:55	**Financial Stewardship**			
	14.	Finance and Turnaround Committee Highlight Report – 24 June and 22 July 2020	Shaun Beebe / Jon Towler	GB/20/063
	15.	2020/21 Financial Report Month Three	Stuart Poynor	GB/20/064
10:15	**Quality and Performance**			
	16.	Quality and Performance Committee Highlight Report – 25 June and 23 July 2020	Eleri de Gilbert	GB/20/065
	17.	Performance Report	Stuart Poynor	GB/20/066

Time	Item	Presenter	Reference
	18. Quality Report	Rosa Waddingham	GB/20/067
	19. Learning Disability Mortality Review (LeDeR)	Rosa Waddingham	GB/20/068
10:40	**Corporate Assurance**		
	20. Audit and Governance Committee Highlight Report – 22 June 2020	Sue Sunderland	GB/20/069
	21. Risk Management Policy	Lucy Branson	GB/20/070
	22. Governing Body Assurance Framework	Lucy Branson	GB/20/071
	23. Corporate Risk Report	Lucy Branson	GB/20/072
-	**Information Items** *The following items are for information and will not be individually presented. Questions will be taken by exception.*		
	24. Ratified minutes of CCG committee meetings: a) Patient and Public Engagement Committee – 19 May and 23 June 2020 b) Quality and Performance Committee – 28 May and 25 June 2020 c) Finance and Turnaround Committee – 27 May and 24 June 2020 d) Primary Care Commissioning Committee – 20 May and 17 June 2020 e) Audit and Governance Committee – 12 May 2020	N/A	GB/20/073
11:15	**Closing Items**		
	20. Any other business	Jon Towler	GB/20/074 – Verbal
	21. Date of the next meeting: 07/10/2020 To be held virtually	Jon Towler	GB/20/075 – Verbal

Confidential Motion:

The Governing Body will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

Register of Declared Interests

• As required by section 14O of the NHS Act 2006 (as amended), the CCG has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without being unduly influenced by external or private interests.

• This document is extracted, for the purposes of this meeting, from the CCG's full Register of Declared Interests (which is publically available on the CCG's website).
This document was extracted on 31 July 2020 but has been checked against the full register prior to the meeting to ensure accuracy.

• The register is reviewed in advance of the meeting to ensure the consideration of any known interests in relation to the meeting agenda. Where necessary (for example, where there is a direct financial interest), members may be fully excluded from participating in an item and this will include them not receiving the paper(s) in advance of the meeting.

• Members and attendees are reminded that they can raise an interest at the beginning of, or during discussion of, an item if they realise that they do have a (potential) interest that hasn't already been declared.

• Expired interests (as greyed out on the register) will remain on the register for six months following the date of expiry.

Name	Current position(s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date From:	Date To:	Action taken to mitigate risk
ARORA, Dr Manik	Governing Body GP Representative	Nottingham City GP Alliance (a federation of GP practices)	Rivergreen Medical Centre (of which Dr Arora is a GP Partner) is a member of the Alliance	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by the City GP Alliance.
ARORA, Dr Manik	Governing Body GP Representative	Rivergreen Medical Centre	GP Partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by GP Practices.
ARORA, Dr Manik	Governing Body GP Representative	Clifton and Meadows Primary Care Network	Deputy Clinical Director	✓				01/08/2019	31/03/2020	Interest expired - no action required
BALL, Alex	Director of Communications and Engagement	Sherrington Park Medical Practice	Registered Patient			✓		01/10/2018	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
BEEBE, Shaun	Non-Executive Director	Eastwood Primary Care Centre	Family members are registered patients				✓	-	01/03/2020	Interest expired - no action required
BEEBE, Shaun	Non-Executive Director	University of Nottingham	Senior manager with the University of Nottingham	✓				-	Present	This interest will be kept under review and specific actions determined as required.
BEEBE, Shaun	Non-Executive Director	Nottingham University Hospitals NHS Trust	Patient in Ophthalmology			✓		-	Present	This interest will be kept under review and specific actions determined as required.

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BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice	Registered Patient			✓		01/11/2005	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
CARTER, Sarah	Director of Transition Operations	Orchid Gold Ltd Consultancy Company	The company delivers services of turnaround, transformation and OD consultancy for NHS organisations	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
CHALLENGER, Alison	Director of Public Health, Nottingham City Council	Nottingham City Council	Employed as Director of Public Health	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
CHALLENGER, Alison	Director of Public Health, Nottingham City Council	Nottingham University Hospitals NHS Trust	Relative is Speciality General Manager of Emergency Department				✓	03/09/2018	Present	This interest will be kept under review and specific actions determined as required.
CLAGUE, Sue	Non-Executive Director	Victoria and Mapperley Practice	Registered Patient and member of Patient Participation Group			✓		09/01/2016	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
CLAGUE, Sue	Non-Executive Director	University Hospitals of Derby and Burton Hospitals NHS Foundation Trust	Family Member, Non Executive Director				✓	31/10/2015	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/10/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Pelham Homes Ltd – Housing provider subsidiary of Nottinghamshire Community Housing Association	Director	✓				01/01/2008	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	3Sixty Care Ltd – GP Federation, Northamptonshire	Chair	✓				01/01/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	First for Wellbeing Community Interest Company (Health and Wellbeing Company)	Director	✓				01/12/2016	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Valley Road Surgery	Registered Patient			✓		19/06/1905	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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DADGE, Lucy	Chief Commissioning Officer	Nottingham Schools Trust	Chair and Trustee			✓		01/11/2017	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Middleton Lodge Surgery	Individual and spouse are registered patients at this practice				✓	-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Rise Park Practice	Son and Daughter in Law registered patients				✓	18/10/2019	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Nottingham Bench	Justice of the Peace		✓			-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Sherwood and Newark Citizens Advice Bureau	Trustee on the board		✓			01/03/2016	07/02/2020	Interest expired - no action required
DE GILBERT, Eleri	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Son, daughter in law and grandchild are registered patients				✓	-	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Cornerstone Church Nottingham	Director			✓		01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Nottinghamshire County Council	employed as Director of Public Health	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Nottingham University Hospitals NHS Trust	Spouse is Consultant in Obstetrics				✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Joint Clinical Leader	Calverton Practice	GP Partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by GP Practices.
HOPKINSON, Dr James	Joint Clinical Leader	Nottingham University Hospitals NHS Trust	Wife is an Allergy Nurse Specialist				✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Joint Clinical Leader	Faculty of Sport and Exercise Medicine (an intercollegiate faculty of the Royal College of Physicians of London and the Royal College of Surgeons of Edinburgh, which works to develop the medical specialty of Sport and Exercise Medicine).	Fellow of		✓			01/04/2013	Present	This interest will be kept under review and specific actions determined as required.

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HOPKINSON, Dr James	Joint Clinical Leader	NEMS Healthcare Ltd	Shareholder	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by NEMS or NEMS CBS; and Services where it is believed that the organisations could be interested bidders.
HOPKINSON, Dr James	Joint Clinical Leader	Primary Integrated Care Service (PICS)	Practice is a member of		✓			-	Present	This interest will be kept under review and specific actions determined as required.
LOVELOCK, Dr Hilary	Governing Body GP Representative	Brierley Park Medical Centre	GP Partner	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by GP Practices.
LOVELOCK, Dr Hilary	Governing Body GP Representative	Primary Integrated Care Service (PICS)	Shareholder in Primary Integrated Community Services individually <5%.	✓				-	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by PICS.
LOVELOCK, Dr Hilary	Governing Body GP Representative	Clinical Research Network	Recruiter to Care-IS, All Heart-You, CANDID research studies, where payment is received per recruited patient	✓				-	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	University Hospitals Birmingham NHS Foundation Trust	Employed as Associate Medical Director and Consultant in Anaesthesia and Pain Management	✓				25/04/2016	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	Spire	Independent private clinical anaesthetic practice undertaken in private hospitals in the Birmingham area	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	BMI	Independent private clinical anaesthetic practice undertaken in private hospitals in the Birmingham area	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	Transform Hospital Group Ltd (formerly known as The Hospital Group Ltd)	Independent private clinical anaesthetic practice undertaken in private hospitals in Bromsgrove	✓				17/12/2015	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	Carwis Consulting Ltd – Healthcare Management Consulting	Director	✓				01/04/2018	Present	This interest will be kept under review and specific actions determined as required.

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OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	Transform Hospital Group Ltd	Group Medical Director and Responsible Officer	✓				01/07/2019	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Chief Finance Officer	No relevant interests declared	Not applicable					-	Present	Not applicable
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group (formerly East Leake Medical Group)	GP Partner	✓				01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by GP Practices.
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group as a subcontractor for Nottingham University Hospitals NHS Trust to deliver surgical dermatological services	GP Partner	✓				-	Present	Participate in discussion or service redesign if organisation is potential provider, withdraw from voting unless otherwise agreed by the meeting chair.
SHORTT, Dr Stephen	Joint Clinical Leader	Partners Health LLP (Weekend Wound care and GP Extended Access)	GP member	✓				01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group (formerly East Leake Medical Group)	Wife is a registered patient				✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group (formerly Keyworth Medical Practice)	Spouse is GP partner				✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Dr Stephen	Joint Clinical Leader	KMP Pharmacy	Wife is Director				✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Dr Stephen	Joint Clinical Leader	HS Primary Care Research Network	Practice receives funding to host research studies and recruit patients	✓				01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Dr Stephen	Joint Clinical Leader	Partners Health LLP (Community Dermatology, Weekend Wound care and GP Extended Access)	Wife GP member				✓	01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.
SHORTT, Dr Stephen	Joint Clinical Leader	Principia Multi-specialty Community Provider	Member	✓				01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Principia; and Services where it is believed that Principia could be an interested bidder.

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STRATTON, Dr Richard	GP Representative	Belvoir Health Group	GP Partner	✓				01/08/2012	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by GP Practices.
STRATTON, Dr Richard	GP Representative	PartnersHealth LLP	GP member	✓				01/11/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.
SULLIVAN, Amanda	Accountable Officer	Hillview Surgery	Registered Patient			✓		2013	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
SUNDERLAND, Sue	Non-Executive Director	Joint Audit Risk Assurance Committee, Police and Crime Commissioner (JARAC) for Derbyshire / Derbyshire Constabulary	Chair		✓			01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Non-Executive Director	NHS Bassetlaw CCG	Governing Body Lay Member		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Non-Executive Director	Inclusion Healthcare Social Enterprise CIC (Leicester City)	Non-Executive Director		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
THOMPSON, Gary	Director of Special Projects	Radcliffe on Trent Health Centre	Registered Patient			✓		01/01/2018	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
THOMPSON, Gary	Director of Special Projects	Radcliffe on Trent Health Centre	Spouse is a patient				✓	01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice.	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

Name	Current position(s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date From:	Date To:	Action taken to mitigate risk
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	-	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Chief Nurse	No relevant interests declared	Not applicable					-	-	Not applicable

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Managing Conflicts of Interest at Meetings

1. A "conflict of interest" is defined as a "set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold".

2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.

3. Conflicts of interest include:
   - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
   - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
   - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
   - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

   The above categories are not exhaustive and each situation must be considered on a case by case basis.

4. In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

5. At the beginning of each formal meeting, Committee members and co-opted advisors will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the Committee (or Deputy Chair in their absence, or where the Chair of the Committee is conflicted) will determine how declared interests should be managed, which is likely to involve one the following actions:
   - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.
   - Allowing the individual to participate in the discussion, but not the decision-making process.
   - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Governing Body (open session)
UNRATIFIED minutes of the meeting held on
03/06/2020, 09:00-11:00
Teleconference

Members present:

Jon Towler	Non-Executive Director and Chair of the meeting
Dr Manik Arora	GP Representative, Nottingham City
Shaun Beebe	Non-Executive Director
Sue Clague	Non-Executive Director
Eleri de Gilbert	Non-Executive Director
Dr James Hopkinson	Joint Clinical Leader
Dr Hilary Lovelock	GP Representative, Mid-Nottinghamshire
Dr Adedeji Okubadejo	Secondary Care Specialist
Stuart Poynor	Chief Finance Officer
Dr Stephen Shortt	Joint Clinical Leader
Dr Richard Stratton	GP Representative, South Nottinghamshire
Amanda Sullivan	Accountable Officer
Sue Sunderland	Non-Executive Director
Rosa Waddingham	Chief Nurse

In attendance:

Alex Ball	Director of Communication and Engagement
Lucy Branson	Associate Director of Governance
Sarah Carter	Incident Executive Director – COVID 19
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Lucy Dadge	Chief Commissioning Officer

Cumulative Record of Members' Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Dr Manik Arora	2	2	Stuart Poynor	2	1
Shaun Beebe	2	2	Dr Stephen Shortt	2	2
Sue Clague	2	2	Dr Richard Stratton	2	2
Lucy Dadge	2	1	Amanda Sullivan	2	2
Eleri de Gilbert	2	2	Sue Sunderland	2	2
Dr James Hopkinson	2	2	Jon Towler	2	2
Dr Hilary Lovelock	2	1	Rosa Waddingham	2	2
Dr Adedeji Okubadejo	2	1			

Introductory Items

GB 20 020 Welcome and Apologies

Jon Towler welcomed everyone to the open session of the meeting of NHS Nottingham and Nottinghamshire CCG's Governing Body. The meeting was being held virtually due to the Covid-19 pandemic and was being live streamed to allow members of the public access to the discussion.

Apologies were noted as above.

GB 20 021 **Confirmation of Quoracy**
The meeting was declared quorate.

GB 20 022 **Declaration of interest for any item on the shared agenda**
No interests were noted on any item on the agenda. Jon Towler reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

GB 20 023 **Management of any real or perceived conflicts of interest**
No interests had been declared; therefore this item was not required.

GB 20 024 **Questions from the Public**
There were no questions.

GB 20 025 **Minutes from the meeting held on 8 April 2020**
The minutes of the meeting on 8 April 2020 had been agreed as an accurate record of the discussions held at the confidential session of the Governing Body meeting of 5 May to facilitate early publication on the CCG's website. The minutes were presented to this meeting for completeness.

GB 20 026 **Action log from the meeting held on 8 April 2020**

- Action GB 20 032: Amanda Sullivan to lead on arranging a Board to Board meeting between the CCG and Nottinghamshire Healthcare NHS Foundation Trust. There had been agreement to hold the meeting, dates had been offered to the Trust and it would be scheduled as soon as practicable.
- Actions GB 20 009, 033, 059, 061 from the predecessor CCGs' Governing Bodies' meetings and action GB 20 011 from the April meeting were noted as due to report to the August meeting.

All other actions were noted as completed.

Strategy and Leadership

GB 20 027 **Accountable Officer and Clinical Leaders' Report**
Amanda Sullivan introduced the report, highlighting the following points:

a) Regarding the management of the continuing response to the Covid-19 pandemic, within Nottingham and Nottinghamshire the number of daily new cases had peaked at the beginning of April, which was in line with the national picture. However since then there had been a levelling off, rather than a decline, which was a concern with the further easing of lockdown restrictions. The situation continued to be closely monitored with partners via the Local Resilience Forum, which continued to model future scenarios.
b) There were on-going challenges with the supply of personal protective equipment (PPE). Supply lines were stable at present; however the potential stepping up of services as lockdown measures eased could put additional pressure on the supply

chain.

c) A comprehensive support package for care homes and home care services had been put in place to support staff and patients, with strong partnership working with the local authorities.
d) Guidance on testing and the Test and Trace programme continued to be received from NHS England and the CCG was supporting Public Health England to scale up the programme.
e) The CCG continued to work closely with the acute trusts on the safest and most equitable way to restore elective services whilst retaining the necessary capacity to respond to any increase in Covid-19 cases.
f) The CCG had reviewed its temporary governance arrangements, agreed in April, and had agreed to recommence committee meetings, with business focused primarily on the CCG's response to the Covid-19 pandemic. A number of further changes were proposed to the CCG's delegated financial limits for the emergency period to enable quick decision-making, as detailed in Appendix A of the report.
g) A number of minor changes had been made to committees' Terms of Reference and delegated financial limits for commissioning and contracting decisions, as detailed in Appendices B and C of the report, which were also presented for approval.
h) The CCG's Clinical Design Authority was now functional and had already engaged in several transformation projects with colleagues across the system.
i) Healthwatch Nottingham and Nottinghamshire had recently issued a report on the information needs of vulnerable people during the Covid-19 pandemic to try and understand the impact of the pandemic on vulnerable people. This was a timely report that would aide restoration plans and communications going forward.
j) Mel Barrett had recently been appointed as the new Chief Executive of Nottingham City Council.
k) Dr Stephen Shortt paid tribute to the extraordinary response of patients and healthcare staff during this time to adapt to new ways of working and communicating. The Primary Care Networks had developed at pace and patients had embraced self-care. Links had also been forged between primary and secondary care colleagues and good practice and learning from the pandemic was being shared. It was proposed that the CCG should write to all staff and partners to demonstrate appreciation of the continued hard work of all staff, which was agreed.

The following points were made in discussion:

l) There was a query over the effectiveness of the Clinical Management Centres. It was noted that Clinical Management Centres had been established to maintain a local GP presence if individual practices came under pressure due to staff absences. However demand had not materialised and all had been quickly stood down except the City Clinical Management Centre. However, they could be quickly mobilised should there be a second wave of Covid-19 cases. It was noted that the Primary Care Commissioning Committee had been overseeing General Practice's response to the Covid-19 pandemic.
m) There was a discussion regarding whether structural barriers to joint working within the healthcare system would prevent long term adoption of new ways of working. It was noted that a changing role for the CCG as a strategic commissioner and the introduction of a system-wide recovery cell would foster shared objectives.
n) Members discussed the findings of the Healthwatch report, noting that both local

and national communications had not reached the whole population. There was a need to communicate clear messages around the restoration of services and how expectations of future healthcare services needed to be well managed. It was noted that learning from the report would be used in communications going forward.

o) It was emphasised that communication and behavioural changes should be an integral element of recovery actions and for the CCG to be cognisant that patients without access to IT technology should not be put at a disadvantage in any new proposed long term service changes.

The Governing Body:

- **NOTED** the Accountable Officer and Clinical Leaders' Report
- **APPROVED** the proposed changes to the CCG's financial limits for the duration of the emergency response period, provided at Appendix A.
- **APPROVED** proposed changes to Committee terms of reference and delegated financial limits for commissioning and contracting decisions, as set out at Appendices B and C.

ACTION:

- **Amanda Sullivan, Dr Steven Shortt and Dr James Hopkinson to draft a letter expressing appreciation of the work undertaken by all colleagues and providers during the response to the Covid-19 pandemic.**

GB 20 028 **2020/21 Key Deliverables**

Stuart Poynor introduced the report, highlighting the following points:

a) Key deliverables for the organisation represented a focus on priorities both internally and for external audiences; and which demonstrated alignment with the Nottingham and Nottinghamshire Integrated Care Strategy and Health and Wellbeing Strategies.

b) Once agreed they would be subject to the development of individual workplans, with clear delivery timeframes and key milestones. This work would be undertaken by the Programme Management Office and overseen by the Finance and Turnaround Committee.

c) The workplans would be brought to the August meeting of the Governing Body for approval.

The following points were made in discussion:

d) The capacity of the CCG to take on new responsibilities with regard to specialised commissioning was discussed. It was noted that any adoption of specialised commissioning roles would be undertaken in an iterative and collaborative way, with no initial financial risk for the CCG. Discussions had been put on hold due to the need to respond to the Covid-19 pandemic and would resume shortly. It was agreed there were opportunities for a more 'whole population' approach to commissioning; however resource considerations would need to be taken into account.

The Governing Body:

- **APPROVED** the CCG's key deliverables for 2020/21.

ACTION:

Stuart Poynor to bring the delivery plans for the CCG's key deliverables to the

August Governing Body meeting

Commissioning Developments

GB 20 029 **Patient and Public Engagement Committee Highlight Report – 19 May 2020**

Sue Clague introduced the report, highlighting the following points:

a) The Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) held its inaugural meeting on 19 May. The Committee had a wide spectrum of representation and from different localities.
b) Two items had been discussed, engagement priorities and engagement with the Recovery Cell. Stuart Poynor's attendance was welcomed by the Committee and he had deemed it important to take the views of patients into account during the recovery phase.
c) Thanks to the Communications and Engagement Team was given for their work in supporting the development of the new Committee.

The following points were made in discussion:

d) Members queried whether there was an engagement representative on the Recovery Cell and it was confirmed there was.
e) Members noted the need to reach those communities who did not have ready access to, or knowledge of, Information Technology. It was noted that members had a good reach into their respective communities and engagement would not just be digital.

The Governing Body:

- **NOTED** the Patient and Public Engagement Committee Highlight Report.

GB 20 030 **Highlight report from the Primary Care Commissioning Committee – 20 April and 20 May**

Eleri de Gilbert introduced the report, highlighting the following points:

a) The Committee had received a report of 'substantial assurance' from the Internal Audit report 'Commissioning of and Procurement of Primary Care Medical Services'.
b) The Committee continued to oversee the response from General Practice to the Covid-19 pandemic and thanked all CCG and practice staff for the way in which they had responded to the Covid-19 pandemic by establishing new ways of working at pace and setting up mutual aid to help those practices with staff shortages.

The Governing Body:

- **NOTED** the Highlight report from the Primary Care Commissioning Committee.

Financial Stewardship

GB 20 031 **Finance and Turnaround Committee Highlight Report – 27 May 2020**

Shaun Beebe introduced the report, highlighting the following points:

a) The CCG had finished the last financial year having met its financial targets, albeit with a challenging underlying position that would be carried forward into 2020/21.
b) Currently the usual financial processes were suspended and payments to providers were being calculated at a national level.

The Governing Body:
- **NOTED** the Highlight report from the Finance and Turnaround Committee.

GB 20 032 **Financial Report Month One**

Stuart Poynor introduced the report, highlighting the following points:
a) The CCG had not produced a full operating cost statement from the ledger for month one, and instead was reporting a breakeven position to NHS England year to date.
b) This position was in line with the latest verbal national guidance received, and reflected the current financial processes in place for Covid-19 where the CCG expected to receive non-recurrent adjustments to its revenue resources that would allow the CCG to report break-even to NHS England.
c) There remained the requirement to deliver savings in total, alongside levels of recurrent savings that would improve the underlying financial position by March 2021.

The following points were made in discussion:
d) Members queried whether there was any indication of when the current financial management arrangements would change. It was not known when they would change; however it was envisaged it may not be before quarter three.
e) Members queried how the CCG could mitigate a retrenchment among providers following any resumption of local financial management processes. It was noted that the Integrated Care System financial sustainability group would be reconvened to continue to foster a partnership approach to local financial management.

The Governing Body:
- **NOTED** the Financial Report Month One.

Quality and Performance

GB/20/033 **Quality and Performance Committee Highlight Report – 28 May 2020**

Eleri de Gilbert introduced the report, highlighting the following points:
a) This was the inaugural meeting of the Quality and Performance Committee, which had received a number of reports related to the CCG's response to the Covid-19 pandemic.
b) An assurance report had been reviewed on work undertaken with care homes and home care, noting the huge challenges for the sector and the amount of support that had been put in place in a very short space of time.
c) Assurance reports on swabbing and testing and PPE were also scrutinised.
d) A report on the emergency streamlined Equality and Quality Impact Assessment (EQIA) process that had been developed for use during the pandemic was discussed. This ensured that potential adverse impacts on service changes were identified and mitigated at an early stage.
e) A significant reduction (over 50%) had been noted with regard to safeguarding referrals, which was of concern to the Committee. It was noted that safeguarding services had continued to be available.
f) The Committee noted excellent progress in relation to Learning Disabilities Mortality Reviews, with the CCG being one of the best performing CCGs against the

requirement.

g) The Committee noted its concern around the impact of the Covid-19 pandemic on long waiters; cancer backlog; and the potential increased demand on services once the public start to have confidence in using health services again.

The following points were made in discussion:

h) Members noted concern over the reduction in safeguarding referrals. It was noted that the Nottinghamshire Adult Safeguarding Board and the Nottinghamshire Children's Safeguarding Board were monitoring the situation closely and assurance had been received that social services were being maintained by the local authorities. A further report would be taken to the next Committee meeting.

The Governing Body:

- **NOTED** the Quality and Performance Committee Highlight Report.

GB/20/034 **Integrated Quality and Performance Report**

Stuart Poynor introduced the report, highlighting the following points:

a) The work to create capacity within the acute trusts in the wake of the Covid-19 pandemic had led to a dramatic reduction in the number of patients undertaking elective surgery. This in turn had resulted in an increase in long-waiting patients and the deterioration of the referral to treatment standard.

b) Wherever possible treatment for patients with cancer had been undertaken in the local independent sector and had resulted in an improvement in cancer waiting times.

c) A reduction in demand for emergency admissions by circa 50% had been in line with national levels.

d) Rosa Waddingham asked Members to note that a detailed Quality Report had been presented to the Quality and Performance Committee. The CCG had continued to oversee and respond to quality and safety concerns and no significant concerns had been escalated.

The following points were made in discussion:

e) Members discussed the need for consistent performance reporting by all system partners; and for the Performance Report to incorporate the ICS outcomes Framework and be made more accessible to readers. It was agreed that a more current report would be developed by the Committee, which reflected Covid-19 impacts on performance and would be brought to the next Governing Body meeting in August.

The Governing Body:

- **NOTED** the Integrated Quality and Performance Report.

ACTION:

- **Stuart Poynor to develop a more current performance report, which reflected Covid-19 impacts on performance, for presentation at the August Governing Body meeting**

Corporate Assurance

GB 20 035 **Audit and Governance Committee Highlight Report – 12 May 2020**

Sue Sunderland introduced the report, highlighting the following points:

a) The Committee had had oversight of the proposed changes to the CCG's delegated financial limits to enable it to respond quickly during the emergency response to the Covid-19 pandemic.
b) The Committee had also overseen and had received assurance of how risk management arrangements were operating during the emergency response.
c) The Committee had reviewed in detail the draft annual reports and accounts for the six predecessor CCGs and had noted the positive progress of the external auditors. The Committee had expressed its thanks for the hard work of the CCG's Governance and Finance Teams in producing six reports to the stated deadline during a very challenging period.

The Governing Body:

- **NOTED** the Audit and Governance Committee Highlight Report.

GB 20 036 **Corporate Risk Report**

Lucy Branson introduced the report, highlighting the following points:

a) There were currently nine major operational risks in the Corporate Risk Register, an increase of five since the last meeting. This was largely due to the risk relating to the Covid-19 pandemic being broken down into its component parts to maintain management of the response to the pandemic.
b) The opening Assurance Framework for 2020/21 would be brought to the August meeting of the Governing Body.

The following points were made in discussion:

c) Regarding risk RR129, relating to a risk of excess deaths across the CCG's population, a relatively low likelihood score was queried. It was noted that there was insufficient data at this time to make a firm judgment and the Quality and Performance Committee would keep this risk under review.

The Governing Body:

- **NOTED** Corporate Risk Report

For Information

GB 20 037 **Ratified minutes of predecessor CCGs' committee meetings in common:**

- **Patient and Public Engagement Committees – 25 February 2020 and 9 April 2020**
- **Quality, Safeguarding and Performance Committees – 26 February 2020**
- **Finance and Turnaround Committees – 27 February 2020**
- **Primary Care Commissioning Committees – 25 March 2020**
- **Audit and Governance Committees – 27 March 2020**

The minutes were **NOTED**.

GB 20 038 **Ratified minutes of CCG committee meetings:**

- **Primary Care Commissioning Committee – 22 April 2020**

The minutes were **NOTED**.

Closing Items

GB 20 039 **Any other business**
There was no other business

GB 20 040 **Date of the next meeting**
5 August 2020
To be held virtually

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Governing Body (open session)
UNRATIFIED minutes of the extra ordinary meeting held on
21/07/2020, 3.00-4.00
Teleconference

Members present:

Jon Towler	Non-Executive Director and Chair of the meeting
Dr Manik Arora	GP Representative, Nottingham City
Lucy Dadge	Chief Commissioning Officer
Eleri de Gilbert	Non-Executive Director
Dr Adedeji Okubadejo	Secondary Care Specialist
Dr Stephen Shortt	Joint Clinical Leader
Dr Richard Stratton	GP Representative, South Nottinghamshire
Amanda Sullivan	Accountable Officer
Sue Sunderland	Non-Executive Director

In attendance:

Alex Ball	Director of Communication and Engagement
Lucy Branson	Associate Director of Governance
Jon Singfield	Head of Strategic Planning
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Shaun Beebe	Non-Executive Director
Sue Clague	Non-Executive Director
Dr James Hopkinson	Joint Clinical Leader
Dr Hilary Lovelock	GP Representative, Mid-Nottinghamshire
Stuart Poynor	Chief Finance Officer
Rosa Waddingham	Chief Nurse

Cumulative Record of Members' Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Dr Manik Arora	3	3	Stuart Poynor	3	1
Shaun Beebe	3	2	Dr Stephen Shortt	3	3
Sue Clague	3	2	Dr Richard Stratton	3	3
Lucy Dadge	3	2	Amanda Sullivan	3	3
Eleri de Gilbert	3	3	Sue Sunderland	3	3
Dr James Hopkinson	3	2	Jon Towler	3	3
Dr Hilary Lovelock	3	1	Rosa Waddingham	3	2
Dr Adedeji Okubadejo	3	2			

Introductory Items

GB 20 041 **Welcome and Apologies**

Jon Towler welcomed everyone to the open session of the extra ordinary meeting of NHS Nottingham and Nottinghamshire CCG's Governing Body. The meeting was being held virtually due to the Covid-19 pandemic and was being live streamed to allow members of the public access to the discussion.

Apologies were noted as above.

GB 20 042 **Confirmation of Quoracy**
The meeting was declared quorate.

GB 20 043 **Declaration of interest for any item on the shared agenda**
No interests were noted on any item on the agenda. Jon Towler reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

GB 20 044 **Management of any real or perceived conflicts of interest**
No interests had been declared; therefore this item was not required.

Commissioning Developments

GB 20 045 **NHS Rehabilitation Centre NHS Rehabilitation Centre - Final Approval of the Pre Consultation Business Case and Consultation Proposal**
Alex Ball introduced the report, highlighting the following points:

a) This report updated the Governing Body on progress made in gaining local and national assurance for the proposed public consultation on the development of the NHS Rehabilitation Centre and requested approval to hold an eight week public consultation from 27 July. The pre-consultation business case (PCBC) for the rehabilitation centre was also included for approval.
b) The assurance processes that both the consultation plan and PCBC had undertaken to date were detailed; and it was noted that in addition to the previous discussions and approvals by the Governing Body, both documents had been approved by the NHS England/Improvement (NHSE/I) Oversight Group for Service Change and Reconfiguration on 2 March 2020 and by the NHSE/I Chief Financial Officer on 26 May 2020.
c) Both Nottingham City and Nottingham County Health Scrutiny Committees had been satisfied with the proposed approach and had endorsed the proposal to consult.
d) Advice had been sought from the CCG’s legal advisors and the Consultation Institute regarding the removal of face-to-face activity from the consultation due to the on-going Covid19 pandemic and both had advised that it did not weaken the exercise if mitigations were built into the plan. The mitigations had been included in the consultation plan and were summarised. Key mitigations were the extending of the length of the consultation; using a range of media; including a live online question and answer session; and working alongside Nottinghamshire Healthwatch to contact traditionally hard to reach groups.
e) An option to postpone the consultation until the easing of social distancing restrictions had been considered in detail; however it was noted that this date was indeterminate and any further delay would put at risk partner support and capital funding for the project build.

The following points were made in discussion:

f) It was requested that the design of the consultation document be amended to ensure it was suitable for individuals with sight impairment; and this was agreed.
g) The changing nature of rehabilitation services post the Covid-19 pandemic were

discussed and whether it would materially change any of the elements within the business plan. It was noted that the business plan continued to evolve and would continue to be developed further, including responding to any learning from the pandemic. It was noted that workshops to develop the business plan continued.

h) Clarification was requested on the argument for not postponing the consultation. It was noted that there were risks to both the ongoing support from the owners of the Stanford Hall Estate and to the continued availability of the capital funding to build the facility. There was also a risk that inflationary pressures would impact on financial assumptions and make the project unaffordable.
i) Members noted the need to be mindful of the need to ensure clarity of language regarding whether the facility was national, regional or local.
j) Members sought assurance that hard to reach groups would be proactively targeted. It was noted that they would and that this would be monitored.

Jon Towler summarised the discussion to ensure that members were content that all concerns regarding the consultation had been addressed:

k) The PCBC had been discussed by the Governing Bodies of the CCG's predecessor organisations on several previous occasions, and was approved in September 2019, subject to a number of concerns that continued to be worked through as part of the process to develop the Decision Making Business Case (DMBC). It was noted that a number of workshops continued to be held with partners across the system to address these concerns in the development of the DMBC. As the PCBC remained materially unchanged, it was proposed that the Governing Body should approve the PCBC.
l) Regarding the proposal to proceed to public consultation:
    - Had the CCG addressed all of the assurance stages required by NHSE/I? Confirmation had been given on this point, with the Governing Body noting a final sign off by the NHSE/I Chief Finance Officer.
    - Had endorsement been received from local scrutiny committees? It had been noted that both the Nottingham City and Nottinghamshire County Health Scrutiny Committees had given their endorsement.
    - Had sufficient engagement been undertaken prior to the start of any formal consultation period? Details of informal engagement with both clinicians and patients had been provided.
    - Given the current constraints about face to face activity, was the consultation valid? The Governing Body had noted the legal advice received and the support from Healthwatch to ensure engagement was as wide as possible. The Governing Body had been assured that the plan complied fully with the requirements for a public consultation.
    - Should the consultation be delayed until social distancing measures were relaxed? The Governing Body noted that there was a time dependency to the consultation, with any delay risking the loss of support from the owners of the estate and the availability of the capital funding. There was also a reputational risk for the CCG should public consultation be further delayed.
m) It was agreed that the CCG would write to NHSE/I to confirm the Governing Body's approval with, for purposes of clarity, a section stating that work was still on-going to address the concerns of the Governing Body in relation to the PCBC and that this work would be considered alongside the consultation findings to inform the

development of the DMBC.

The Governing Body:

- **APPROVED** the proposal to proceed to an 8 week public consultation, launching on 27 July 2020.
- **APPROVED** the pre consultation business case for the NHS Rehabilitation Centre.

ACTION:

- **CCG to write to NHSE/I to confirm the Governing Body's approval with a section stating that work was still on-going to address the concerns of the Governing Body in relation to the PCBC and that this work would be considered alongside the consultation findings to inform the development of the DMBC.**

Closing Items

GB 20 046 **Any other business**

There was no other business.

GB 20 047 **Date of the next meeting**

5 August 2020

To be held virtually

Action log from meeting in common held on 3 June and 21 July

Governing Body
ACTION LOG for the meetings held on 03/06/2020 and 21/07/2020

Meeting date	Agenda reference	Agenda item	Action	Lead	Date to be completed	Comment
ACTIONS OUTSTANDING						
-	-	-	*No actions outstanding*	-	-	-
ACTIONS ONGOING / NOT YET DUE						
08/04/2020	GB 20 011	Accountable Officer and Clinical Leaders' Report	To consider longer term cyber security issues associated with the greater use of IT during the emergency response.	Lucy Branson	30/09/20	The agenda for the Audit and Governance Committee meeting on the 30 September will include a specific item relating to cyber security.
03/06/2020	GB 20 028	2020/21 Organisational Priorities	To bring the delivery plans for the CCG's 2020/21 organisational priorities to the August meeting of the Governing Body.	Stuart Poynor	07/10/20	The delivery plans for the CCG's organisational priorities are currently being finalised and scheduled for the October meeting of the Governing Body, following review and scrutiny at the August meeting of the Finance and Resources Committee.

9.00, Virtual meeting-05/08/20

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting date	Agenda reference	Agenda item	Action	Lead	Date to be completed	Comment
21/07/20	GB 20 045	NHS Rehabilitation Centre NHS Rehabilitation Centre - Final Approval of the PCBC and Consultation Proposal	To write to NHSE/I to confirm the Governing Body's approval with a section stating that work was still on-going to address the concerns of the Governing Body in relation to the pre consultation business case and that this work would be considered alongside the consultation findings to inform the development of the decision making business case.	Alex Ball	31/07/20	A verbal update will be provided at the meeting.
ACTIONS COMPLETE						
09/01/2020	GB 20 009	Statutory Equality Duties	To ensure the new Equality, Diversity and Inclusion Policy includes reference to the role and responsibilities of Non-Executive Directors.	Rosa Waddingham	-	The role of Non-Executive Directors, as members of the Governing Body and as Committee Chairs, is described in the Equality, Diversity and Inclusion Policy presented at agenda item GB 20 060.
05/02/2020	GB 20 032	Quality, Safeguarding and Performance Committee's Highlight Report	To lead on arranging a Board to Board meeting between the CCG and Nottinghamshire Healthcare NHS Foundation Trust.	Amanda Sullivan	-	The Board to Board meeting was held on the 30 June 2020.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting date	Agenda reference	Agenda item	Action	Lead	Date to be completed	Comment
05/02/2020	GB 20 033	Organisational Development Report	To provide an update on actions to improve diversity within the CCG's workforce as part of the next scheduled workforce report.	Sarah Carter	-	Added to the forward work programme for presentation on this agenda under item GB 20 058.
05/03/2020	GB 20 059	Staff Survey	To ask representatives of the Staff Engagement Group to present the action plan in response to the results of the staff survey to the Governing Body.	Stuart Poynor	-	Added to the forward work programme for presentation on this agenda under item GB 20 058.
05/03/2020	GB 20 061	Governing Body Assurance Framework	To develop risk nine with Lucy Dadge for 2020/21.	Lucy Branson	-	The revised strategic risks are provided at agenda item GB 20 072 and relevant risks have been discussed with the Chief Commissioning Officer.
03/06/2020	GB 20 027	Accountable Officer and Clinical Leaders' Report	To draft a letter expressing appreciation of the work undertaken by all colleagues and providers during the response to the Covid-19 pandemic.	Amanda Sullivan	-	Letters have been sent to all ICS system partners and CCG's member GP practices.
03/06/2020	GB 20 034	Performance Report	Stuart Poynor to develop a more current performance report, which reflects Covid-19 impacts on performance, for presentation at the August Governing Body meeting.	Stuart Poynor	-	On this agenda under item GB 20 066.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Bodies (Open Session)	**Date:**	05 August 2020
Paper Title:	Governing Body Work Programme	**Paper Reference:**	GB 20 058
Sponsor:	Rosa Waddingham, Chief Nurse	**Attachments/ Appendices:**	A: 2020/22 Governing Body Work Programme
Presenter:	Lucy Branson, Associate Director of Governance		

Summary Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

Executive Summary			
The purpose of this report is to present an initial work programme for the Governing Body for review and approval.			
Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Establishment of a Strategic Commissioner	☒
Financial Management	☒	Wider system architecture development (e.g. ICP, PCN development)	☒
Performance Management	☒	Cultural and/or Organisational Development	☒
Strategic Planning	☒	Procurement and/or Contract Management	☒

Conflicts of Interest:
☒ No conflict identified

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.

Risk(s):
No risks are identified within this report.
Confidentiality:
☒No

Recommendation(s):
The Governing Body s requested to: 1. **APPROVE** its initial 2020/22 Work Programme, with a further iteration to be presented to the 7 October 2020 meeting.

Governing Body Work Programme

1. Introduction

The purpose of this report is to present an initial work programme for the Governing Body for review and approval.

Due to the need to prioritise the CCG's response to the COVID-19 pandemic, there has been a delay in developing the work programme for this year, therefore it is proposed that the work programme covers the remainder of 2020/21 and also incorporates 2021/22 to enable consideration of a full business cycle.

The work programme will be subject to further review by the Executive Management Team over the coming weeks to ensure that it accurately captures all reporting requirements. It will continue to be reviewed on a regular basis throughout the period covered.

2. Background Information

Good governance practice dictates that Boards and Committees should be supported by a work programme, which sets out a coherent cycle of business for the next year of meetings. The Work Programme is a key mechanism to ensure appropriately timed governance oversight, scrutiny and transparency in a way that doesn't place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

3. Meeting Schedule

Formal meetings of the Governing Body will be held on a bi-monthly basis, during the first week month on a Wednesday morning. The meetings are scheduled for April, June, August, October, December and February.

The continued avoidance of face-to-face meetings is one of the ongoing measures to limit the spread of COVID-19. Therefore, Governing Body meetings will continue to be held virtually until further notice. In the interests of openness and transparency, all open sessions of the Governing Body will be held via the Zoom application to allow members of the public to watch proceedings.

4. Work Programme

4.1 The proposed work programme for 2020/22 is attached at **Appendix A**. This has been designed around the following key areas to support good governance:

a) Strategy and Leadership

b) Financial Stewardship

c) Quality and Performance

d) Corporate Assurance

The work programme will be subject to change throughout the year, but will steer agenda planning going forward. It will also drive the work programmes for the Governing Body's committees, which will be aligned to the Governing Body's work programme to ensure effective upward reporting.

4.2 In addition to the specific papers detailed within the work programme, the Governing Body will also:

a) Routinely consider the registered and declared interests of members of the Governing Body at the start of each meeting in common.

b) Receive minutes from the previous meeting, along with updates against an on-going log of agreed actions.

c) Receive highlight reports from the Governing Body's committees in order to demonstrate that delegated responsibilities are being effectively discharged. These reports summarise the key strategic discussions and approvals made by each committee in the intervening months and allow the committee to escalate any areas of concern. Each committee will also present a committee effectiveness report at financial year-end. Ratified minutes of the Governing Body's committees will also be routinely received for information and to ensure completeness of reporting.

d) Receive updates from key strategic partnership forums, including the Nottingham and Nottinghamshire Integrated Care System Partnership Board and the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.

e) Approve investment and disinvestment proposals and contract awards in line with the thresholds set out in the CCG's Standing Financial Instructions.

f) Progress specific strategic commissioning programmes (e.g. NHS Rehabilitation Centre, Tomorrow's NUH, Collaborative and Integrated Commissioning).

5. Development Sessions

In order to support the continued effectiveness of the Governing Body, development sessions will be scheduled for the months in between the formal meetings.

Discussions are currently on-going to finalise the approach to these sessions to ensure that they are utilise to best effect. The proposed topics, which are anticipated to be a combination of developmental sessions and topic-based strategic discussions, will be brought to the 7 October 2020 meeting for formal endorsement.

6. Recommendations

The Governing Body is asked to **APPROVE** its initial 2020/22 Work Programme, with a further iteration to be presented to the 7 October 2020 meeting.

Lucy Branson
Associate Director of Governance

August 2020

Appendix A – 2020/22 Governing Body Work Programme

Please Note: All reporting timeframes are currently indicative and subject to review and confirmation.

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Strategy and Leadership										
Accountable Officer and Joint Clinical Leaders' Report To receive routine updates on pertinent strategic and leadership areas from the Accountable Officer and Joint Clinical Leaders	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Organisational Priorities To provide an update on the delivery of the organisational priorities for 2020/21 (as approved by the Governing Body in June 2020). To present the organisational priorities for 2021/22 and provide a subsequent delivery update.		✓			✓			✓		
Annual Commissioning Plan To present the CCG's annual commissioning plan for consideration and approval in line with the CCG's statutory duty to prepare and publish a commissioning plan before the start of each financial year. *Note: Reporting requirements will be reflected once known, following publication of national requirements.*										
Commissioning Strategy 2020-2022 To provide an update on progress in delivering the 2020-2022 Commissioning Strategy. This will provide assurance in relation to the CCG's duty to reduce inequalities of access and inequalities of outcomes for the Nottingham and Nottinghamshire population. To present a refreshed commissioning strategy for consideration and approval.			✓						✓	

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Financial Strategy 2019-2024 To provide an update on progress in delivering the 2019-2024 Financial Strategy. To present a refreshed financial strategy for consideration and approval.					✓					
People Strategy 2019-2021 To provide an update on progress in delivering the 2019-2021 People Strategy. To present a refreshed people strategy for consideration and approval.				✓						✓
Organisational Development Strategy 2019-2021 To provide an update on progress in delivering the 2019-2021 Organisational Development Strategy. To present a refreshed organisational development strategy for consideration and approval.				✓						✓
Quality Strategy 2019-2022 To provide an update on progress in delivering the 2019-2022 Quality Strategy. To present a refreshed quality strategy for consideration and approval.		✓						✓		
Communications and Engagement Strategy 2019-2021 To provide an update on progress in delivering the 2019-2021 Communications and Engagement Strategy. To present a refreshed communications and engagement strategy for consideration and approval.				✓						✓

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Health and Wellbeing Strategies To present an update on progress in delivering the Nottingham City and Nottinghamshire Joint Health and Wellbeing Strategies. This will provide assurance in relation to the CCG's statutory duty to contribute to the delivery of any joint health and wellbeing strategy.			✓						✓	
Joint Strategic Needs Assessments To present an annual assurance report on compliance with the CCG's statutory duties relating to the Joint Strategic Needs Assessments.		✓						✓		
Merger Benefits Realisation Report To present a report demonstrating realisation of the benefits of CCG merger.				✓						
Financial Stewardship										
Finance Report To provide a routine update on the CCG's financial position and compliance with statutory financial duties.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2021/22 Financial Plan and Opening Budgets To present the 2021/22 Financial Plan and Opening Budgets for consideration and approval.					✓					
Quality and Performance										
Performance Report To provide a routine update on the performance of commissioned services (NHS Constitution Standards, other national and local requirements).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Report To provide a routine update on the quality of commissioned services (patient safety, patient experience and clinical effectiveness).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Patient and Public Involvement To provide an annual assurance report on compliance with the CCG's statutory duties relating to patient and public involvement.					✓					
Public Sector Equality Duty To present an annual assurance report on compliance with the general public sector equality duty. This will include information relating to the establishment and delivery of the CCG's equality objectives.				✓						✓
Research, Evidence and Evaluation To present an annual assurance report on compliance with the CCG's statutory duties relating to research and the use of evidence.						✓				
Safeguarding Adults and Children To present the Annual Reports of the Adults and Children's Safeguarding Boards for consideration and assurance.		✓						✓		
Learning Disability Mortality Review (LeDeR) Annual Report To provide an update on the implementation, progress and learning from the Learning Disabilities Mortality Review (LeDeR).	✓						✓			
Corporate Assurance										
CCG Constitution and Governance Handbook To present the outcome of an annual review of the CCG's Constitution and Governance Handbook. This will include a review of committee effectiveness.					✓					
Governing Body Assurance Framework To present the opening, mid-year and year-end positions of the Governing Body Assurance Framework. This will include annual approval of the CCG's strategic risks.	✓	✓			✓			✓		

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Corporate Risk Report To present routine updates in relation to all major risks to ensure that the Governing Body is kept informed of the management actions in place to mitigate the risks.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Workforce Report To present a regular workforce report, which will report on performance against a range of Governing Body approved workforce indicators.		✓	✓			✓			✓	
Staff Survey Report To present the results of the CCG's annual staff survey and the associated action plan.				✓						✓
Health and Safety To present an annual report on the CCG's compliance with relevant health and safety legislation.			✓						✓	
Information Governance To present an annual assurance report on the effectiveness of the CCG's information governance arrangements. This will include the Information Governance Management Framework for approval.		✓						✓		
Emergency Preparedness, Resilience and Response (EPRR) To provide an annual assurance report on the CCG's compliance with the EPRR Core Standards.			✓						✓	
Policy Approvals										
Equality, Diversity and Inclusion Policy To present the Equality, Diversity and Inclusion Policy for consideration and approval.	✓									

Agenda Item/ Purpose	2020/21				2021/22					
	5 Aug	7 Oct	2 Dec	3 Feb	7 Apr	2 Jun	4 Aug	6 Oct	1 Dec	2 Feb
Risk Management Policy To present the Risk Management Policy for consideration and approval. This will include consideration and approval of the CCG's risk appetite.	✓									
Raising Concerns (Whistleblowing) Policy To present the Raising Concerns (Whistleblowing) Policy for consideration and approval.			✓							
Managing Conflicts of Interests Policy To present the Managing Conflicts of Interests Policy for consideration and approval.						✓				
Gifts, Hospitality and Sponsorship Policy To present the Gifts, Hospitality and Sponsorship Policy for consideration and approval.						✓				

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Bodies (Open Session)	**Date:**	05 August 2020

Paper Title:	Accountable Officer and Clinical Leader Report	**Paper Reference:**	GB 20 059

Sponsor: **Presenter:**	Amanda Sullivan, Accountable Officer Amanda Sullivan, Accountable Officer	**Attachments/ Appendices:**	A: Summary of Committee Roles and Responsibilities B: Quarterly Communications and Engagement Dashboard

Summary Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary			
The purpose of the Accountable Officer and Clinical Leader Report is to summarise recent local and national developments and areas of interest for Clinical Commissioning Groups and the wider NHS. As appropriate, the report may also include specific items requiring approval or for noting by Governing Body members.			
Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Establishment of a Strategic Commissioner	☒
Financial Management	☐	Wider system architecture development (e.g. ICP, PCN development)	☒
Performance Management	☐	Cultural and/or Organisational Development	☐
Strategic Planning	☒	Procurement and/or Contract Management	☐
Conflicts of Interest:			
☒ No conflict identified			

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.

Risk(s):
No risks are identified within this report.
Confidentiality:
☒No
Recommendation(s):
The Governing Body s requested to: 1. **RECEIVE:** the Accountable Officer and Clinical Leader Report for information. 2. **APPROVE:** the proposed changes to the terms of reference for the re-named Finance and Resources Committee.

Accountable Officer and Clinical Leader Report

COVID-19 Response

1. Current Incident Status

Prevalence – Over the seven days to 27 July, 48 pillar 1 and pillar 2 lab-confirmed cases were reported for our population, compared to 46 in the previous seven days. We are now seeing very low levels of new cases locally and these are isolated to discrete postcodes and even households, these are being identified, investigated and managed through the Local Resilience Forum's Outbreak Cell led by the Directors of Public Health. A prevalence survey from the Office for National Statistics tested more than 30,000 participants in households across England. They found that on average for the week commencing 13 July, one in 2,000 people in the community (excludes hospitals and care homes) had COVID-19 and one in 19,000 individuals became newly infected in this week**.**

Antibody Testing – All NHS staff have now been offered, and where requested received, an antibody test including General Practice coordinated through the Strategic Testing Cell, which is hosted by the CCG. Social care staff antibody testing will commence during August and will include care home staff and domiciliary care workers. Liaison is ongoing with regard to the delivery plan with both Local Authorities. Between Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust 21,411 staff antibody tests were performed between 29 May and 26 July.

Mobile Testing Units – As of 31 July, the Mobile Testing Units that have previously been delivered by the military will be delivered by private providers. A Regional Coordination Group has been established that meets weekly in order to oversee and coordinate these units across the East Midlands and a forward plan of three weeks is in progress. A rolling programme of Mobile Testing Unit placement will commence from 10 August across each District and Borough footprint whilst Nottingham and Nottinghamshire remains in steady state.

Care Homes – During the deployment of the National Testing Programme, we have coordinated the implementation of the programme of testing and facilitated, where needed, access to assisted swabbing through our colleagues in Nottinghamshire Healthcare NHS Foundation Trust and Nottingham CityCare Partnership. To date over 13,000 care home staff and over 8,000 care home residents have received antigen testing and this has now moved to a rolling programme of testing care home residents every 28 days and care home staff every seven days in line with the National Testing Strategy.

Personal Protective Equipment (PPE) – Over the last four months we have secured and delivered more than 2.5 million pieces of PPE across General Practice, and for recipients of personal health budgets, with support from volunteer delivery drivers. The supply chain has now stabilised and General Practice is steadily moving towards a recovered position whereby they directly order PPE.

Incident Control – The Incident Control Centre has now stepped back to operating five days per week in line with NHS England/Improvement guidance.

2. Restoration and recovery of services

Work continues to restore services to pre-COVID-19 levels. All partners have developed restoration plans that address the need to mitigate the risk to patients by bringing all services back on line as soon as practicable, whilst keeping patients and colleagues safe from COVID-19; and maintaining colleagues' health and wellbeing by ensuring they have adequate rest and recuperation after a challenging four months. During phase 1 of the incident, there have been some changes to service delivery that the system will retain – e.g. use of technology to support virtual consultations, changes to the discharge pathway.

The system has agreed priorities for restoration as follows:

- Patients feel confident to access primary care as appropriate and in a timely manner.
- Embedding the change in public and clinician behaviours so that care is accessed and delivered in the most clinically appropriate setting.
- Sufficient capacity is available for the predicted increase in non-elective admissions (COVID and non-COVID).
- Flow is maintained through the system recognising that the impact on community and social care services is after peaks are seen in acute care.
- Continued access to time – critical urgent services (for surgical services, the Royal College of Surgeons prioritisation has been used as a guide).
- Phased safe return of routine services.
- Staff continue to be alert to safeguarding issues for both adults and children, particularly as lockdown is lifted.

A rapid assessment has also been completed to look at what we can do quickly to support those with a mental health condition to cope during and after COVID-19.

The headline position is:

- For the week commencing 6 July, non-elective admissions at Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust have been at 91% of 2019 levels for the same week.
- Outpatient activity continues to increase, albeit slowly – this is at approximately 60% of pre-COVID levels for first attendances and 70-75% for follow-up attendances at both Trusts; focused work is underway to ensure that the move to non-face to face appointments is maintained, where appropriate.
- Elective and day case activity is at approximately 60% of pre-COVID levels.
- Referrals to secondary care are increasing, with cancer two-week wait referrals at approximately 80% of pre-COVID levels.
- Use of independent sector capacity continues to support the delivery of time critical surgery and the gradual increase of routine surgery.

Diagnostic capacity remains a rate limiting factor for service restoration; a diagnostic work stream and detailed demand and capacity model are being developed.

A letter outlining the national requirements for the remainder for 2020/21 is currently awaited.

3. Local outbreak control planning

On 1 July 2020, Nottingham City Council and Nottinghamshire County Council launched their respective Local Outbreak Control Plans which form part of the Government's commitment to enable upper tier local authorities to develop local strategies to reduce, suppress and contain future outbreaks of COVID-19. Recent publication of Pillar 2 data (testing within the wider population) put together with the Pillar 1 data (testing of health and care workers) will give a better picture about the whole number of infections in communities. This will help inform plans to manage local outbreaks or advise the public on the best course of action to take.

On 17 July 2020, the Government published their COVID-19 contain framework: a guide for local decision-makers, which sets out how national and local partners will work with the public at a local level to prevent, contain and manage outbreaks, which has clarified responsibilities between local and national decision making.

For the majority of areas, local community spread will largely be manageable within local COVID-19 arrangements, as has been the case during the national lockdown. However, depending on the prevalence and progression of the virus local systems will be designated into three 'escalation' categories which would enable specialist expertise and resource to be drawn down from regional and national levels to augment the local systems:

- Areas of concern – a watch list of areas with the highest prevalence, where the local area is taking targeted actions to reduce prevalence – for example additional testing in care homes and increased community engagement with high risk groups.
- Areas of enhanced support – areas at medium/high risk of intervention where there is a more detailed plan, agreed with the national team and with additional resources being provided to support the local team (e.g. epidemiological expertise, additional mobile testing capacity).
- Areas of intervention – where there is divergence from the measures in place in the rest of England because of the significance of the spread, with a detailed action plan in place, and local resources augmented with a national support.

4. COVID-19 rehabilitation service

On the 72nd anniversary of the establishment of the NHS (5 July 2020), NHS England launched an online COVID-19 rehabilitation service to support people who are suffering long-term effects of the coronavirus. Nurses and physiotherapists will respond to patients' needs either online or over the phone as part of the service. The new 'Your COVID Recovery' service forms part of NHS plans to expand access to COVID-19 rehabilitation treatments for those who have survived the virus, but still have problems with breathing, mental health problems or other complications. Further information can be found here.

5. Understanding the impact of service delivery changes

The CCG and our partner NHS organisations have made changes to the way services are delivered during the COVID-19 pandemic. Some of these changes have the potential to transform the way we provide healthcare. We are currently undertaking a programme of research and engagement to understand the impact of these changes on our population.

This work involves a large scale survey of the Nottingham and Nottinghamshire population; a series of interviews and focus groups with people who are mostly well; people with long term health conditions; and people with multiple long-term health conditions. Targeted engagement is also taking place with our most vulnerable communities and those facing the greatest barriers to accessing services. The programme will produce interim results in August 2020, with a final report due in October 2020. Click here to participate in the survey.

6. New scheme for Nottingham's rough sleepers

In March the Government launched the 'Everyone In' scheme to help get rough sleepers off the streets and into temporary accommodation during lockdown. Nottingham City Council worked with partners to respond quickly and supported more than 180 rough sleepers in two hotels in the city. The majority of the rough sleepers have been supported to move on with Nottingham City Council's Housing Aid team working with partners to re-home those who were in temporary accommodation. So far, long-term accommodation has been found for 36 people, who, prior to the pandemic, were sleeping rough.

Following on from this positive work, the Nottingham City Integrated Care Partnership (ICP) is working together with local partners, including Emmanuel House, to establish a new service to ensure that when someone is provided with a home, they don't lose contact with the services that can help to settle them into their new home and provide on-going physical and mental health care. More information can be found here.

7. Vulnerable staff assessments

As an employer, the CCG has a legal duty to protect the health, safety and welfare of our staff and completing risk assessments for at-risk members of staff during this challenging period is a vital component of this.

The CCG continues to proactively support our members of staff who are particularly vulnerable, including those who are shielded, those from black, Asian and minority ethnic (BAME) backgrounds, and those with other risk factors.

A summary of the risk assessments that have been conducted to date is set out in the table below. The key mitigation is that the vast majority of staff are working from home. If staff are required to attend a place of work, then these have all been COVID secured and social distancing is observed. Staff are also provided with PPE where this is appropriate.

Metric	CCG Review
Number of staff risk-assessed and percentage of whole workforce.	To date, 286 employees have been risk assessed (62% of the employed workforce)
Number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workforce.	100% of employed BAME staff have been risk assessed (36). This equates to 13% of the total risk assessments and 8% of the employed workforce.

Metric	CCG Review
Percentage of staff risk-assessed by staff group	Based on national guidance from NHS Employers and from the Faculty of Occupational Medicine, the following additional staff groups have been risk assessed: • 100% of pregnant employees • 100% of employees aged 16-25 and 60+ • 98% of employees who identified a long term condition at the start of the pandemic • 84% of employees with a declared disability on the Electronic Staff Record (ESR) • 60% of male employees

National and Local Updates and Developments

8. Extension of the flu vaccination programme

As part of the Government's planning to relieve winter pressures on the health system, the flu vaccination programme will be widened to include free vaccinations for people aged between 50-64 once vaccination of the most 'at risk' groups has commenced. Vaccinations will also be available to Year 7 school pupils and to people in the household of a shielded patient.

9. 111 First

As part of the Government's winter planning preparations, and in response to retaining some of the good practice from the COVID-19 pandemic, a new pathway, which requires patients with non-life threatening conditions to call NHS 111 before attending accident and emergency services, is currently being piloted nationally. The initiative will support more patients to access help for urgent, but not life threatening, conditions through booked appointments in primary care, pharmacy, community services and other alternatives in a bid to prevent overcrowding in emergency departments and prevent hospital acquired infection by ensuring patients do not congregate together in emergency department waiting rooms. 111 First will also be able to book patients directly into appointments/time slots in the hospital emergency departments and to other urgent specialist rapid assessment units in hospital.

A Midlands-wide Programme Board will oversee the development of the programme and Nottingham has established a Programme Board to deliver the change, with representation from our acute trusts, community providers, primary care and commissioners. Key to the development of the programme is a clear communications and engagement strategy, not least of all with our public and patients. The Programme Board will also oversee the

development of a capacity and demand model, develop digital solutions and ensure clinical pathways are designed to support patients safely. The aim is for 111 First to 'go live' by 1 December 2020.

10. NHS Rehabilitation Centre

Following approval at an extra-ordinary meeting of the CCG's Governing Body on 21 July, the CCG has launched an eight week consultation on the development of an NHS Rehabilitation Centre on the Stanford Hall Rehabilitation Estate. The consultation will run until 18 September. It follows two periods of patient engagement during 2019 and seeks the views of the public on the proposal to transfer existing rehabilitation services to the proposed new site.

The consultation document is available online here. People can share their views via an online survey or by attending an online engagement event.

11. GP Patient Survey 2020

The GP Patient Survey is an England-wide survey providing practice level data about patients' experiences of their GP practices. It is a survey undertaken on behalf of NHS England and fieldwork for the survey was undertaken between January and March this year. Headline figures from the survey found that 83% of patients in the CCG's area who responded described their overall experience of their GP as good, compared to a national average of 82%. Our patients also found it slightly easier to get through to their GP practice and then make an appointment than the national average. The detailed results will be scrutinised by the CCG's Primary Care Commissioning at a forthcoming meeting.

12. CCG Governance Handbook

The CCG's Governance Handbook includes the terms of reference for each of the Governing Body's appointed committees and the CCG's Scheme of Reservation and Delegation. The Governance Handbook was approved by the Governing Body in April 2020, with a small number of further additional duties to some of the Committee terms of reference subsequently approved in June 2020.

Since this time, discussions have taken place in relation to the role and responsibilities of the Finance and Turnaround Committee. As a result it is proposed that this committee broadens its remit to include oversight and assurance role for a number of areas relating to the CCG's corporate role, as set out in the table below.

In light of the above, it is also proposed to change the name of the committee to the Finance and Resources Committee.

A summary of all committee roles and responsibilities is provided at **Appendix A**.

Committee	Proposed additional duties
Finance and Resources Committee	• Oversee the development and implementation of the CCG's Workforce Strategy, including establishment of, and monitoring performance against, a set of key workforce

	indicators. • Oversee the development and implementation of the CCG's equality improvement plan in relation to Goals 3 and 4 of the NHS Equality Delivery System (empowered, engaged and included staff / inclusive leadership at all levels) and delivery of associated equality objectives. • Oversee arrangements for responding to the views and experiences of the CCG's workforce, as highlighted by the annual staff survey. • Oversee the development and implementation of the CCG's Organisation Development Strategy. • Oversee the development and implementation of the CCG's Information Management and Technology Strategy. • Oversee the development of the CCG's Green Plan and monitor and scrutinise progress in its delivery.

Members of the Governing Body are requested to:

- **APPROVE** the proposed changes to the terms of reference for the re-named Finance and Resources Committee.

13. Predecessor CCGs' 2019/20 Annual Reports and Accounts

The 2019/20 Annual Reports and Annual Accounts for the six predecessor Nottingham and Nottinghamshire CCGs have been published on the CCG's website in line with the Department of Health reporting requirements. The Annual Reports provide in-depth reviews of the predecessor CCGs' financial accounts and an analysis of their performance, including details of their challenges and achievements during 2019/20. The Annual Reports and Accounts can be accessed here

Arrangements for the CCG's 2019/20 Annual Public Meeting are currently being developed.

14. Quarterly Communications and Engagement Dashboard

Attached at **Appendix B** is a Quarterly Communications and Engagement Dashboard for the first quarter of 2020/21. The report provides an overview of the communications and engagement activity that has been delivered during the period, which has been extended by one month to allow for the lapse in reporting.

Reports will follow on a monthly basis and develop over time to present the information and data in a succinct and easy to read format. At the end of the second quarter we will review the frequency and seek feedback on the report to ensure it provides the appropriate level of detail to the Governing Body.

Partnership Updates

15. Nottinghamshire Health and Wellbeing Board

Councillor Steve Vickers has resigned from his role as Chair of the Nottinghamshire Health and Wellbeing Board. Councillor Tony Harper will take over as the new Chair. The Board is due to meet virtually on 24 July 2020.

Amanda Sullivan	**Dr Stephen Shortt**	**Dr James Hopkinson**
Accountable Officer	**Joint Clinical Leader**	**Joint Clinical Leader**

August 2020

Appendix A – Summary of Committee Roles and Responsibilities

Committee		Role/Responsibilities
Audit and Governance Committee *Chair: Sue Sunderland*	**Type:** Statutory **Focus:** Internal **Purpose:** Scrutiny and Assurance	• Internal audit, external audit, counter fraud • Risk management and incident management • Probity arrangements • Annual report and accounts • Information governance • Health and safety • EPRR and business continuity arrangements • Statutory and mandatory training compliance
Remuneration and Terms of Service Committee *Chair: Jon Towler*	**Type:** Statutory **Focus:** Internal **Purpose:** Decision-making	• Remuneration, fee, allowances, contractual terms (non-A4C) • Termination and special payments (incl. redundancy, severance) • Human resources policies • Gender pay gap
Primary Care Commissioning Committee *Chair: Eleri de Gilbert*	**Type:** Statutory **Focus:** External **Purpose:** Decision-making	• Decisions on delegated functions (incl. commissioning, procurement and management of GMS, PMS and APMS contracts, enhanced services, practice mergers and closures, discretionary payments, premises costs directions) • GP Forward View • Primary Care Network (PCN) delivery
Quality and Performance Committee *Chair: Eleri de Gilbert*	**Type:** Non-Statutory **Focus:** External **Purpose:** Scrutiny and Assurance	• Quality and performance of commissioned services • Safeguarding vulnerable adults and children • Patient and public engagement • Equality, diversity and inclusion (relating to CCG role as commissioner)
Finance and Resources Committee *Chair: Shaun Beebe*	**Type:** Non-Statutory **Focus:** Internal **Purpose:** Scrutiny and Assurance	• Financial performance, QIPP and contract activity • Procurement decisions/ contract awards for non-healthcare contracts • Annual organisational priorities • Green Plan • Workforce and organisational development • Equality, diversity and inclusion (relating to CCG role as employer) • IM&T
Prioritisation and Investment Committee *Chair: Jon Towler*	**Type:** Non-Statutory **Focus:** External **Purpose:** Decision-making	• Commissioning decisions (new investments, recurrent funding allocations and decommissioning and disinvestment of services) • Procurement decisions/ contract awards for healthcare contracts • Evaluate return on investment (reduced health inequalities and improved health outcomes)
Patient and Public Engagement Committee *Chair: Sue Clague*	**Type:** Non-Statutory **Focus:** External **Purpose:** Advisory	• Feeding views of patients, carers, community groups into the CCG's decision-making processes

Nottingham and Nottinghamshire
Clinical Commissioning Group

Quarterly Communications and Engagement Dashboard

Quarter One - 2020

Highlights

This report provides an overview of the communications and engagement activity that has been delivered in Quarter One and has been extended by one month to allow for the lapse in reporting.

Reports will follow on a monthly basis and develop over time to present the information and data in a succinct and easy to read format.
At the end of the second quarter we will review the frequency and seek feedback on the report to ensure it provides the appropriate level of detail to the Governing Body.

Highlights from this slightly extended quarter (March – June)

MEDIA COVERAGE	Top stories- Our case study of a local woman who had treatment for a cancer diagnosis during lockdown featured in local and regional news as well as well as ITV and BBC. Urging public to be responsible ahead of lockdown easing also created good coverage in print and broadcast. During June the new team have been able to deliver an increased amount of proactive stories.
DIGITAL AND SOCIAL MEDIA	Numbers of people visiting the newly launched CCG website has more than doubled during Quarter One due to content being targeted and shared on our social media. Human interest stories driving people to the site. Stories generating good public interest include: Local keyworkers pulling together to free up beds for sickest Coronavirus patients. Videos increasing the reach of our posts on social media including the video entitled 'Stay at home'. Resulted in 24,393 Views.
INTERNAL - STAFF AND MEMBERSHIP	Introduced new channels to adapt to remote working and to improve two-way communication with colleagues and our leadership team. This includes a monthly virtual briefing with Q&A with an average attendance of 290. A weekly GP bulletin reaching on average 284 people. The introduction of a staff wellbeing pulse survey and 'wellbeing week' has received high praise from colleagues and will continue to be a priority.
ENGAGEMENT	NHS Rehabilitation Centre - On Monday 27 July the CCG launched an 8 week consultation on the development of an NHS Rehabilitation Centre. The con-sultation will run until 18 September. Recovery Insights Work - NHS organisations have made changes to the way services are delivered during the Covid-19 pandemic. Some of these changes have the potential to transform the way we provide healthcare. We are cur-rently undertaking a programme of research and engagement to understand the impact of these changes on our population

Media

MEDIA HIGHLIGHTS	
MARCH	Nicole Atkinson appeared on BBC East Midlands Today discussing how telephone and video consultations will be used to see patients in Primary Care.
APRIL	GP leaders urge patients not to ignore signs of cancer during coronavirus outbreak
MAY	Cancer survivor shares her story on getting treatment duing Covid
JUNE	GP case study: how GPs are operating following pandemic

Media summary

MARCH

PROACTIVE

Local GP Dr Jamie Parker did a rendition of 'Frozen', changing the lyrics to stay at home to encourage people to stay safe. This was picked up by Sky News, BBC Breakfast, Capital FM and Virgin FM.

Nicole Atkinson appeared on BBC East Midlands Today discussing how telephone and video consultations will be used to see patients in Primary Care.

Mansfield Woodhouse great-grandfather with emphysema urges everyone to follow Government advice – Mansfield Chad

REACTIVE

BBC Radio Nottingham query about John Ryle Medical Practice closure due to cleaning because of suspected case of coronavirus.

BBC Radio Nottingham query regarding whether Urgent Treatment Centre was closed

BMJ query regarding how single handed GP practices are coping with coronavirus. Full quote from Dr Manik Arora provided and included within piece.

Nottingham Post query regarding tweet calling out for visors to be made. GP statement provided:

APRIL

PROACTIVE

Easter: GP Practices and Pharmacy opening times Easter

Local keyworkers pull together to free up beds for sickest Coronavirus patients

Education sector supports the local NHS with gifts of protective equipment

GP leaders urge patients not to ignore signs of cancer during coronavirus outbreak – quote by Dr Thilan Bartholomeuz and both Trusts.

Local university engineers team up with NHS to develop vital face shield for keyworkers

REACTIVE

Query from BBC Nottingham about number of public sector workers off sick due to coronavirus. Information released via FOI.

Dr Jamie Parker appeared on BBC Breakfast for Q&A

MAY

PROACTIVE

Cancer survivor shares her story on getting treatment during Covid – CCG led on the story and linked in with NUH communications team to get the case study.

Mental health awareness week

Locality Director David Ainsworth and ICP Clinical Lead Thilan Bartholomeuz covered how to get a good night sleep during lockdown

REACTIVE

Care home closing due to Covid-19

Podiatry service being moved from Newark Hospital to a GP surgery in Carlton – Nottinghamshire Healthcare Trust and Sherwood Forest Hospitals Trust led response and issued statement in which we were sighted. Story not run.

Testing centre at Motorpoint arena

New hospital at the National Rehabilitation Centre

JUNE

PROACTIVE

Veterans delivering PPE throughout the pandemic

New Netherfield state-of-the-art GP opening

Dr James Hopkinson shared advice about how to stay safe in the sun during June's heatwave

Dr Phillips' practice at Radford Health Centre closed following her retirement

GP case study: how GPs are operating following pandemic – produced with a video and FAQ to respond to Healthwatch feedback that patients need more guidance on understanding what happens now in GP practices.

Ahead of lockdown easing, a press release was issued urging the public to be responsible

Announcement regarding plans to launch sexual violence survivor hub in Nottinghamshire

Service changes during Covid and launch of public survey

REACTIVE

Woman with brain tumour raising money

Number of GPs signing up to DES

RHR Medical Centre closing

ADHD services for adults

Digital Communications

Website

On April 1 2020, our new CCG website launched to reflect the six CCGs across Nottingham and Nottinghamshire becoming one new organisation.

	APRIL	MAY	JUNE
USERS	1,274	1,551	4,871
PAGE VIEWS	2,462	3,987	9,118

MOST VISITED PAGE	
APRIL	Local keyworkers pull together to free up beds for sickest Coronavirus patients
MAY	Cancer survivor's plea to people ignoring symptoms during coronavirus pandemic
JUNE	GP appointment guidance

Increase in users and page views due to content focusing on case studies and information related to the public.

Social media

As we are now one CCG for Nottingham and Nottinghamshire we have reflected this by having one social media channel per platform. Sharing stories about people who live and work in our patch, where appropriate using humour and videos have helped increase our engagement with our audience.

Twitter - 11.2k followers
@NHSNottsCCG

	APRIL	MAY	JUNE
TWEETS	172	139	132
IMPRESSIONS (Number of people the content reached)	444k	229k	92.2k

Facebook - 1,556 followers
NHSNottsCCG

	APRIL	MAY	JUNE
POSTS	139	131	130
ENGAGEMENT (Number of people that have shared, liked, or opened the post)	1,026	903	881

Instagram - 1,463 followers
@nhsnottsccg

	APRIL	MAY	JUNE
POSTS	15	52	60
ENGAGEMENT (Number of people that have shared, liked, or opened the post)	129	176	332

Since April 1 2020, we set up the CCG Instagram account to reach a new online audience. This account has continued to grow in popularity, with an increase in people following our account, and those actively engaging with our content.

Video

Videos are a simple way of sharing messages and engaging with our audience. During the peak of the pandemic we worked with system wide communications teams to create a video in 48 hours accompanied by a system lead communications plan, which proved incredibly popular.

YOUTUBE	
NEW VIDEOS	4
VIEWS	1,117

Together we are Notts

2080 Engagement
(Number of people that have shared, liked, or opened the post)

24,393 Views

Due to the popularity of the Together we are Notts video, we engaged with a wider digital audience that previously did not connect with the CCG's channels. This brought together communication partners across local organisations to collaborate and share widely.

Internal Communications

Internal communication channels:

Staying engaged with our staff has been vitally important during the pandemic when overnight the vast majority of people began working from home, in line with the government guidance.
We quickly adapted the frequency of existing channels to deliver key messages and information and implemented new methods to support our new way of working together. This has included daily editions of staff news, introducing video messages from members of our Executive Team and monthly exec virtual staff briefings.

February 27 - Present

Number of recipients
540

Emails sent
56

Average open rate
45%

Topics range from office closures, sharing information from our health partners across the system and staff wellbeing editions.

	MARCH	APRIL	MAY	JUNE
NUMBER OF BULLETINS	16	17	11	11
AVERAGE OPEN RATE	52%	45%	49%	42%

Wellbeing content

A key focus for staff content is wellbeing and so we introduced a weekly 'Wellbeing Wednesday' edition of staff news providing advice and tips on staying well, signposting to free NHS apps, gratitude and a wellbeing webinar. We organised a Wellbeing Week during June.This included daily events such as a virtual yoga session and the introduction of an exercise hour every Wednesday. This email campaign has been opened 1,634 times.

Staff feedback:

"Just to say … this is really positive thank you"

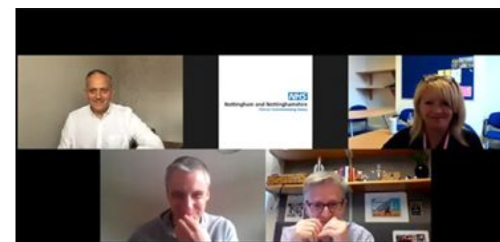
"I got a lot out of Helen's webinar and would find it really beneficial if there were to be more."

"It is obvious a lot of work will have gone into organising this for staff so I just wanted to say a huge thank you to you and your team. It is great."

Monthy staff briefings

Monthly Executive Team briefings provide opportunities for staff to put their questions directly to the team.

	APRIL	MAY	JUNE
NUMBER OF REGISTRANTS	290	294	282



Staff feedback:

"I've been really impressed with the internal communication and thought the videos have been good… I feel more connected at the moment to the organisation than ever before."

"I think the Zoom briefs are great and I hope they continue in some sort of electronic format going forward. The staff updates are regular and informative."

Membership

The pandemic has generated some positive results and in this instance has for example accelerated the Teamnet programme of work with our membership. We launched a COVID-19 CCG GP Bulletin on 16.03.20 which all practices have committed to viewing and sharing with their teams.

As we have moved into Phase 2 of the pandemic the bulletin has moved to weekly, with readership still continuing to remain at high levels.
Other channels introduced include Exec webinars held quarterly and weekly webinars led by the Primary Care Team to cover hot topics.

NUMBER OF BULLETINS	70
WEEKLY WEBINARS	15

Videos from executive team

Number of videos
12

Number of views
2,231

Engagement

NHS Rehabilitation Centre

On Monday 27 July the CCG launched an 8 week consultation on the development of an NHS Rehabilitation Centre on the Stanford Hall Rehabilitation Estate. The consultation will run until 18 September. It follows two period of patient engagement over 2019 and seeks the views of the public on the proposal to transfer existing rehabilitation services to the proposed new site.

The consultation document is available online at https://nottsccg.nhs.uk/rehab-centre-consultation/.

People can share their views via an online survey at https://www.surveymonkey.co.uk/r/NHS-RC or by attending an online engagement event via http://nhsrc.eventbrite.com/.

Recovery Insights Work

The CCG and other NHS organisations have made changes to the way services are delivered during the Covid-19 pandemic. Some of these changes have the potential to transform the way we provide healthcare. We are currently undertaking a programme of research and engagement to understand the impact of these changes on our population. This work involves:

- A large scale survey of the Nottingham and Nottinghamshire population, delivered by an independent social research agency
- A series of interviews and focus groups with people who are mostly well; people with long term health conditions and people with multiple long-term health conditions
- Targeted engagement with our most vulnerable communities and those facing the greatest barriers to accessing services.

The programme will produce interim results in August, with a final report due in October.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Equality, Diversity and Inclusion Policy	**Paper Reference:**	**GB 20 060**
Sponsor:	Rosa Waddingham – Chief Nurse	**Attachments/ Appendices:**	Appendix A: Equality, Diversity and Inclusion Policy
Presenter:	Rosa Waddingham – Chief Nurse		

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

Executive Summary

The CCG is committed to embedding equality, diversity and inclusion (EDI) considerations into our policy development, commissioning processes and employment practices, with the aim of:

- Improving equality of access to health services and health outcomes for the diverse population we serve.
- Building and maintaining a diverse, culturally competent CCG workforce, supported by an inclusive leadership team.
- Creating and maintaining an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

The purpose of this paper is to present the Equality, Diversity and Inclusion Policy for review and approval. The policy sets out how the CCG meets it statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 and how the CCG will work to achieve good equality performance outcomes. It also ensures that equality, diversity and inclusion considerations routinely underpin the CCG's governance structures and are actively promoted by the CCG's leadership team.

Policy Summary

The policy sets out:

- The legislative framework for equality, including key definitions that apply for the purpose of the policy.
- The roles and responsibilities of the Governing Body, its committees and for key individuals within the CCG.
- How the CCG's equality performance is assessed and equality improvement plans developed.
- Arrangements for identifying and monitoring the delivery of the CCG's equality objectives and for publishing relevant and proportionate equality information to demonstrate compliance with legislation.

Next Steps

The next steps are to:

- Publish and communicate the Equality, Diversity and Inclusion Policy to all staff.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☐
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item

Risk(s):

None stated

Confidentiality:

☒No
☐Yes (please indicate why it is confidential by ticking the relevant box below)

Recommendation(s):

1. APPROVE the Equality, Diversity and Inclusion Policy

Nottingham and Nottinghamshire
Clinical Commissioning Group

Equality, Diversity and Inclusion (EDI) Policy

2020 – 2023

Version:	**1.0**
Approved by:	**Governing Body**
Date approved:	**August 2020**
Date of issue (communicated to staff):	*To be completed*
Next review date:	**July 2023**
Document author:	**Equality, Diversity and Inclusion Co-ordinator**

CONTROL RECORD			
Reference Number *To be completed*	**Version** 1.0	**Status** Draft	**Author** Equality, Diversity and Inclusion Co-ordinator **Sponsor** Chief Nurse **Team** Nursing and Safeguarding
Title	Equality, Diversity and Inclusion (EDI) Policy		
Amendments	N/A		
Purpose	To set out how the CCG meets its statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations) and how the CCG will work to achieve good equality performance outcomes. It also ensures that EDI considerations routinely underpin the CCG's governance structures and are actively promoted by the CCG's leadership team.		
Superseded Documents	N/A		
Audience	All employees of the Nottingham and Nottinghamshire CCG (including all individuals working within the CCG in a temporary capacity, including agency staff, seconded staff, students and trainees, and any self-employed consultants or other individuals working for the CCG under contract for services), individuals appointed to the Governing Body and its committees and any other individual directly involved with responding to complaints and concerns from patients and members of the public.		
Consulted with	Quality and Performance Committee		
Equality Impact Assessment	Completed July 2020		
Approving Body	Governing Body	**Date approved**	5 August 2020
Date of Issue	*To be completed*		
Review Date	July 2023		
This is a controlled document and whilst this policy may be printed, the electronic version available on the CCG's document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.			

NHS Nottingham and Nottinghamshire CCG's policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Communications Team at ncccg.team.communications@nhs.net

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1. Introduction

1.1. NHS Nottingham and Nottinghamshire Clinical Commissioning Group (hereafter referred to as 'the CCG') is committed to embedding equality, diversity and inclusion (EDI) considerations into all aspects of our work, including policy development, commissioning processes and employment practices.

1.2. We aim to:

- Improve equality of access to health services and health outcomes for the diverse population we serve.
- Build and maintain a diverse, culturally competent CCG workforce, supported by an inclusive leadership team.
- Create and maintain an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

2. Purpose

2.1. This policy sets out how the CCG meets its statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations) and how the CCG will work to achieve good equality performance outcomes. It also ensures that EDI considerations routinely underpin the CCG's governance structures and are actively promoted by the CCG's leadership team.

2.2. A summary of the legislative framework for equality is provided at **Appendix A**.

2.3. It should be noted that this policy focuses specifically on the duties set out in the Equality Act and its associated regulatory requirements and not on the statutory health inequality duties placed on the CCG by the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Whilst these duties are linked, it is important to appreciate that they are distinct duties and recognise the difference in requirements.

3. Scope

3.1. This policy applies to all employees and appointees of the CCG and any individuals working within the CCG in a temporary capacity (hereafter referred to as 'individuals').

4. Definitions

4.1. The following key definitions apply for the purposes of this policy:

Term	Definition
Equality	Equality is about ensuring everybody has equal access to opportunities in line with their needs and protecting them from being treated differently or discriminated against because of their characteristics.
Diversity	Diversity is about recognising and respecting the differences between people and groups of people, and placing a positive value on those differences.
Inclusion	Inclusion refers to an individual's experience within their workplace and in wider society, and the extent to which they feel valued and included.

4.2. Descriptions of the key terms used in the legislative framework for equality are provided at **Appendix A**, including definitions of the nine characteristics protected by the Equality Act 2010.

5. Roles and responsibilities

Role	Responsibilities
Governing Body	All Governing Body members have a collective and individual responsibility for ensuring compliance with the public sector equality duty, which will in turn secure the delivery of successful equality outcomes for the organisation, both as a commissioner and an employer. The Governing Body is required to provide strategic leadership to the EDI agenda, which is in part achieved through its approval of this policy, and also by: a) Agreeing the CCG's objectives for improving its equality performance and monitoring their delivery. b) Ensuring that EDI is a core consideration in Governing Body and committee discussions and decisions. c) Leading by example by actively championing the EDI agenda and attending staff forums and meetings of patient and community groups.
Quality and Performance Committee	The Quality and Performance Committee is responsible for monitoring the CCG's equality performance in relation to its role as a commissioner of health services. This includes monitoring the delivery of the CCG's equality

Role	Responsibilities
	improvement plan in relation to Goals 1 and 2 of the NHS Equality Delivery System (see section 7 of this policy).
Finance and Resources Committee	The Finance and Resources Committee is responsible for monitoring the CCG's equality performance in relation to its role as an employer. This includes monitoring the delivery of the CCG's equality improvement plan in relation to Goals 3 and 4 of the NHS Equality Delivery System (see section 7 of this policy).
Prioritisation and Investment Committee	The Prioritisation and Investment Committee is responsible for making investment, disinvestment and resource allocation decisions. As part of this responsibility, the Committee ensures that appropriate equality impact assessments have been completed and their findings considered. This includes consideration of the collective impact of previous decisions and current and future proposals.
Remuneration and Terms of Service Committee	The Remuneration and Terms of Service Committee is responsible for overseeing compliance with the gender pay gap requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.
Accountable Officer	The Accountable Officer has responsibility for ensuring that the necessary resources are available to progress the EDI agenda within the organisation.
Chief Nurse	The Chief Nurse, as the CCG's executive lead for the EDI agenda, will work with executive colleagues to: a) Develop and monitor the implementation of robust working practices that ensure that EDI requirements are an integral part of the commissioning cycle. b) Ensure that EDI considerations are effectively embedded within human resources working practices. c) Ensure that the CCG's Governing Body and staff remain up to date with the latest thinking around diversity management and have access to appropriate resources, advice and informal and formal training opportunities.
Line Managers	All line managers have responsibility for: a) Ensuring that the CCG's recruitment and retention processes relating to the advancement of equality of opportunity are applied consistently to all grades

Role	Responsibilities
	throughout the organisation. b) Ensuring that employees have equal access to relevant and appropriate training and development opportunities. c) Highlighting any staff training needs arising from the requirements of this policy and associated procedures.
Individuals	All individuals have responsibility for treating everyone with dignity and respect and must not discriminate or encourage others to discriminate.

6. Having due regard to equality

6.1 An assessment of the CCG's functions, both as a commissioner of health services and as an employer, has identified the key business activities where due regard to the general public sector equality duty is required.

6.2 Focussing on the key business activities set out at paragraphs 6.3 to 6.8 below (as a minimum) helps the CCG to prioritise effort to ensure compliance with the general equality duty.

6.3 **Assessing the health needs of our population** – It is essential for the CCG to fully understand the health needs of the population we serve. This is done is by producing Joint Strategic Needs Assessments (JSNAs) in conjunction with our Local Authorities. The JSNAs identify where inequalities exist and describes the future health and wellbeing needs of Nottingham and Nottinghamshire's population.

The CCG will work with Local Authority Public Health colleagues to ensure that JSNA chapters consider all protected characteristic and other disadvantaged groups to accurately inform equality considerations in the CCG's commissioning intentions.

6.4 **Public engagement and communications** – The CCG is committed to putting the voice of patients and the public at the heart of our commissioning activities. This includes involving people in how decisions are made, how services are designed and how they are reviewed. The CCG is also committed to continuing to improve communications with local people.

The CCG will:

- Engage with people from all protected characteristic groups (and other disadvantaged groups) in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms to ensure that we have the right information to commission the right health services that can be accessed by the people who need them.

- Deliver targeted and tailored messaging that reaches the right people more effectively.

6.5 **Equality impact assessments** – The completion of equality impact assessments is central to being a transparent and accountable organisation. Equality analyses ensure that we do not disadvantage people from protected characteristic and other disadvantaged groups by the way that we commission and change health services, or through our employment practices. They are also a way of making sure that any negative consequences are minimised or eliminated, and opportunities for promoting equality are maximised.

The CCG will complete equality impact assessments whenever we plan, change or remove a service, policy or function. These are completed through integrated equality and quality impact assessments (EQIAs) that also incorporate wider quality considerations (patient safety, patient experience and clinical effectiveness). EQIAs will be treated as 'live' documents and be revisited at key stages of scheme development and implementation, particularly following the conclusion of any patient and public engagement and consultation activities to inform decision-making.

6.6 **Procurement and contract management** – The CCG commissions health services for the local population from a range of NHS, independent and third sector providers and it is important for all associated procurement and contract management arrangements to incorporate appropriately equality considerations.

The CCG will include an assessment of compliance with equality legislation requirements as a routine aspect of all procurement exercises. The CCG will also use the national NHS Standard Contract, which in its full-length version mandates providers of NHS services to implement[1]:

- The NHS Equality Delivery System (see section 7 of this policy)
- The NHS Accessible Information Standard – an approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
- The NHS Workforce Race Equality Standard (WRES) – which requires providers of NHS services to demonstrate progress against nine indicators of workforce equality, including recruitment, training, harassment/bullying and levels of board representation by black and minority ethnic (BME) people.
- The NHS Workforce Disability Equality Standard (WDES) – a set of ten specific Metrics that enable providers of NHS services to compare the workplace and career experiences of disabled and non-disabled staff.

[1] These provisions do not apply to the shorter-form version of the NHS Standard Contract, which is typically used for commissioning lower value services with smaller providers.

A range of assurances on compliance with the above requirements are incorporated within the CCG's routine quality and performance monitoring processes.

6.7 **Recruitment, selection and the working environment** – The CCG is committed to developing a more representative workforce at all levels and to maintaining a working environment that promotes the health and wellbeing of our employees.

The CCG will operate a fair, inclusive and transparent recruitment and selection process and will maintain relevant workforce accreditations (e.g. Disability Confident Scheme) to help demonstrate that the CCG promotes equality of opportunity. The CCG will maintain a working environment that promotes the health and wellbeing of the whole workforce through a suite of human resources policies, which have been assessed from an equality perspective, and the establishment of staff groups/networks. The CCG will also implement the Workforce Race Equality Standard (WRES) and will work to the requirements of the Workforce Disability Equality Standard (WDES).

6.8 **Cultural competence** – All CCG staff are responsible for treating everyone with dignity and respect and must not discriminate or encourage others to discriminate. Consequently, it is a mandatory requirement for new staff to complete equality and diversity and human rights training as part of their induction and every three years subsequently (see section 10 of this policy).

To enhance the mandatory training requirements, the CCG will provide relevant training and development opportunities to staff with the aim of improving their cultural competence and their understanding of the needs of our diverse population.

7. Assessing our equality performance

7.1. The CCG has adopted the NHS Equality Delivery System (EDS) for assessing the organisation's equality performance.

7.2. The EDS is framed around 18 outcomes, grouped under four overarching goals, and it is against these outcomes that organisational performance is required to be assessed and action determined, where required.

Goal	Outcomes
Goal 1: Better health outcomes	• Services are commissioned, procured, designed and delivered to meet the health needs of local communities. • Individual people's health needs are assessed and met in appropriate and effective ways. • Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed. • When people use NHS services their safety is prioritised and

Goal	Outcomes
	they are free from mistakes, mistreatment and abuse. • Screening, vaccination and other health promotion services reach and benefit all local communities.
Goal 2: Improved patient access and experience	• People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds. • People are informed and supported to be as involved as they wish to be in decisions about their care. • People report positive experiences of the NHS. • People's complaints about services are handled respectfully and efficiently.
Goal 3: A represented and supported workforce	• Fair NHS recruitment and selection processes lead to a more representative workforce at all levels. • The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations. • Training and development opportunities are taken up and positively evaluated by all staff. • When at work, staff are free from abuse, harassment, bullying and violence from any source. • Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives. • Staff report positive experiences of their membership of the workforce.
Goal 4: Inclusive leadership	• Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations. • Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed. • Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

7.3. The outcome of the EDS assessment process will inform the development of an equality improvement plan for the CCG, which will be will be monitored by the Quality and Performance Committee (in relation to the CCG's role as a commissioner of health services) and the Finance and Resources Committee (in relation to the CCG's role as an employer.

8. Our equality objectives

8.1. The CCG will prepare and publish specific and measureable equality objectives at least every four years. This will help us to better perform against the three aims of the general equality duty by focusing attention on the priority equality issues within the organisation to deliver improvements in policies, commissioned services and employment.

8.2. When identifying the equality objectives, we will ensure that they are: specific; measurable; outcome-focused; and ambitious, yet realistically achievable.

8.3. For each equality objective, we will be explicit about:

- The policy, function or practice that it relates to
- The people that are affected
- The outcome the CCG is seeking to achieve
- Why the equality objective has been selected
- How success will be measured (qualitative as well as quantitative evidence can be used to measure progress)

8.4. The equality objectives will be approved and monitored by the Governing Body.

9. Communication, monitoring and review

9.1. The CCG will establish effective arrangements for communicating the requirements of this policy through the CCG's staff induction and internal communication Mechanisms. This will include ensuring accessibility of this policy on the CCG's website and staff intranet.

9.2. The implementation of this policy, and the effectiveness of the arrangements detailed within it, will be monitored by the CCG's Governing Body, primarily through the work of its Quality and Performance Committee and Finance and Resources Committee.

9.3. On an annual basis, following Governing Body consideration and approval, the CCG will publish relevant and proportionate equality information to demonstrate compliance with the general public sector equality duty. This will include information relating to the delivery of the CCG's equality objectives.

9.4. This policy will be reviewed every three years. Amendments and reviews will be undertaken as necessary to ensure best practice is in place and compliance with legislation is maintained.

9.5. Any individual who has queries regarding the content of this policy, or has difficulty understanding how this policy relates to their role, should contact the policy author.

10. Staff training

10.1. Training on equality and diversity and human rights will be completed by all individuals in line with the CCG's mandatory and statutory training and induction matrix.

10.2. Relevant individuals will also be trained on the CCG's Equality and Quality Impact Assessment requirements and the associated procedural guidance.

11. Equality and diversity statement

11.1. NHS Nottingham and Nottinghamshire CCG pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, both as a commissioner and as an employer.

11.2. As a commissioning organisation, we are committed to ensuring our activities do not unlawfully discriminate on the grounds of any of the protected characteristics defined by the Equality Act, which are age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

11.3. We are committed to ensuring that our commissioning activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, roma and travellers.

11.4. As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

11.5. To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy (**Appendix B**).

12. Interaction with other policies

12.1. This policy should be read in conjunction with the following CCG policies and procedures:

- Relevant HR Policies (e.g. Recruitment and Selection Policy; Acceptable Behaviours Policy; Flexible Working Policy; Learning, Education and Development Policy)
- EQIA Procedure

13. References

13.1. The following guidance was used in the development of this policy:

- The Equality Act 2010
- The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017
- The Human Rights Act 1998
- The Equality and Human Rights Commission: Advice and Guidance for the Public Sector
- A refreshed Equality Delivery System for the NHS (November 2013)

Appendix A: Summary of the legislative framework for equality

Part 1: The Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single legal framework with clear law to better tackle disadvantage and discrimination.
Nine characteristics are protected by the Act, as set out in Table 1 below.

The Act makes it unlawful to discriminate, harass or victimise a person or group of people because they have any of the protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic. The Act also requires that reasonable adjustments be made for disabled people.

- Discrimination means:
  - Treating one person worse than another because of a protected characteristic (known as **direct discrimination**); or
  - Putting in place a rule or policy or way of doing things that has a worse impact on someone with a protected characteristic than someone without one, when this cannot be objectively justified (known as **indirect discrimination**).
- **Harassment** includes unwanted conduct related to a protected characteristic which has the purpose or effect or violating someone's dignity or which creates a hostile, degrading, humiliating or offensive environment for someone with a protected characteristic.
- **Victimisation** is treating someone unfavourably because they have taken (or might be taking) action under the Equality Act or supporting somebody who is doing so.

The Act applies to Government departments, service providers, employers, education providers, providers of public functions, associations and membership bodies and transport providers.

Table 1 – The Nine Protected Characteristics

Age	For the purpose of the Act, this refers to a person with a particular age (for example, 32 year olds) or belonging to an age group. Age groups can be quite wide (for example, 'people over 50' or 'under 18s'). They can also be quite specific (for example, 'people in their mid-40s'). Terms such as 'young person' and 'youthful' or 'elderly' and 'pensioner' can also indicate an age group.
Disability	In the Equality Act, a disability means a physical or sensory impairment, a learning disability, or a mental condition that has a substantial and long-term impact on a person's ability to do normal day to day activities. For the purposes of the Act, these words have the following meanings:

Appendix A: Summary of the legislative framework for equality

	• 'Substantial' means more than minor or trivial. • 'Long-term' means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions). • 'Normal day-to-day activities' include everyday things like eating, washing, walking and going shopping. There are additional provisions relating to people with progressive conditions. People with HIV, cancer or multiple sclerosis are protected by the Act from the point of diagnosis, even if they are currently able to carry out normal day to day activities. People are also covered by the Act if they have had a disability in the past. For example, if they have had a mental health condition in the past that lasted for over 12 months, but they have now recovered, they are still protected from discrimination because of that disability.
Gender re-assignment	This is defined for the purpose of the Act as where a person has proposed, started or completed a process to reassign physiological or other attributes of their sex. A transsexual person (some people may prefer the description transgender person or trans male or female) has the protected characteristic of gender re-assignment.
Marriage and civil partnership	The Equality Act says you must not be discriminated against in employment because you are married or in a civil partnership. Marriage is a union between an opposite-sex or same-sex couple. Same-sex and opposite-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Appendix A: Summary of the legislative framework for equality

Race	In the Equality Act, race can mean a person’s colour or their nationality (including their citizenship). It can also mean their ethnic or national origins, which may not be the same as their current nationality. For example, a person may have Chinese national origins and be living in Britain with a British passport. Race also covers ethnic and racial groups. This means a group of people who all share the same protected characteristic of ethnicity or race. A racial group can be made up of two or more distinct racial groups, for example black Britons, British Asians, British Sikhs, British Jews, Romany Gypsies or Irish Travellers.
Religion or belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. To be covered by the Act, a belief needs to be genuinely held; be a belief and not an opinion or viewpoint; be a belief as to a weighty and substantial aspect of human life and behaviour; attain a certain level of cogency, seriousness, cohesion and importance; and be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others. The Act cites Humanism and Atheism as examples of philosophical beliefs.
Sex	For the purposes of the Act, sex can mean either male or female, or a group of people like men or boys, or women or girls.
Sexual orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. For the purposes of the Act, sexual orientation includes how you choose to express your sexual orientation, such as through your appearance or the places you visit.

Appendix A: Summary of the legislative framework for equality

Part 2: The Public Sector Equality Duty

The Public Sector Equality Duty (section 149 of the Equality Act) applies to ‘relevant’ public authorities, which includes CCGs and it consists of a general equality duty, supported by specific duties that are imposed by secondary legislation (see Part 3 below).

The general equality duty requires public bodies to have **due regard** to the following three aims:

- To **eliminate discrimination**, harassment, victimisation and any other conduct prohibited by the Act.
- To **advance equality of opportunity** between people who share a relevant protected characteristic and those who don’t.
- To **foster good relations** between people who share a relevant protected characteristic and those who do not.

The Act explains that having ‘due regard’ for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people (the Act states that meeting different needs involves taking steps to take account of disabled people's disabilities).
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act describes ‘fostering good relations’ as tackling prejudice and promoting understanding between people from different groups.

The broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. If consideration is not given to how a function can affect different groups in different ways, then it is unlikely to have the intended effect. This can contribute to greater inequality and poor outcomes. The general equality duty therefore requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

Appendix A: Summary of the legislative framework for equality

Part 3: Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

These Regulations set out the specific equality duties for relevant public bodies, including CCGs, as described in Table 2 below.

The Regulations supersede the previous Equality Act 2010 (Specific Duties) Regulations 2011 and introduced the requirement for gender pay gap information to be published.

Table 2 – Detailed Requirements of the 2017 Regulations

Publish information demonstrating compliance with the general equality duty.	This needed to be done for the first time by 31 January 2012 and at least annually thereafter. This information must include, in particular, information relating to people who share a protected characteristic who are: • Its employees, and • People affected by its policies and practices. Publishing relevant and proportionate equality information will make public bodies transparent about their decision-making processes, and accountable to their service users. It will give the public the information they need to hold public bodies to account for their performance on equality.
Prepare and publish one or more equality objectives.	This needed to be done for the first time by 6 April 2012 and at least every four years thereafter. Equality objectives help focus attention on the priority equality issues within an organisation, to deliver improvements in policy-making, service delivery and employment, including resource allocation. Ideally, the development of equality objectives should be carried out as part of normal business planning processes. Equality objectives must be specific and measurable, and the progress made towards them is likely to be an important piece of evidence to demonstrate compliance with the general equality duty.
Publish information to demonstrate how large the pay gap is between their male and female employees.	This needed to be done (by employers with 250 or more employees) for the first time by 31 March 2018 and at least annually thereafter. The following information is required to be published: • The difference between the mean hourly rate of pay of male full-pay employees and that of female full-pay employees (full-pay employees are those who are not being paid at a reduced rate or nil as a result of them

Appendix A: Summary of the legislative framework for equality

	being on leave). • The difference between the median hourly rate of pay of male full-pay employees and that of female full-pay employees. • The difference between the mean bonus pay paid to male employees and that paid to female employees. • The difference between the median bonus pay paid to male employees and that paid to female employees. • The proportions of male and female employees who were paid bonus pay. • The proportions of male and female full-pay employees in the lower, lower middle, upper middle and upper quartile pay bands. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised. The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

Appendix A: Summary of the legislative framework for equality

Part 4: Other Disadvantaged Groups

In addition to considering the health needs of people on the basis of their protected characteristics, it is also important for CCGs as commissioners of health services to consider the needs of people from other disadvantaged groups who can experience difficulties in accessing and/or benefitting from health services.

Some disadvantaged groups are referred to as 'Inclusion Health' groups. These include:

- Vulnerable migrants (refugees and asylum seekers)
- Homeless people
- Members of the travelling community (who do not belong to an ethnic group recognised under the Equality Act)
- People in stigmatised occupations (such as sex workers)

Other disadvantaged groups include:

- Carers
- People who misuse drugs
- People experiencing economic and social deprivation
- People who have limited family or social networks
- People who are geographically isolated

For some of the above disadvantaged groups there are significant overlaps with people whose characteristics are protected by the Equality Act. These links should be borne in mind when work on either protected or other disadvantaged groups is taken forward.

Appendix B: Equality impact assessment

Date of assessment:	July 2020			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age[2]	No	N/A	N/A	Yes – The CCG acknowledges the needs of the diverse population it serves and is committed to improving equality of access to health services and health outcomes. The commitments in this policy cover all of the protected characteristic groups defined by the Equality Act 2010 and other disadvantaged groups.
Disability[3]	Yes	Mechanisms are in place via the Communications and Engagement Team to provide this policy in a range of languages, large print, Braille, audio, electronic and other accessible formats.	N/A	
Gender reassignment[4]	No	N/A	N/A	
Marriage and civil	No	N/A	N/A	

[2] A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

[3] A person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

[4] The process of transitioning from one gender to another.

Appendix B: Equality impact assessment

Date of assessment:	July 2020			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
partnership[5]				
Pregnancy and maternity[6]	No	N/A	N/A	
Race[7]	No	N/A	N/A	
Religion or belief[8]	No	N/A	N/A	
Sex[9]	No	N/A	N/A	
Sexual orientation[10]	No	N/A	N/A	

[5] Marriage is a union between a man and a woman or between a same-sex couple.
Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.

[6] Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

[7] Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

[8] Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

[9] A man or a woman.

[10] Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Patient and Public Engagement Committee Highlight Report – 23 June and 28 July 2020	**Paper Reference:**	**GB 20 061**
Chair of the meeting:	Sue Clague	**Attachments/ Appendices:**	-

Summary Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Summary of the Meeting

The Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) has continued to expand its membership to ensure it is as representative as possible of the diverse populations of Nottingham and Nottinghamshire. Further representation has been confirmed with My Sight Nottinghamshire, the African Institute for Social Development, Nottinghamshire Cardiac Support Group and an officer of Nottinghamshire County Council who supports delivery of co-production with the authority.

PPEC has continued to meet virtually on a monthly basis and meetings have taken place on 23 June and 28 July 2020.

At its meeting on 23 June 2020, PPEC members received two key presentations covering:

- Update on Restoration of Services from Lucy Dadge, Chief Commissioning Officer.
- Mental health services commissioning proposals and plans for engagement from Gary Eves, Head of Mental Health, Learning Disability and Children's Commissioning and Kate Burley, Deputy Head of Mental Health Commissioning. Specific information was shared about engagement plans in relation to the development of the Children and Young People's Emotional Wellbeing and Mental Health Early Intervention and Prevention Pathway and IAPT services.

At its subsequent meeting held on 28 July 2020, Rosa Waddingham, Chief Nurse, updated PPEC members on the CCG's response to Covid-19 with a focus on health inequalities. Reference was made to a report published by Public Health England in June 2020 that described how Covid-19 had exacerbated pre-existing health inequalities and that the national evidence reflected local risk. The full impact of Covid-19 would take some months to emerge. Work is progressing to understand the impact of changes to the way services have been delivered on vulnerable groups through the recovery engagement. PPEC members were invited to be involved in a check and balance process as part of the development of cultural competence processes.

Other key agenda items were:

- Primary Care Network toolkit and guide that will be used to support Primary Care Networks in the delivery of patient and public engagement. The toolkit had been co-produced with PPEC members and provides an innovative solution to deliver practical resources and links to sources of information.
- Voluntary Sector Alliance Patient and Public Engagement contract and progress to deliver the contract across Nottingham and Nottinghamshire through a partnership involving:
    - Ashfield Voluntary Action
    - Mansfield Community & Voluntary Service (CVS)

- Newark & Sherwood CVS
- Nottingham CVS
- Rushcliffe CVS

Details of the recovery engagement being delivered by the Voluntary Sector Alliance was provided and a commitment given to return to a future meeting to share the interim findings.

- Update on the Covid-19 Recovery Engagement. An interim report would be shared with PPEC members and used to inform the focus of further qualitative engagement.

Key Messages for the Governing Body

The key messages that PPEC members agreed to share with the Governing Body at its meeting held on 23 June 2020 were:

- PPEC is encouraged by the early engagement that is taking place and the strong link that is emerging between commissioning and public engagement. The engagement team has good staffing levels and there are signs of a much stronger engagement process and an expectation regarding implementation of outcomes.
- There is a reported lack of confidence amongst people shielding. The challenge to the CCG is to ensure this cohort of patients is not forgotten about and PPEC members emphasised the importance of good communication with shielded patients.

The key messages that PPEC members agreed to share with the Governing Body at its subsequent meeting held on 28 July 2020 were:

- Health inequalities and equality and diversity should be incorporated into every aspect of patient and public engagement. PPEC agreed to establish a sub group led by Jasmin Howell, PPEC Vice-Chair, to develop a framework to provide assurances around this. Several PPEC members expressed an interested in being involved in this group. Furthermore, PPEC members would welcome the opportunity to be involved in a check and balance process linked to the development of cultural competence processes.
- Effectively measuring the impact of engagement is a challenge and PPEC and the CCG will collectively develop solutions that will deliver assurance on this.
- Planning should incorporate clarification of future roles for volunteers who have come to the fore during the pandemic and provided a lifeline to some of the most vulnerable in our communities.
- PPEC members welcomed the progress being made on recovery engagement and look forward to receiving an interim report at the next meeting to be able to inform the focus of further qualitative engagement.

The ratified minutes of Patient and Public Engagement Committee held on 28 July will be presented to the Governing Body on 07 October 2020.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Highlight report from the (virtual) meeting of the CCG's Primary Care Commissioning Committee	**Paper Reference:**	**GB 20 062**
Chair of the meeting:	Eleri de Gilbert – Non-Executive Director	**Attachments/ Appendices:**	-

Summary Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Summary of the Meeting

The Primary Care Commissioning Committee (PCCC) met on the 17 June and 15 July 2020. Due to the current Coronavirus (Covid-19) situation, the meeting was held virtually.

At the meetings, the Committee:

- **APROVED** a temporary three month boundary reduction at Giltbrook Surgery.
- **APPROVED** the increase in number of Whole Time Equivalent (WTE) First Contact Physiotherapists eligible to be reimbursed under the Additional Roles Reimbursement Scheme for 2020/21 for the following Primary Care Networks (PCNs):
  - Rushcliffe PCN from 2.0 WTE to 5.0 WTE
  - Nottingham West PCN from 2.0 WTE to 4.0 WTE
  - Byron PCN from 1.0 WTE to 2.0 WTE
  - Radford & Mary Potter PCN from 1.0 WTE to 2.0 WTE
  - Nottingham City East PCN from 1.0 WTE to 1.8 WTE
  - Clifton and Meadows PCN from 1.0 WTE to 2.0 WTE
- **APPROVED** the proposed safeguarding focus for the care co-ordinator role under the Additional Roles Reimbursement Scheme for 2020/21. The committee welcomed this proposal which will complement existing CCG safeguarding arrangements, whilst providing much needed additional capacity and resource within primary care around the often challenging safeguarding agenda.
- **RECEIVED** confirmation that Orchard Medical Practice is due to reopen its patient list on the 1 October 2020 as planned. The Committee was encouraged to note that the practice had benefited from the list closure, which had provided breathing space whilst the practice recruited and revisited how they worked.

Key Messages for the Governing Body

The Committee recently approved criteria for the consideration of list closure applications, which included the use of supporting workforce data from practices. An exercise has been completed in which three

previous list closure decisions were revisited to compare the General Practice Workforce Data returns against the workforce measures referenced in each of the list closure applications. The outcome of the testing exercise revealed that the accuracy of the data submitted by the practices across Nottingham and Nottinghamshire is varied. As a result, support and encouragement is being given by the primary care team to practices to ensure that data submitted is accurate, not just to support a list closure application but to support effective workforce planning. In all three instances, the workforce position faced by the practice was considered as part of the decision to approve the list closure and in all cases had improved during the period of closure. It is important to note that other challenges faced by practices were also taken into account as part of the list closure application process.

The ratified minutes of the June meeting will be received by the Governing Body on the 5 August 2020.

The ratified minutes of the July meeting will be received by the Governing Body on the 7 October 2020.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	05 August 2020

Paper Title:	Highlight report from the (virtual) meeting of the CCG's Finance and Turnaround Committee	Paper Reference:	GB 20 063

Chair of the meeting:	Shaun Beebe – Non-Executive Director (June) Jon Towler – Non-Executive Director (July)	Attachments/ Appendices:	-

Summary Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Summary of the Meeting
The Finance and Turnaround Committee (FTC) met on the 24 June and 22 July 2020. Due to the current Coronavirus (Covid-19) situation, the meetings were held virtually. Over the course of the meetings the Committee: • **NOTED** the Cross Provider Report, which gave an overview of financial and activity performance for the Nottingham and Nottinghamshire CCG at months one and two, with a particular focus on the major acute contracts. • **NOTED** the financial position of the CCG. For the first four months of the 2020/21 financial year, NHS England/Improvement (NHSE/I) replaced the CCG allocation for 2020/21 with a £537.1 million budget informed by reference to the overall (recurrent and non-recurrent) outturn for the 2019/20 financial year. This is against anticipated budget requirement for this period of £544.9 million, resulting in an expected budget pressure of £7.8 million. It is anticipated that an adverse variance will attract funding from NHSE/I which will be top sliced as necessary to enable the CCG to report a breakeven position. However, a key risk at this stage is that the variance does not attract central funding, leaving the CCG in a deficit position. • **NOTED** the costs associated with Covid-19 which as at June 2020 totalled £9.253 million, and were assured that the allocation from NHSE/I for the month one and two Covid-19 claims, totalling £4.805 million, had been received. • **RECEIVED ASSURANCE** at month three in relation to the steps being taken to progress financial recovery and Quality, Innovation, Productivity and Prevention (QIPP) plans. Following review of the plans identified as at March 2020, it was a concern that only £19 million of the £67 million are schemes over which the CCG has direct influence. • **RECEIVED** at month three the Organisational Priorities Progress Review for quarter one and were assured that work continues with each Senior Responsible Officer (SRO) to populate a plan on a page and identify key milestones for their key task and/or deliverable. Concern was raised that there may be a fundamental issue with subject matter experts agreeing a plan on a page in advance of confirming

team objectives and capacity. This was discussed in detail and it was agreed that the strategic objectives should drive the priorities and resource requirements of each department, which Amanda Sullivan would take forward.

- **RECEIVED** the risk report and agreed at month two that the overall risk score of twenty for RR 121 remained appropriate and would be reconsidered once formal guidance regarding the 2020/21 allocation was received. At month three, it was agreed that the narrative of risk RR 121 would be amended to reflect the CCG's limited area of influence over the current financial position; and the narrative of the three main financial risks would be reviewed following receipt of the phase three letter.

Key Messages for the Governing Body
Although a breakeven position is forecasted as at month three, the temporary financial regime is challenging to the CCG, minimising opportunities to flex the budget and impacting on the management of 2019/20 legacy commitments, new investment, transformation and impacting on the 2021/22 position.

The ratified minutes of the July 2020 meeting will be received by the Governing Body on the 7 October 2020.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Finance Report Month Three	**Paper Reference:**	**GB 20 064**
Sponsor: **Presenter:**	Stuart Poynor, Chief Finance Officer Stuart Poynor, Chief Finance Officer	**Attachments/ Appendices:**	

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

This paper presents the financial position for the CCG for Month three of 2020/21. The report and accompanying Operating Cost Statement (OCS) have been prepared in accordance with the nationally directed "Temporary Financial Regime" (TFR) implemented by NHS England Improvement (NHSEI) in response to the current COVID-19 pandemic crisis. By way of re-cap, the CCG is required to report its financial position by reference to the following:

- To report its position compared to a four month budget allocation.
  - Instead of receiving an expected 12 month Revenue Resource Limit (RRL), the CCG has had a four month budget calculated based on historic 2019/20 spend.
- To report actual costs against that budget. Adverse variances are anticipated since the budget does not reflect the true rate of 2020/21 costs that have been incurred. At month three there is a variance of (£14.7m):

	M3 (Adverse) Variance
COVID-19 costs to be reimbursed	(£4.4m)
Under- accruals from 19/20	(£1.8m)
20/21 commitments deferred from 19/20	(£3.1m)
Price impact of Funded Nursing Care (FNC)	(£1.0m)
Run rate of spend higher than budget provided *	(£4.4m)
TOTAL	**(£14.7m)**

[In 2019/20 the CCG reported non-recurrent benefits that reduced the quantum of spend in 2019/20. Those benefits will not happen again. However the one-off effect has not been added back into the four month budget that would be required in 2020/21. This leads to a shortfall between budget received and budget required. (The annual equivalent gap being originally estimated at c. £23.5m (or £5.9m over three months). Thus leading to a higher rate of spend in 2020/21 compared to the budget provided].*

NHSEI has indicated that the budget will be altered each month to allow any variance to be negated. This is why the CCG is reporting a breakeven position. The detailed report provides a breakdown of the £14.7m variance; £6.4m of which is the brought forward from Month two. The detailed report highlights risks associated with the financial position. The key risk at this stage is that the variance does not attract central funding, leaving the CCG in a deficit position.

Under the TFR, the non-recurrent benefits that helped reduce spend and achieve financial balance in

2019/20, have now lowered the four months budgets that it would have otherwise received. The budgeted allocation it has received is out of the CCG's span of control.

In addition the CCG also estimates that c. 73% (£391m) of projected month one to month four costs are outside of its span of control (mainly as a result of the amount of payments that are mandated by NHSEI to pay to providers in the form of "block" contract arrangements). Whilst resources remain focused in providing an appropriate level of response to the current COVID-19 crisis, the CCG is also is re-doubling its efforts elsewhere. In particular it is taking action to identify savings opportunities in areas where it can directly influence; notably corporate, CHC and prescribing.

In conclusion, the CCG will continue its efforts to deliver best value for the population it serves. At the same time the CCG is reliant on the national allocation process to address the unintended consequences of the TFR that remain outside of the CCG's span of control.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	☐	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☐
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item

Risk(s):

Confidentiality:

☒No
☐Yes (please indicate why it is confidential by ticking the relevant box below)

Recommendation(s):

1. The Governing Body is asked to **NOTE** the Finance Report

Finance Report – Month 3 2020/21

1.0 Introduction

1.1 This paper provides commentary to the Operating Cost Statement (OCS) report prepared for month 3 2020/21. The OCS statement has been prepared in the context of the COVID crisis and the resultant financial regime implemented by NHSEI.

1.2 The month 2 finance report gives a full explanation of the financial regime that the CCG is currently operating in, together with an explanation of the derivation of the current budget that the CCG is working with.

1.3 As a brief recap, NHSEI have replaced the CCG allocation for 2020/21 with a four month budget covering the period to end July 2020. This budget has been informed with regard to the overall (recurrent and non-recurrent) outturn of the 2019/20 financial year.

1.4 This budget amounts to £537.1 million. The CCG anticipated budget requirement for this period is £544.9 million, resulting in an expected budget pressure of £7.8 million for the four month period. This is primarily due to the level of non-recurrent benefits that the CCG reported in 2019/20.

1.5 The CCG is to report actual costs against this budget. Initial guidance from NHSEI indicated that any variance would either attract funding or be top-sliced as relevant, so that the CCG could report a breakeven position.

1.6 In regard to the reported month 2 over spend of £11.2 million, the CCG has received an allocation of £4.8 million, solely in relation to the COVID specific costs. The remaining £6.4 million remains unfunded at this stage.

2.0 Month 3 Financial Position

2.1 As noted in 1.6 above, the CCG has received an additional allocation in month 3 of £4.8 million, to cover year to date (YTD) COVID costs. The budget received under the new financial regime now therefore stands at:

NHSEI m1-4 Funding	
	£000
Opening budget (as at m2)	£537,103
m2 COVID funding	£4,805
m1-4 Budget as at m3	£541,908
m3 YTD budget	
Pro rata opening budget	£402,827
m2 COVID funding	£4,805
m3 YTD budget	£407,632

2.2 Against this £407.6 YTD million budget, the CCG is reporting an adverse variance of £14.7 million, and a forecast overspend for the period to the end of July of £19.6 million. The £14.7 million is made up of the following key areas:

Item / Month 3 variance (adverse) / favourable £000	Month 2 YTD variance	Month 2 Funding received	Month 2 adjusted position	Month 3 YTD Variance	Movement from m2 adjusted
COVID specific costs (Non Recurrent)	-£4,805	£4,805	£0	**-£4,448**	-£4,448
2019/20 accrual fall out (NR)	-£1,502	£0	-£1,502	**-£1,807**	-£305
2020/21 commitments from deferred costs in 2019/20 non NHS (NR)	-£2,124	£0	-£2,124	**-£2,200**	-£76
2020/21 ICS commitments from 2019/20 deferral (NR)	-£900	£0	-£900	**-£900**	£0
2019/20 Funded Nursing Costs price impact in respect of 2019/20	£0	£0	£0	**-£978**	-£978
2020/21 budget pressures (on-going)	-£1,908	£0	-£1,908	**-£4,410**	-£2,502
Total	**-£11,239**	**£4,805**	**-£6,434**	**-£14,743**	**-£8,309**

Variance Explanations:

2.3 The £4.448 million relates to COVID specific costs incurred during June across the following areas. The majority of these costs have been incurred in Hospital Discharge Programme (including Continuing Healthcare) £2.9 million, Primary Care Services £0.7million and Community Health Services £0.6 million. The balance of £0.2 million has been incurred across Acute Services, Mental Health Services, Running costs and Other Programme. The COVID costs reported in month 2 (£4.8 million) have been funded by NHSEI.

2.4 The key item in the £1.8 million 2019/20 fall out variance is prescribing, as described in the month 2 report, at £1.1 million. The movement of £0.3 million in June relates to further 2019/20 fall out emerging in relation to schemes funded from the 2019/20 system transformation monies.

2.5 The 2019/20 fall out costs have not yet been funded by NHSEI. NHSEI has not yet confirmed if these costs will receive funding, and the CCG awaits guidance from the centre in respect of any amended approach to this variance.

2.6 The 2020/21 commitments from deferred costs in 2019/20 are as reported in month 2, with a small movement of £76,000 relating to Primary Care Network commitments. It should be noted that there are further non NHS commitments that are not reported in the financial position. These are being finalised and will be reported in the month 4 position.

2.7 As with the items noted in 2.5 above, the 2020/21 deferred commitments costs have not yet been funded by NHSEI. NHSEI has not yet confirmed if these costs will receive funding, and the CCG awaits guidance from the centre in respect of any amended approach to this variance.

2.8 The ICS commitment is as reported in month 2, and again, the CCG awaits for confirmation as to whether funding will follow.

2.9 The Funded Nursing Care (FNC) pressure relates to the national FNC pricing policy whereby prices were increased in this financial year but back-dated to cover 2019/20. NHSEI instructed CCGs to pay providers for this price uplift in month 2 and to now account for the expenditure in month 3 position. Funding is anticipated for these costs.

2.10 The £4.4 million on-going pressure relates to the overspend that the CCG had anticipated as noted in para. 1.4 above. A YTD pressure of £5.9 million was anticipated, so the position represents costs that are, in effect, £1.5 million below expected. This is primarily due to CHC costs and GPIT costs being below budget as noted in month 2. However, there are several key new areas that are driving a pressure within this £4.4m:

2.10.1 Prescribing. Cost data for April has now been received, and this is c £340,000 above the planned costs. This one month cost has been extrapolated for the YTD period, and a pressure of c£1.0 million therefore reported

2.10.2 Primary Care Co-Commissioning. There are 4 practices that are being managed on a ‘care-taking’ contract basis. A reconciliation of base costs compared to the full cost recovery costs charged by the providers has resulted in a year to date adjustment of c £0.4 million.

2.11 A summary Operating Cost Statement (OCS) is set out in the table below, and a full OCS is included at appendix one.

NHS Nottingham & Nottinghamshire	YTD Plan £m	YTD Actual £m	YTD Variance £m	M1-4 Plan £m	M1-4 Forecast Outturn £m	M1-4 Forecast Variance £m
Programme Healthcare Costs						
Acute Care - base budget	195.61	195.85	(0.24)	260.81	261.07	(0.25)
- COVID expenditure	0.17	0.25	(0.08)	0.17	0.33	(0.16)
-Balancing line to NHSEI budget	2.79	(0.00)	2.79	3.72	0.00	3.72
Community Care - base budget	34.64	34.67	(0.03)	46.19	46.18	0.01
- COVID expenditure	0.62	1.24	(0.62)	0.62	1.73	(1.11)
-Balancing line to NHSEI budget	(1.02)	0.00	(1.02)	(1.36)	0.00	(1.36)
Mental Health Care - base budget	41.93	42.61	(0.68)	55.89	56.86	(0.97)
- COVID expenditure	0.04	0.04	0.00	0.04	0.04	(0.00)
-Balancing line to NHSEI budget	(0.59)	0.00	(0.59)	(0.78)	0.00	(0.78)
Primary Care - base budget	46.42	46.82	(0.40)	61.89	62.27	(0.38)
- COVID expenditure	1.05	1.78	(0.73)	1.05	2.00	(0.95)
-Balancing line to NHSEI budget	(2.14)	(0.00)	(2.14)	(2.86)	0.00	(2.86)
Prescribing	38.03	40.12	(2.10)	50.70	53.45	(2.75)
Continuing Care - base budget	30.02	28.48	1.54	40.03	37.52	2.51
- COVID expenditure	2.63	5.57	(2.95)	2.63	7.68	(5.05)
-Balancing line to NHSEI budget	(1.27)	0.00	(1.27)	(1.69)	0.00	(1.69)
Total Programme Healthcare Costs	**388.91**	**397.44**	**(8.53)**	**517.05**	**529.13**	**(12.08)**
Programme Non Healthcare Costs						
Other Contracts - base budget	11.86	14.53	(2.67)	15.81	18.55	(2.74)
- COVID expenditure	0.19	0.21	(0.01)	0.19	0.24	(0.04)
-Balancing line to NHSEI budget	1.13	0.00	1.13	1.51	0.00	1.51
Corporate Costs (excl. admin/ running costs)	5.34	5.41	(0.08)	7.12	7.22	(0.10)
Programme Reserves - base budget	0.00	0.00	0.00	0.00	0.00	0.00
-Balancing line to NHSEI budget	(4.48)	0.00	(4.48)	(5.98)	0.00	(5.98)
Total Programme Non Healthcare Costs	**14.04**	**20.15**	**(6.11)**	**18.65**	**26.01**	**(7.36)**
Total Net Operating Expenditure - Programme	**402.95**	**417.59**	**(14.64)**	**535.70**	**555.14**	**(19.44)**
Running Costs (Admin) - base budget	4.92	4.62	0.30	6.55	6.15	0.40
- COVID expenditure	0.12	0.17	(0.06)	0.12	0.23	(0.11)
-Balancing line to NHSEI budget	(0.35)	0.00	(0.35)	(0.46)	0.00	(0.46)
Running Costs Total	**4.69**	**4.79**	**(0.10)**	**6.21**	**6.38**	**(0.17)**
Total CCG Initial Financial Position	**407.63**	**422.37**	**(14.74)**	**541.91**	**561.52**	**(19.61)**
Anticipated NHSEI Budget adjustment	**14.74**	**0.00**	**14.74**	**19.61**	**0.00**	**19.61**
Anticipated CCG Total Financial Position	**422.37**	**422.37**	**0.00**	**561.52**	**561.52**	**0.01**
memorandum						
Total COVID costs	**4.81**	**9.25**	**(4.45)**	**4.81**	**12.23**	**(7.43)**
Total 'NHSEI Balancing Line'	**(5.93)**	**(0.00)**	**(5.93)**	**(7.90)**	**0.00**	**(7.90)**

3.0 Risks and Mitigations

3.1 The key risk to the reported position is that the adverse variance to plan does not attract the funding as originally noted in the NHSEI guidance to the amended financial regime. COVID costs have been funded, and guidance is awaited on whether funding is likely to follow for the remaining items. The CCG has undertaken a full reconciliation on the non-recurrent items that are generating the base budget pressure noted in para 1.4 above and this will be shared with NHSEI colleagues.

3.2 As noted in para 2.5, there are likely to be further non NHS deferred commitments that are not yet in the financial position. The range of commitment is between £0.4 million to £1.8 million and the finance team is working to confirm the final level required.

3.3 Prescribing costs for months 2 and 3 have been estimated based on April data. These estimates may change once actuals are received.

3.4 Estates costs. These costs are accrued to plan for the period, and are subject to change once billing models from the providers are received and validated. The CCG also has the legacy issue with NHSPS for mid Notts charges and the CCG is engaged in a process to resolve these, facilitated by the Department of Health.

3.5 Mental Health Investment Standard (MHIS). As reported in month 2 and in line with guidance, the reported position assumes no investments are made for the period. This may result in risk to the delivery of the MHIS. It seems likely that the CCG will be expected to deliver the standard during the financial year.

3.6 The CCG is working on mitigations, and is examining the areas of controllable expenditure for potential savings that could be made. Savings cannot be made against expenditure with NHS providers as this is covered by the mandated block contracts. This thus reduces the scope for savings to be generated, however, the CCG is examining all remaining expenditure areas for opportunities. In addition, the finance team is examining as to whether there are any favourable fall outs relating to the year end 2019/20 reported position.

4.0 Other Financial Areas to note

4.1 Better Payment Practice Code (BPPC). The suggested approach to correct the BPPC anomalies caused by an error in the baseline data for transactions from the six legacy CCGs (as noted in the month 2 finance report) has been approved by the Audit & Governance Committee.

4.2 The BPPC position for June reflects the approved corrections. The table below is based upon a 30 day compliance.

Volume / Value invoices paid within 30 days	Cumlative Quantity/ Value	Jun-20 Quantity/ Value	Jun-20 Quantity/ Value Fails	Non NHS		NHS		TOTAL	
				Jun-20	Cumulative	Jun-20	Cumulative	Jun-20	Cumulative
Volume	11,689	3,329	36	99.32%	99.14%	97.73%	99.22%	98.92%	99.16%
Value	£445,642,701	£119,570,485	£294,486	99.19%	99.31%	99.97%	99.99%	99.75%	99.83%

4.3 Recent NHSEI guidance is that invoices should be paid within 7 days due to the COVID crisis, so as to not give suppliers cash flow issues. A revised BPPC report on performance against the 7 day target is being developed and will be reported in the month 4 finance report.

4.4 Cash Position. The Cash Management regime expects CCGs to have a cash balance at the end of the month, that is no more than 1.25% of the months drawdown (this equates to c.£1.46 million). The CCG had 0.03% of the month's drawdown as a cash balance at the end of June.

4.5 Debtors. The debtor position for the CCG is as follows:

Non NHS								NHS							
Not Yet Due		Overdue 1 - 30 Days		Overdue 31 - 60 days		Overdue 60 days +		Not Yet Due		Overdue 1 - 30 Days		Overdue 31 Days+		Overdue 60 days +	
Volume	Value	Volume	Value	Volume	Value	Volume	Value	Volume	Value	Volume	Value	Volume	Value	Volume	Value
4	£276,035	11	£280,025	18	£295,155	21	£1,867,378	4	£97,474	1	£1,650	5	£55,822	7	£215,625

The key debts noted in the table are:
Non NHS – CHC recharges with nine care homes £470k; Nottinghamshire County Council £1,926k (£1,553k received in July); Nottinghamshire Police £341k and NHS - £95.6k ULHT;

£187k Derby and Derbyshire CCG; Health education England £54k. None of these debts are expected to be at risk.

5.0 Summary

5.1 The CCG is operating in a revised financial regime with a non-recurrent budget determined by NHSEI. The adverse variance to date (£14.7 million) is anticipated to be funded from the centre, so that the CCG can report a breakeven position. However, £6.4 million of the variance remains unfunded from month 2 and there is uncertainty as to the level of funding that will be provided to cover this pressure.

Ian Livsey
Deputy Director of Finance
July 2020

Appendix one

Full OCS

NOTTINGHAM & NOTTINGHAMSHIRE CCG	YEAR TO DATE			FORECAST		
	Plan £'000	Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Forecast Variance £'000
Acute Services						
Nottingham University Hospitals	122,843	122,843	(0)	163,791	163,791	0
Nottingham University Hospitals - Treatment Centre	0	0	0	0	0	0
Nottingham University Hospitals - Non Core	0	0	0	0	0	0
Sherwood Forest Hospitals	54,784	54,784	0	73,045	73,045	0
Sherwood Forest Hospitals - Non Core	0	0	0	0	0	0
East Midlands Ambulance Service	10,088	10,088	0	13,450	13,450	0
University Hospitals Of Derby And Burton	1,682	1,682	0	2,242	2,242	0
United Lincolnshire Hospitals	1,355	1,355	0	1,806	1,806	0
Doncaster & Bassetlaw	888	888	0	1,184	1,184	0
University Hospitals Leicester	510	510	(0)	680	680	0
Sheffield Teaching	324	324	0	432	432	0
Chesterfield Royal	108	108	0	144	144	0
Acute - NHS - Other Block Contracts	730	730	0	974	974	0
Acute - NHS	0	0	0	0	0	0
Acute Contracts - Position on Prior Year	0	17	17	0	18	18
Other NHS - NCA's	354	354	(0)	472	472	0
Ramsay Woodthorpe	0	0	0	0	0	0
BMI Healthcare	0	0	0	0	0	0
Barlborough	0	0	0	0	0	0
Spire	0	0	0	0	0	0
Other Non NHS - Acute	0	0	0	0	0	0
Cancer Monies	5	5	(0)	7	7	0
Resilience	1,180	1,242	63	1,573	1,653	80
Urgent Care Centres	745	921	176	994	1,169	176
Acute Investment QIPP	0	0	0	0	0	0
Activity - Other	16	0	(16)	21	0	(21)
Acute - COVID	167	247	81	167	328	162
Acute - Balancing Adjustments to NHSE/I Model	2,773	(0)	(2,773)	3,697	0	(3,697)
Acute - CCG Coding Change Adjustments	17	0	(17)	22	0	(22)
Total Acute Services	**198,568**	**196,098**	**(2,470)**	**264,701**	**261,395**	**(3,306)**
Community Services						
Nottinghamshire Healthcare - General Health	17,660	17,660	(0)	23,547	23,547	0
Sherwood Forest Hospitals	2,609	2,609	(0)	3,479	3,479	0
Sherwood Forest Hospitals - Activity Reserve / QIPP / FRP	0	0	0	0	0	0
Other NHS - Community	826	826	0	1,102	1,102	0
Other Non NHS - Community	13,117	13,148	31	17,489	17,483	(7)
End of Life	430	430	0	573	573	0
Community QIPP not transacted	0	0	0	0	0	0
Community Investment QIPP	0	0	0	0	0	0
Community - Other	0	0	0	0	0	0
Community - COVID	616	1,237	622	616	1,728	1,112
Community - Balancing Adjustments to NHSE/I Model	(122)	0	122	(162)	0	162
Community - CCG Coding Change Adjustments	(900)	0	900	(1,200)	0	1,200
Total Community Services	**34,237**	**35,911**	**1,674**	**45,444**	**47,911**	**2,468**
Mental Health Services						
Nottinghamshire Healthcare - Mental Health	30,550	30,550	0	40,733	40,733	0
Other NHS - Mental Health	525	525	(0)	701	701	0
Other Non NHS - Mental Health	3,930	4,577	647	5,229	6,068	840
S117 Placements	6,924	6,961	37	9,232	9,361	129
Mental Health QIPP not transacted	0	0	0	0	0	0
Mental Health Investment QIPP	0	0	0	0	0	0
Mental Health - Other	0	0	0	0	0	0
Mental Health - COVID	38	38	0	38	38	0
Mental Health - Balancing Adjustments to NHSE/I Model	(309)	0	309	(402)	0	402
Mental Health - CCG Coding Change Adjustments	(284)	0	284	(378)	0	378
Total Mental Health Services	**41,374**	**42,651**	**1,277**	**55,153**	**56,901**	**1,748**
Primary Care Services						
Primary Care Contracting	37,869	38,523	654	50,492	51,303	811
Primary Care Contracting - Balancing Adjustments to NHSE/I Mo	(2,283)	0	2,283	(3,043)	0	3,043
Prescribing	38,026	40,122	2,096	50,701	53,454	2,753
Prescribing - QIPP	0	0	0	0	0	0
Medicine Management - Clinical	929	830	(99)	1,238	1,107	(131)
CCG Pathways	0	0	0	0	0	0
EH - Primary Care	50	40	(10)	66	66	(0)
EH - GP Forward View	1,232	1,232	0	1,643	1,643	0
Enhanced Services	2,401	2,911	510	3,201	3,710	510
Practice Transformation fund	0	0	0	0	0	0
GPIT	1,144	328	(816)	1,526	441	(1,085)
Out of Hours	2,646	2,794	149	3,527	3,770	243
Primary Care - Other	148	163	15	197	232	35
Primary Care - COVID	1,046	1,778	732	1,046	1,996	949
Primary Care - Balancing Adjustments to NHSE/I Model	137	0	(137)	182	0	(182)
Primary Care - CCG Coding Change Adjustments	3	(0)	(4)	4	0	(4)
Total Primary Care Services	**83,348**	**88,722**	**5,374**	**110,782**	**117,721**	**6,940**
Other Healthcare						
Continuing Care & Free Nursing Care	29,226	27,789	(1,437)	38,968	36,602	(2,366)
City Care CHC Assessment	762	689	(73)	1,016	919	(98)
Continuing Care - COVID	2,627	5,575	2,948	2,627	7,678	5,051
Continuing Care - Balancing Adjustments to NHSE/I Model	(1,266)	0	1,266	(1,688)	0	1,688
Continuing Care - CCG Coding Change Adjustments	34	0	(33)	45	0	(44)
Total Other Healthcare Costs	**31,383**	**34,053**	**2,670**	**40,969**	**45,199**	**4,230**
TOTAL PROGRAMME HEALTHCARE COSTS	**388,910**	**397,435**	**8,526**	**517,048**	**529,128**	**12,079**

Other Contracts						
Other Non-NHS Services	135	2,708	2,573	180	2,823	2,643
Patient Transport	1,776	1,776	0	2,367	2,367	0
Other Non-NHS Services - 111	1,184	1,184	0	1,579	1,579	0
Other NHS Services	181	279	98	241	341	100
Social Care	8,584	8,584	(0)	11,445	11,445	0
Other - COVID	195	206	11	195	236	41
Other - Balancing Adjustments to NHSE/I Model	0	0	0	0	0	0
Other - CCG Coding Change Adjustments	1,130	0	(1,130)	1,507	0	(1,507)
Total Other Contracts	**13,184**	**14,736**	**1,552**	**17,514**	**18,791**	**1,277**
Corporate Non-Running Costs						
Corporate - Estates	2,622	2,622	0	3,496	3,496	0
Corporate Costs - Chief Officer	991	1,178	187	1,321	1,570	249
Corporate Costs - Chief Commissioning Officer	610	604	(6)	814	806	(8)
Corporate Costs - Chief Finance Officer	0	0	0	0	0	0
Corporate Costs - ICS	(0)	(0)	0	0	(0)	(0)
Corporate Costs - Chief Nurse	1,114	1,005	(109)	1,486	1,340	(146)
Corporate - COVID	0	0	0	0	0	0
Corporate - Balancing Adjustments to NHSE/I Model	0	0	0	0	0	0
Corporate - CCG Coding Change Adjustments	0	0	0	0	0	0
Depreciation, provisions & technical adjustments	0	5	5	0	5	5
Total Corporate Non-Running Costs	**5,337**	**5,414**	**77**	**7,116**	**7,217**	**101**
Programme Reserves						
Risk Reserves (inc. running cost headroom)	0	0	0	0	0	0
PCCC	0	0	0	0	0	0
QIPP	0	0	0	0	0	0
Other Reserves	0	0	0	0	0	0
Reserves - COVID	0	0	0	0	0	0
Other Reserves - Balancing Adjustments to NHSE/I Model	(4,485)	0	4,485	(5,979)	0	5,979
Other Reserves - CCG Coding Change Adjustments	0	0	0	0	0	0
Total Programme Reserves	**(4,485)**	**0**	**4,485**	**(5,979)**	**0**	**5,979**
TOTAL PROGRAMME NON- HEALTHCARE COSTS	**14,037**	**20,150**	**6,114**	**18,651**	**26,008**	**7,357**
TOTAL NET OPERATING EXPENDITURE - PROGRAMME	**402,946**	**417,586**	**14,639**	**535,699**	**555,135**	**19,436**
Planned Surplus	0	0	0	0	0	0
TOTAL AVAILABLE RESOURCE - PROGRAMME	**402,946**	**417,586**	**14,639**	**535,699**	**555,135**	**19,436**
Running Costs						
Running Costs	0	0	0	0	0	0
Running Costs - Chief Officer	576	447	(129)	768	596	(172)
Running Costs - Chief Finance Officer	1,534	1,510	(23)	2,045	2,014	(31)
Running Costs - Chief Commissioning Officer	1,528	1,403	(124)	2,037	1,871	(166)
Running Costs - Chief Nurse	323	245	(78)	431	327	(104)
Running Costs - Special Projects	143	199	57	190	266	76
Running Costs - Communications	160	141	(19)	214	188	(26)
Running Costs - Estates	652	672	19	870	891	21
Running Costs - Reserves	0	0	0	0	0	0
Running Costs - COVID	117	172	55	117	229	112
Running Costs - Balancing Adjustments to NHSE/I Model	(347)	0	347	(462)	0	462
Running Costs - CCG Coding Change Adjustments	0	0	0	0	0	0
TOTAL AVAILABLE RESOURCE - ADMIN	**4,686**	**4,789**	**103**	**6,209**	**6,381**	**172**
TOTAL	**407,632**	**422,375**	**14,743**	**541,908**	**561,516**	**19,608**

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Highlight report from the meeting of the CCG's Quality and Performance Committee	**Paper Reference:**	**GB 20 065**
Chair of the meeting:	Eleri de Gilbert, Non-Executive Director	**Attachments/ Appendices:**	-

Summary Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Summary of the Meetings

The Quality and Performance Committee met on the 25 June 2020 and 23 July 2020. Due to the current Coronavirus (Covid-19) situation, the meetings were held virtually. Over the course of the meetings, the Committee:

- **RECEIVED** and **NOTED** the monthly Performance Report and updates on work taking place on restoration and recovery of services. The Committee recognised that services post-Covid-19 will be delivered differently. Work is now taking place to validate elective waiting lists to prioritise patient treatment. Recovery plans are being developed around cancer services and it was noted that elective referrals were starting to increase again, although performance against elective care standards continue to deteriorate. Plans for the restoration and recovery of these services are under development and the Committee stressed the challenge that this will pose.

- **RECEIVED** and **NOTED** a report regarding workforce and wellbeing based on the CCG internal Wellbeing Survey, Vulnerable Staff Risk Assessment and System Workforce Response. The survey showed that approximately 60% of staff were "feeling good" at the time of the report with areas of concern or challenge mitigated with a wellbeing package offer to staff. Risk assessments have been undertaken due to the disproportionate effect that Covid-19 was having on the BAME community and highlighted various concerns for which actions have been taken to mitigate the level of risk to these staff.

- **RECEIVED** and **NOTED** a presentation regarding health inequalities and actions taken during the pandemic to address these, alongside Equality and Quality Impact Assessments relating to service changes on disadvantaged groups. It was agreed that the presentation was a starting point and that a more detailed report with empirical data, linking to population health management work will be brought back to the meeting in August.

- **RECEIVED** and **NOTED** a report regarding Safeguarding in relation to the impact of the Covid-19 response. Members received assurance that all statutory functions have been maintained. Concerns exist around those "hidden from view" in particular, children and young people and the

reduction in referrals during the pandemic. The Committee was assured that this is recognised by Safeguarding Boards and mitigation plans are being put in place, in addition to plans to cope with a potential surge in referrals as lockdown eases.

- **RECEIVED** and **NOTED** a detailed update regarding Nottinghamshire Healthcare NHS Foundation Trust, in relation to previous concerns around quality and performance issues and in response to the CQC inspection. It was noted that there was evidence of improvement in a number of areas and the Trust had responded well in relation to Covid-19, however, the risk score is to remain unaltered pending a Board to Board meeting scheduled at the end of the month (July).

- **RECEIVED** and **NOTED** an update around Infection, Prevention and Control (IPC) during the Covid-19 pandemic. The Committee recognised and applauded the efforts of this small team, who worked tirelessly in challenging circumstances during the pandemic response. As the CCG moves toward restoration and recovery and prepares for potential future surges, it is crucial that the CCG is at the forefront of discussion with the Local Authorities around the sustainability of the IPC function in terms of team capacity and long term funding.

- **RECEIVED** routine reports relating to Quality and Risk. Additionally, updates regarding Nottinghamshire Healthcare NHS Foundation Trust were received along with the Complaints and Patient Experience Annual Report 2019/20, the Patient Experience Policy and Equality and Quality Impact Assessments report.

Key Messages for the Governing Body
Work towards restoration, recovery and preparation should a second wave occur continue to be supported by the strengthening of partnership working and the embracing new ways of working, whilst considering the impact of the pandemic across all aspects of service delivery and CCG staff.

The ratified minutes of the meeting will be received by the Governing Body on 5 August and 7 October.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020

Paper Title:	Performance Report	**Paper Reference:**	**GB 20 066**

Sponsor:	Stuart Poynor, Chief Finance Officer	**Attachments/ Appendices:**	Performance Report
Presenter:	Stuart Poynor, Chief Finance Officer		

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

The Integrated Performance Report for July provides a summary of performance against key standards and targets for the NHS Nottingham and Nottinghamshire CCG (with aggregate 2019-20 performance for the previous six CCGs to illustrate trends). Supplementary information showing, where appropriate, the equivalent performance for individual provider organisations.

The report is broken down in to sections for Planned Care, Urgent Care and Mental Health indicators offering assurance by indicating:

- The root cause of performance issues being reported?
- What mitigating actions are in place to recover performance?
- What assurance can be given to its sustainability?
- Are there any gaps in assurances?

Members are asked to note the continuation of a stepping down of some national reporting requirements during the COVID-19 outbreak. Although some of these have now been restarted, the report may not include these metrics as it covers periods prior to this reinstatement. More detail in include on page 1 of the report.

As predicted and discussed at the June meeting the Governing Body will see a further deterioration of the performance against elective care standards. Work continues across the health community to confirm plans for the restoration and recovery of such services. During this period the use of the independent sector continues to provide alternatives for patients where clinically appropriate. Further deterioration of the performance against elective care standards is anticipated as demand in Primary Care resumes and social distancing measures continue in secondary care.

NHS England / Improvement has very recently engaged with a Commissioning Support Unit and commissioned a national process for:

- Validating elective waiting lists, in order to support NHS trusts to correctly prioritise patients' treatments, both clinically and chronologically.
- Confirming plans for the recovery of Cancer services and the corresponding reduction in backlog, including 104-day waiters.
- Testing the level of accuracy of NHS-patient waiting lists managed by trusts.

The corresponding letter from NHS England and NHS Improvement requires submission of daily Patient

Treatment Lists and the CCG will work with providers to ensure this is carried out. It provides the Committee a further level of assurance which, owing to the date on which the letter was received, was unable to be included in the main body of the report.

Demand into urgent care services remains suppressed although recent weeks have seen an increase in Accident and Emergency (A&E) activity, albeit not to pre-COVID levels. Bed occupancy remains low and is actively managed as such to provide appropriate distancing and sufficient capacity for surges in demand. The bed occupancy will remain low and is an intended feature of the recovery plans being finalised. Ambulance response time remain above standard.

The measured performance against mental health service standards remains good overall with low waiting time for patients accessing services. Some variation still exists across geographical areas for some services and this is being investigated through the Integrate Care System (ICS) wide deep-dive. Access to some diagnostic services is seen to be affecting confirmation of dementia diagnosis. Members will see the inclusion of additional mental health indicators, which reflect those considered by Regulators.

For all services there is anecdotal evidence of patients delaying access to treatment due to the COVID-19 outbreak. National and local communication channels are being used to remind patients to access services as required.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☐
Performance Management	☒	Procurement and/or Contract Management	☒
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable for this item
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable for this item

Risk(s):

N/A

Confidentiality:

☒No

Recommendation(s):

The Governing Body is asked to:

1. **RECEIVE** and **NOTE** the report for information and assurance.
2. **NOTE** the new narrative throughout the report which seeks to identify:
    a. The root cause of performance issues being reported?
    b. What mitigating actions are in place to recover performance?
    c. What assurance can be given to its sustainability?
    d. Are there any gaps in assurances?

3.	**NOTE** the work being undertaken to Restore services and Recover performance following the outbreak of COVID-19.

NHS Nottingham & Nottinghamshire CCG Performance Report August 2020

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

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This report sets out the performance against key standards and targets for the NHS Nottingham and Nottinghamshire CCG (with aggregate 2019-20 performance for the previous six CCGs to illustrate trends) with supplementary information showing, where appropriate, the equivalent performance for individual provider organisations.

The report is broken down in to sections for Planned Care, Urgent Care and Mental Health indicators offering assurance by indicating:

- The root cause of performance issues being reported?
- What mitigating actions are in place to recover performance?
- What assurance can be given to its sustainability?
- Are there any gaps in assurances?

Releasing Capacity to respond to the COVID-19 Pandemic

In a letter of the 28th March 2020, NHSE set out the approach to the performance and quality standards that are most directly impacted by the COVID-19. The letter provided clarity on the range of indicators that will continue to be monitored and managed during the COVID-19 pandemic and those that will be suspended for a three month period.

On the 6th July, the CCG received a letter from NHSE/I, which focused on stepping back up key reporting and management functions. As the system has passed the initial peak of COVID-19 and phase 2 of recovery planning is underway, there is a requirement to reactivate some of the activities that had previously been paused. The following data collections and associated metrics will be re-instated:

- Referral to treatment patient tracking list (RTT PTL): with specific challenges in the restoration of elective care, the RTT PTL will enable national, regional and local oversight of waiting lists and waiting times, particularly for the longest waiting patients.
- Ambulance clinical outcomes (AmbCO): reactivating AmbCO will mean the full suite of ambulance systems indicators (AmbSYS) will be in place. This will provide an understanding of patients on urgent and critical care pathways such as those used to treat strokes, for example.

Providers were asked within the letter of the 28th March to continue collecting data on the following mental health indicators, where capacity allowed. These collections will resume as normal for the Q2 reporting period:

- Children and young people’s eating disorders waiting times
- Physical health checks for people with severe mental illness
- Out of area placements.

NHSE/I have also confirmed that there will be permanent suspension of the Quarterly Activity Return from Quarter 1 of 2020/21 and that the scope of the Monthly Activity Return will reduce to cover referrals only starting with the collection for June 2020.

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NHS Nottingham & Nottinghamshire CCG Indicator Summary

The table below provides an overview of the performance metrics within this report along with the required standard. Further insight around these indicators can be found at the corresponding page.

Theme	Indicator 1	Indicator 2	Period	Standard	Performance	Page Number
Planned Care	RTT	Percentage of Incomplete Patients Waiting Less Than 18 Weeks	May-20	=> 92%	73.66%	3-4
		Incomplete Waiting List Size		N/A	59,505	5-6
		Incomplete number of 52 week waiters		= 0	117	7-8
	Diagnostics	Percentage of Patients Waiting Longer Than 6 Weeks	May-20	<= 1%	59.68%	9-10
	Cancer	2 Week Wait	May-20	=> 93%	91.59%	11
		2 Week Wait - Breast Symptoms		=> 93%	95.56%	11
		28 Day Faster Diagnosis Standard		=> 70%	77.66%	12
		31 Day Decision to Treat to First Treatment		=> 96%	92.79%	13
		62 Day GP Urgent Referral to Treatment		=> 85%	72.78%	14-17
Urgent Care	A&E	4 Hour Standard	May-20	=> 95%	88.17%	18-19
	Ambulance - Nottinghamshire Division (including Bassetlaw)	Category 1 – Life-threatening illnesses or injuries - Average	May-20	<= 00:07:00	00:06:00	22
		Category 2 – Emergency calls - Average		<= 00:18:00	00:12:19	22
		Category 1 – Life-threatening illnesses or injuries - 90th centile		<= 00:15:00	00:10:29	22
		Category 2 – Emergency calls - 90th centile		<= 00:40:00	00:23:03	22
		Category 3 – Urgent calls - 90th centile		<= 02:00:00	00:51:58	22
		Category 4 – Less urgent calls - 90th centile		<= 03:00:00	01:08:05	22
Mental Health	Improving Access to Psychological Therapies	Entering Treatment - Rolling Three Months	Apr-20	=> 6303	5370	23-24
		Recovery Rate - Rolling Three Months		=> 50%	52.92%	23-24
		Waiting Times - First Treatment within 6 Weeks		=> 75%	82.45%	23-24
		Waiting Times - First Treatment within 18 Weeks		=> 95%	99.06%	23-24
	Dementia	Diagnosis Rate	May-20	=> 66.7%	71.56%	25
	Perinatal MH	% of Population Birthrate	May-20	=> 6.4%	7.69%	26
	SMI	Physical Health Checks for People With an SMI	May-20	=> 60%	31.10%	27
	OAP	Inappropriate Out of Area Bed Days	Q4 19/20	< 1440	306	28
	EIP	Started Treatment in Two Weeks - Rolling Three Months	Apr-20	=> 60%	68.30%	29
	CYP Eating Disorders	Routine Cases <4 Weeks - Rolling Twelve Months	Q4 19/20	=> 95%	85.48%	30-31
		Urgent Case <1 Week - Rolling Twelve Months		=> 95%	100%	30-31

Provider Indicator Summary

The table below provides a view of the performance metrics and associated standards for the key providers of healthcare for the CCG population.

Theme	Indicator 1	Indicator 2	Period	Standard	Performance		Page Number
					NUH	SFH	
Planned Care	RTT	Percentage of Incomplete Patients Waiting Less Than 18 Weeks	May-20	=> 92%	69.85%	77.35%	3-4
		Incomplete Waiting List Size		N/A	38,773	27,763	5-6
		Incomplete number of 52 week waiters		= 0	61	47	7-8
	Diagnostics	Percentage of Patients Waiting Longer Than 6 Weeks	May-20	<= 1%	61.63%	57.58%	9-10
	Cancer	2 Week Wait	May-20	=> 93%	88.92%	98.33%	11
		2 Week Wait - Breast Symptoms		=> 93%	95.24%	100%	11
		28 Day FD		=> 70%			
		31 Day Decision to Treat to First Treatment		=> 96%	94.36%	88.75%	13
		62 Day GP Urgent Referral to Treatment		=> 85%	69.69%	72.48%	14-17
Urgent Care	A&E	4 Hour Standard	May-20	=> 95%		97.55%	18-19
		12hr trolley waits		= 0	0	0	20
	DToC	Delayed Transfers of Care as a percentage of occupied beds	Jun-20	<= 3.5%	0.98%	0.21%	21

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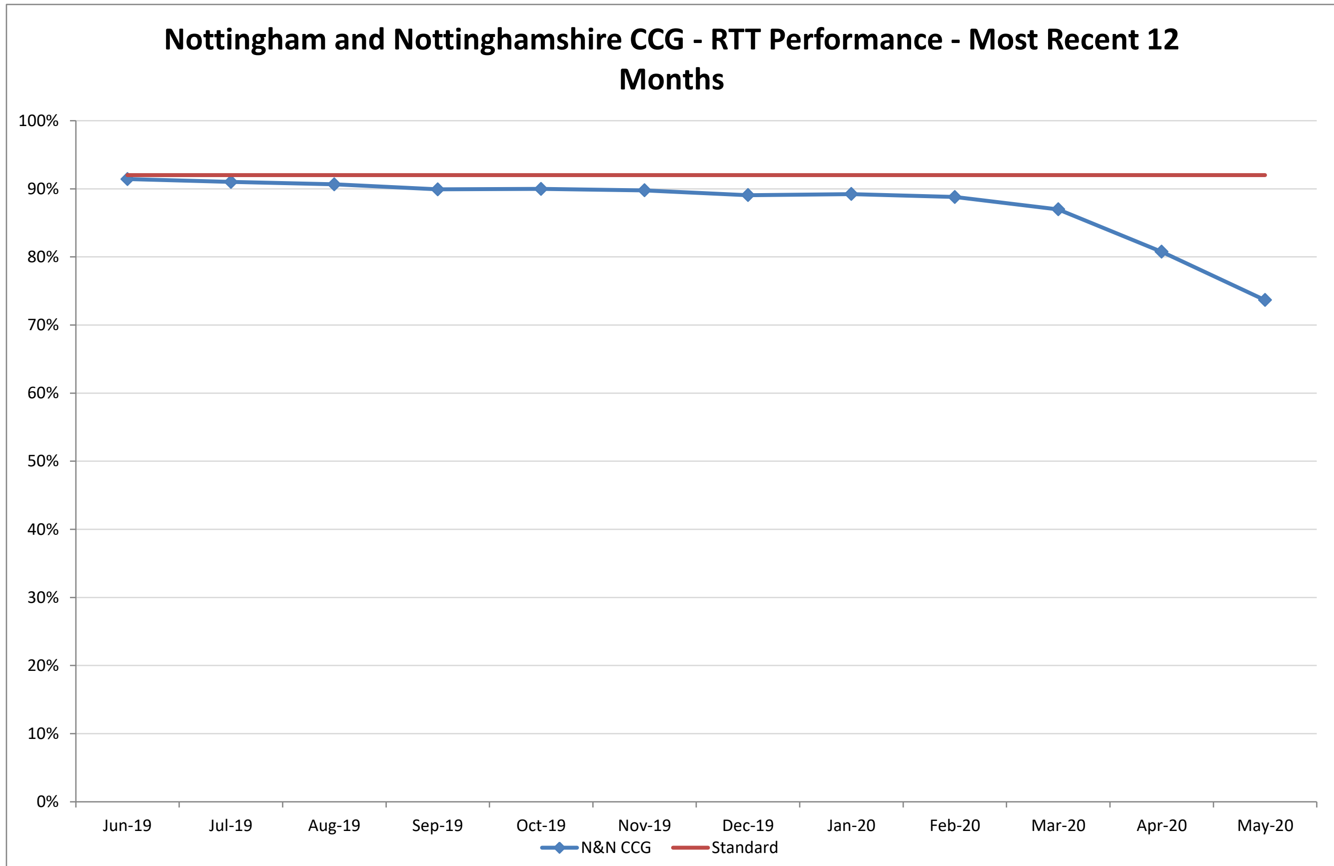
Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	RTT Waiting Times	The percentage of patients waiting less than 18 weeks between referral and treatment for Incomplete pathways (patients still waiting for treatment at the end of the reporting period)	Nina Ennis	CCG Acute Providers

Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than	91.43%	91.00%	90.66%	89.92%	89.98%	89.77%	89.07%	89.23%	88.80%	86.97%	80.76%	73.66%	↓
NUH	or equal to	92.79%	92.52%	92.21%	92.04%	91.70%	90.77%	90.00%	89.73%	89.56%	86.52%	78.85%	69.85%	↓
SFH	92%	89.37%	88.89%	88.33%	87.06%	86.62%	86.26%	86.04%	86.33%	86.18%	85.39%	82.15%	77.35%	↓



RTT Specialty - May 2020	N&N CCG			NUH			SFH		
	Patients	Breaches	>18Wks	Patients	Breaches	>18Wks	Patients	Breaches	>18Wks
General Surgery	2623	851	67.56%	678	317	53.24%	2027	575	71.63%
Urology	2747	642	76.63%	1661	369	77.78%	1237	316	74.45%
Trauma & Orthopaedics	8018	2751	65.69%	4945	1901	61.56%	3328	1111	66.62%
Ear, Nose & Throat (ENT)	6270	1940	69.06%	3291	1261	61.68%	3982	952	76.09%
Ophthalmology	10376	3421	67.03%	5155	2044	60.35%	5480	1413	74.22%
Oral Surgery	1	0	100.00%	1662	642	61.37%	573	160	72.08%
Neurosurgery	209	30	85.65%	512	94	81.64%	0	0	
Plastic Surgery	356	88	75.28%	446	107	76.01%	64	11	82.81%
Cardiothoracic Surgery	91	15	83.52%	175	26	85.14%	0	0	
General Medicine	31	4	87.10%	9	0	100.00%	0	0	
Gastroenterology	3587	955	73.38%	2507	913	63.58%	1465	170	88.40%
Cardiology	3021	668	77.89%	1403	452	67.78%	1980	317	83.99%
Dermatology	3045	961	68.44%	2561	847	66.93%	869	244	71.92%
Thoracic Medicine	2001	449	77.56%	1140	200	82.46%	1345	381	71.67%
Neurology	702	73	89.60%	825	71	91.39%	0	0	
Rheumatology	1404	194	86.18%	623	133	78.65%	965	79	91.81%
Geriatric Medicine	567	66	88.36%	118	27	77.12%	512	47	90.82%
Gynaecology	4095	721	82.39%	1660	317	80.90%	1654	336	79.69%
Other	10361	1844	82.20%	9402	1970	79.05%	2282	176	92.29%
Total	**59505**	**15673**	**73.66%**	**38773**	**11691**	**69.85%**	**27763**	**6288**	**77.35%**

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Root Cause
The decision in mid-March by NHS England to cease all routine elective work to create capacity for COVID-19 patients has had a material impact on RTT performance and associated elective pathway metrics.

There were a number of existing challenges prior to the cessation of routine elective services within a number of pathways, including increased backlogs as a result of non-urgent elective procedures cancelled in previous winter periods; consultant vacancies; reduction in waiting list initiatives due to the pensions tax issue; and increased number of urgent/cancer patients. COVID has introduced a number of additional challenges with overall bed capacity in the trusts reduced to meet social distancing and infection control prevention standards, productivity reduced through theatres, diagnostic capacity and in the delivery of out patient procedures. Many theatre staff, including anaesthetists, were re-deployed into critical care during phase 1 of the incident and have not yet been returned to their normal duties; within critical care shielding and changed working practices following risk assessments of staff is still impacting on workforce availability.

The specialty level breakdown of the April 2020 position (shown on the previous page) details that performance was 73.7% for the Nottingham and Nottinghamshire CCG against the national standard of 92%. This is a deterioration from the position reported last month of 80.8%. NUH and SFH failed the standard with performance of 69.9% and 77.4% respectively across all specialties. The specialties with the highest proportion of patients waiting beyond 18 weeks for the Nottingham and Nottinghamshire CCG were Trauma and Orthopaedics, Ophthalmology and General Surgery. Outpatient activity continues to increase, but is not yet at pre-COVID levels– 60% of pre-COVID levels for OPFAs, 70-75% for OPFUs, at both trusts. Daycase activity also increasing slowly – c.58% of normal levels at NUH, c.48% SFH.

Mitigating Actions

- Continued restoration of urgent and cancer activity which has been the agreed planned care priority for restoration, and capacity for these patients at both Trusts (including the use of independent sector capacity) is close to 100% of pre COVID levels, although significant challenges remain in relation to endoscopy.
- A national programme of work on waiting list validation has begun to assist Trusts to:
  - Improve waiting list accuracy and data quality by identifying pathways which have data quality issues, in particular those caused by the impacts of COVID-19.
  - Reduce incomplete patient tracking list (PTL) size and improve referral to treatment (RTT) performance by identifying pathways that can likely be removed from the incomplete PTL
  - Optimise internal resources through ensuring validation activity is targeted at pathways which require attention.
  - The timescales for this programme of work are not yet clear.. The immediate action is for Trusts to submit their waiting list data to enable a diagnostic exercise to be completed. Once the diagnostic reports are received the regional team will agree timescales with Providers to validate the pathways flagged as a priority to review.
- Whilst NUH and SFH are utilising capacity within the Independent sector predominantly for cancer and urgent activity, where appropriate to do so, residual capacity is to be utilised for long waiting routine elective cases
- A capital requirements submission was requested by NHSEI from all systems, including requirements in relation to general and acute beds, theatre, critical care and diagnostic capacity– the outcome of this submission is not yet known
- Additional actions being taken by NUH and SFH are bulleted below:
  - Continue to reinstate routine elective capacity, Outpatients, Diagnostics and Surgery in line with social distancing limitations and PPE/Testing requirements.
  - Continue the focus on non face to face outpatient activity – Telephone and Virtual clinics. The system recovery group has identified an approach to identify and evaluate the system transformation priorities for 2020/21 and has agreed to use the evaluation framework in two areas, one of which is Outpatients
  - Secure external modelling expertise to support medium to longer term recovery scenarios.

Assurances

- Weekly dialogue takes place between the CCG and providers in the recovery cell as well as other meetings focusing on specific aspects of services including performance.
- Reports are in place tracking all relevant elective measures and the impact of the COVID 19-19 pandemic
- Providers are adapting to new ways of working, which can be evidenced by the substantial growth in non-face to face appointments since mid-March.

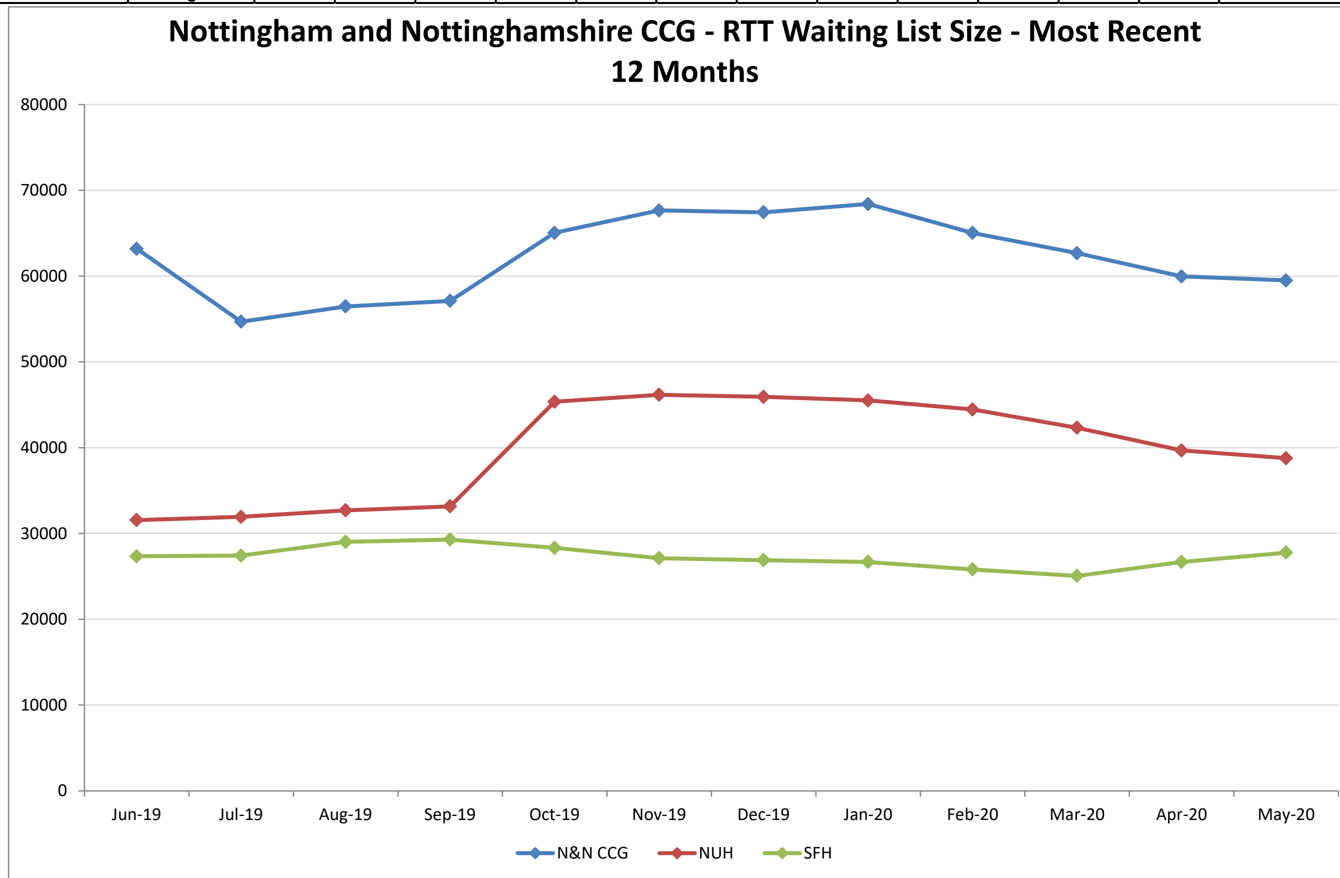
Gaps in Assurance

- There are risks to restoration which include patient anxiety to attend an acute setting and requirement to maintain social distancing in waiting areas. There will be reduced productivity in all settings due to social distancing and increased time between patient treatment times.
- It is likely to take many months to recover performance to pre COVID 19 levels
- The pace at which the backlog of patients can be treated is yet to be agreed and we are, therefore, unable to provide a recovery trajectory until plans are finalised.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	RTT Waiting Times	The total number of patients on an incomplete pathway at the end of the month	Nina Ennis	CCG Acute Providers

The total number of patients on an incomplete RTT pathway at the end of the month (the waiting list size)

Organsation	Standard	Most Recent 12 Months Waiting List												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Reduction in	63197	54688	56467	57120	65057	67662	67435	68412	65033	62670	59969	59505	↑
NUH	patients	31563	31941	32697	33159	45357	46171	45927	45515	44452	42326	39684	38773	↑
SFH	waiting	27348	27426	29025	29294	28325	27120	26896	26681	25812	25059	26690	27763	↓



N&N CCG Waiting List Trend	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
General Surgery	2559	2483	2576	2684	2608	2698	2796	2784	2707	2693	2637	2623
Urology	3872	3382	3369	3424	3551	3585	3688	3651	3417	3172	2934	2747
Trauma & Orthopaedics	6127	5650	5863	5982	6516	6753	6943	7090	7102	6946	7443	8018
Ear, Nose & Throat (ENT)	5083	5149	5589	5554	5405	5208	5434	5773	5710	5697	5965	6270
Ophthalmology	10243	10339	10776	10973	10748	10770	10772	11248	10697	10728	10338	10376
Oral Surgery	468	1	3	2	6	6	3	61	2	5	18	1
Neurosurgery	233	210	229	267	264	280	265	264	261	221	225	209
Plastic Surgery	343	335	342	334	345	327	341	336	343	343	352	356
Cardiothoracic Surgery	104	93	93	78	76	96	95	97	103	107	102	91
General Medicine	418	36	11	38	12	26	24	25	24	31	36	31
Gastroenterology	4260	3158	3377	3594	4633	4788	4706	4449	4288	3855	3642	3587
Cardiology	3463	3362	3559	3508	3243	3101	3144	3163	3128	3101	2988	3021
Dermatology	3752	1263	1269	1323	5123	5152	4915	4657	4424	3686	3046	3045
Thoracic Medicine	1881	1601	1609	1618	2157	2195	2198	2073	2139	2058	2002	2001
Neurology	1479	1468	1684	1772	1817	1755	1690	1693	1620	1392	1069	702
Rheumatology	1481	631	594	516	1416	1251	1231	1124	1194	1217	1315	1404
Geriatric Medicine	590	533	565	588	572	536	544	474	472	426	475	567
Gynaecology	3340	2451	2526	2368	2909	3094	3006	3619	2955	4064	4033	4095
Other	13501	12543	12433	12497	13656	16041	15640	15831	14447	12928	11349	10361
Total	**63197**	**54688**	**56467**	**57120**	**65057**	**67662**	**67435**	**68412**	**65033**	**62670**	**59969**	**59505**

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Root Cause

The size of the waiting list (PTL) is driven by the volume of clock starts (new referrals and overdue reviews) and the volume of clock stops (for treatment or no treatment required). The total number of Nottingham and Nottinghamshire CCG patients waiting for treatment at the end of April 2020 was 59,505. The vast majority of patients are waiting for treatment at NUH and SFH with waiting lists of 38,773 and 27,763 respectively. The waiting list for NUH includes patients waiting for treatment at the Nottingham Treatment Centre.

The largest waiting list at specialty level is for Ophthalmology. The 'Other' specialty and Trauma and Orthopaedics also have large waiting lists. Note that the 'Other' specialty includes a wide range of specialties including colorectal surgery, Allergy and Upper GI.

At SFH clock starts for May 20 were c7,100 or 2% higher than the April 20 position of 6,978 starts. Clock stops increased from 4796 in April 20 to c6,100 in May 20. Given that the volume of clock stops was lower than the clock starts, this has caused the total waiting list to rise from 26,690 to 27,763 between April and May 2020.

At NUH Clock starts for May 20 were 12.6% higher than April 20 at c.7,500. Clock stops at the trust showed a small reduction of –1.65% lower than April 20 at c.7,300, this has caused the total waiting list to decrease from 39,684 to 38,773.

Mitigating Actions

A summary of the key actions being taken by SFH are bulleted below:

- Continue to re-instate routine (long wait) capacity – OP, Diagnostics and Surgery in line with social distancing limitations and PPE/Testing requirements.
- Maintain the on-going use of the Independent sector for Orthopaedics and Radiology, which has been in place from W/C 18/05/2020
- On-going review of clinic set up for all specialties to determine limitations of social distancing on face to face capacity and formalise non face to face capacity.
- 60% KMH site restored and plans for Newark and MCH by the end of June 2020.
- Secure external modelling expertise to support medium to longer term recovery scenarios.
- Continue the focus on non face to face outpatient activity in the form of telephone and virtual clinics. Currently around 60% of clinics are held via telephone or virtually

The recovery plan for NUH is currently under development (as detailed on page 4) with the support of an external consultancy.

Assurances

- Weekly dialogue takes place between the CCG and providers in the recovery cell as well as other meetings focusing on specific aspects of services including performance.
- Reports are in place tracking all relevant elective measures and the impact of the COVID 19-19 pandemic
- Urgent and cancer capacity has been restored to 100% of pre-COVID levels at SFH
- Providers are adapting to new ways of working, which can be evidenced by the substantial growth in non-face to face appointments since mid-March.

Gaps in Assurance

The PTL at SFH has continued to grow over recent months; from 25,059 In March to 26,690 in April and 27,763 in May 2020. The trust are indicating that the size of the PTL will continue to grow for a number of months. The rationale for this being that; new referrals (clock starts) are likely to increase in the coming weeks as the lockdown restrictions are relaxed further and clock stops particularly for routine activity will remain low.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	RTT Waiting Times	The number of incomplete pathways exceeding 52 weeks at the month end	Nina Ennis	CCG Acute Providers

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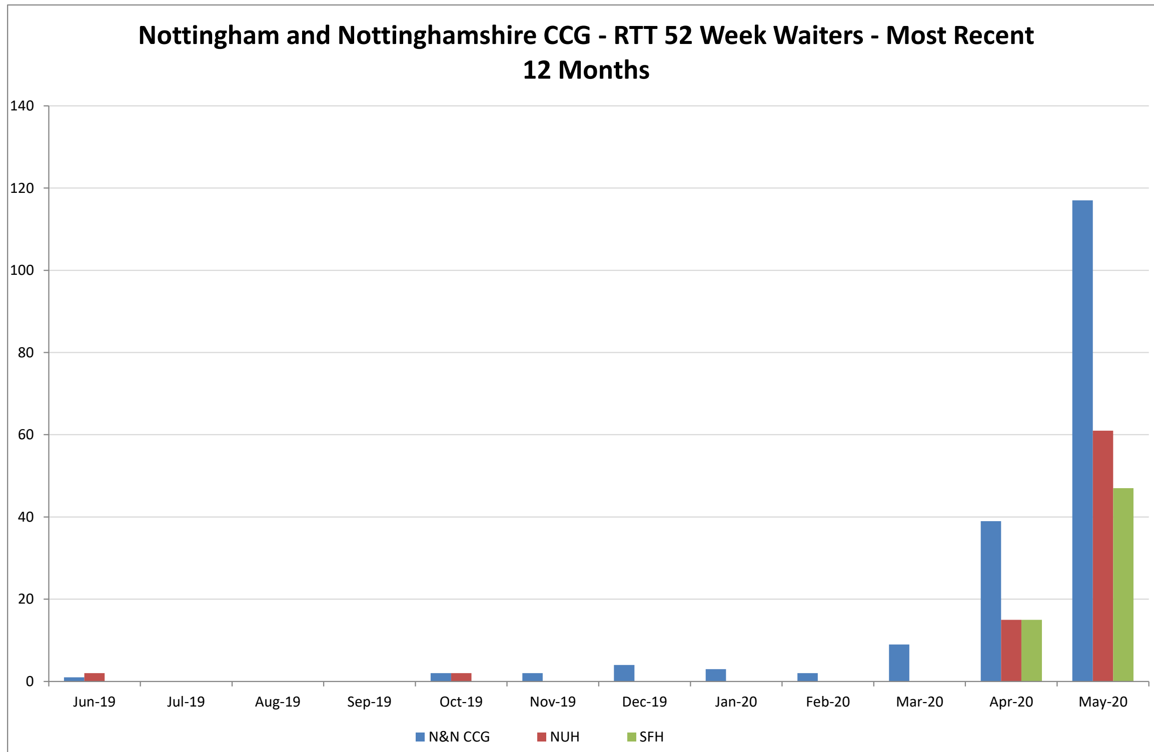
The number of incomplete pathways exceeding 52 weeks at the end of the month

Organsation	Standard	Most Recent 12 Months 52 Week Waiters												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	No patients waiting over 52 Weeks	1	0	0	0	2	2	4	3	2	9	39	117	↓
NUH		2	0	0	0	2	0	0	0	0	0	15	61	↓
SFH		0	0	0	0	0	0	0	0	0	0	15	47	↓



N&N CCG Patients Waiting Over 52 Wks - Top 10 Providers	Patients
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	45
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	41
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	15
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	6
SPIRE NOTTINGHAM HOSPITAL	4
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	2
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1
BOLTON NHS FOUNDATION TRUST	1
WOODTHORPE HOSPITAL	1
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1

Root Cause

During March 2020 NHS England made a decision to cease all routine electives due to the COVID-19 pandemic. As a result of this there has been an increase in the number of long wait patients awaiting routine surgery across the country, these are largely patients that have been assessed as safe to wait.

Long waiting patients and their root cause were being actively managed by providers prior to the COVID pandemic in a range of specialties. At SFH there were issues in Ophthalmology where there was a capacity gap c.18 clinics per week for 1st Outpatient appointments. There were also long waits for follow up appointments in T&O which were associated with reduced elective operating over Winter.

Mitigating Actions

- Weekly RTT meeting reinstating during June 2020
- Development of plans for patients waiting beyond 52 weeks
- Restoration of elective capacity extended across the Nottinghamshire system including on-going use of Independent Sector capacity

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Assurances

- Patients deemed as urgent or where a long wait has the potential to cause harm still have the option of being treated
- Restoration of elective services is underway within the main providers of the CCG. Additional detail around this for SFH and NUH can be found within the RTT assurances on page 4 of this report.
- Providers are continuing to utilise the independent sector where appropriate for longer waiting patients

Gaps in Assurance

It is likely that there will be further increase in long waiting patients over the coming months. This is due to several factors including - restrictions placed on capacity within hospitals, a requirement for patients to self-isolate for 14 days before and after treatment, and patient anxieties regarding attending healthcare facilities.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	Diagnostics Waiting Times	Waiting Times for 15 key diagnostics tests and procedures. Waiting Times are expected to be 6 weeks or less	Nina Ennis	CCG Acute Providers

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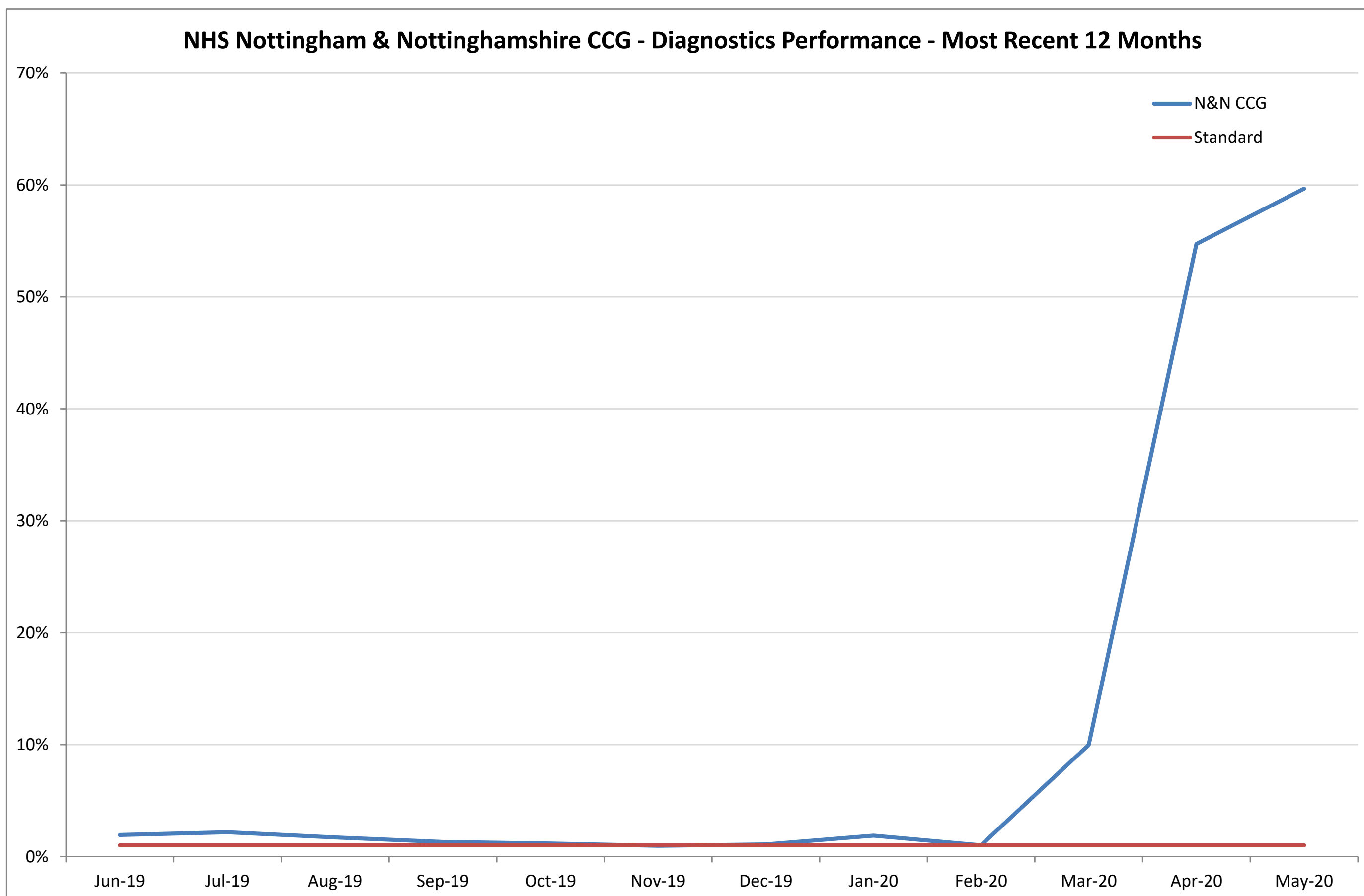
Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Less than	1.92%	2.17%	1.70%	1.31%	1.17%	0.96%	1.08%	1.87%	0.99%	9.97%	54.73%	59.68%	↓
NUH	or equal	2.70%	3.04%	1.76%	1.25%	1.27%	1.00%	0.99%	2.32%	1.01%	12.42%	57.23%	61.63%	↓
SFH	to 1%	0.99%	0.83%	2.00%	1.35%	0.95%	0.88%	0.96%	1.45%	1.43%	6.19%	53.00%	57.58%	↓



Tests Below Standard - May 2020	N&N CCG			NUH			SFH		
	Patients	Breaches	<6Wks	Patients	Breaches	<6Wks	Patients	Breaches	<6Wks
MRI	4869	3305	67.88%	4394	2984	67.91%	1442	988	68.52%
Computed Tomography	2055	1060	51.58%	1426	745	52.24%	867	464	53.52%
Non-obstetric ultrasound	5475	2614	47.74%	3039	1588	52.25%	2398	991	41.33%
Barium Enema	0	0		0	0		0	0	
DEXA Scan	992	662	66.73%	771	492	63.81%	311	219	70.42%
Audiology	821	710	86.48%	449	389	86.64%	451	392	86.92%
Echocardiography	2395	1428	59.62%	1605	935	58.26%	1030	618	60.00%
Cardiology - Electrophysiology	0	0		0	0		0	0	
Neurophysiology	392	270	68.88%	491	345	70.26%	0	0	
Sleep studies	249	206	82.73%	93	87	93.55%	252	189	75.00%
Urodynamics	59	41	69.49%	8	5	62.50%	66	46	69.70%
Colonoscopy	898	581	64.70%	693	460	66.38%	296	177	59.80%
Flexi sigmoidoscopy	362	213	58.84%	236	143	60.59%	174	96	55.17%
Cystoscopy	310	130	41.94%	123	18	14.63%	237	134	56.54%
Gastroscopy	991	637	64.28%	730	473	64.79%	388	242	62.37%
Total	**19868**	**11857**	**59.68%**	**14058**	**8664**	**61.63%**	**7912**	**4556**	**57.58%**

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Root Cause

At the end of May 2020, the CCG failed the Diagnostic Standard with performance of 59.68% against a standard of <1%. Routine diagnostic test activity and waiting times have been significantly impacted by the COVID 19 Pandemic. There were 11,857 breaches of the standard, which is 11,658 more than the limit of 199 (equivalent to 1% of patients). At diagnostic test level, performance varied between Cystoscopy which had performance of 41.94% and Audiology with performance of 86.48% in May. Endoscopy has been classified as an air generating procedure; in order to meet the IPC standards for AGPs, less procedures can be undertaken per list

Both NUH and SFH failed the standard in March with performance levels of 61.63% and 57.58% respectively.

Mitigating Actions

NUH and SFH are working with the CCG and ICS to further develop and refine recovery plans. These detail the timescale and method for services becoming operational and increasing their capacity. Key dates within the SFH recovery plan are bulleted below:

- On-going use of the Independent sector for MRI capacity in place which began 18/05/2020
- SFH are continuing to restore routine diagnostic capacity for Radiology (CT and Ultrasound weekend sessions), Audiology and Endoscopy. The Newark CT scanner has been upgraded in order to support CT cardiac capacity, with software installation taking place in early July.
- Key dates where additional capacity was secured are detailed below:

◊ Radiology weekend sessions for ultrasound commenced 20/06/2020
◊ Radiology additional CT on site W/C 22/06/2020
◊ DEXA scans W/C 22/06/2020
◊ Endoscopy capacity obtained from the Independent sector W/C 29/06/2020

The recovery plan for NUH is currently under development. An external consultancy is providing support around granular capacity and demand modelling, which will inform when service capacity can begin to be restored. The model will include the utilisation of hospital resources such as theatres, workforce, equipment, services, consumables and PPE. This provider specific modelling will integrate into the wider modelling work coordinated by the Recovery Cell to provide a composite view for the ICS.

Assurances

- Urgent and cancer diagnostic capacity was restored by 15/06/2020
- Weekly dialogue takes place between the CCG and providers in the recovery cell as well as other meetings focusing on specific aspects of services including Performance.
- Collaborative work is taking place in the COVID 19 Recovery Cell to collectively agree the underlying capacity for each modality, given the reduction due to the additional Infection Control procedures required.
- NUH continue to use the local Independent Sector providers for some imaging services and this will continue as a feature of the recovery of the standard.

Gaps in Assurance

- There are material risks to restoration which include patient anxiety to attend an acute setting and requirement to maintain social distancing in waiting areas.
- The pace at which the backlog of patients can be treated is yet to be agreed and we are, therefore, unable to provide a recovery trajectory until plans are finalised.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	Cancer—2 Week Wait	Waiting Times against the 2 week wait cancer standard	Simon Castle	CCG Acute Providers

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance - Two Week Wait												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 93%	94.98%	94.23%	92.20%	91.28%	93.73%	94.06%	94.52%	94.11%	94.82%	94.86%	92.64%	91.59%	↓
NUH		96.26%	95.87%	92.09%	90.74%	93.36%	93.61%	93.97%	93.19%	93.82%	94.10%	83.40%	88.92%	↑
SFH		95.15%	93.91%	93.03%	93.36%	94.84%	95.35%	96.34%	95.52%	97.05%	96.83%	96.25%	98.33%	↑

Organsation	Standard	Most Recent 12 Months Performance - Two Week Wait - Breast Symptoms												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 93%	99.47%	98.11%	97.46%	98.06%	96.15%	98.21%	98.52%	98.17%	96.67%	94.96%	86.11%	95.56%	↑
NUH		99.42%	99.22%	100%	100%	100%	98.85%	99.15%	96.81%	96.63%	94.44%	74.07%	95.24%	↑
SFH		100%	100%	92.68%	94.29%	95.56%	97.50%	100%	97.87%	97.96%	100%	100%	100%	↔

Root Cause

- COVID-19, lockdown and restriction of movement has impacted on numbers of 2ww referrals from Primary Care. Primary Care is still seeing some reduction in patients presenting with symptoms, particularly older patients. GPs have not stopped referring.
- Referral numbers have started to increase across all tumour sites. 2ww referrals now back to 70 /80% of pre-COVID levels. UGI and Breast have seen the biggest increases in the recent two weeks.
- Reduced diagnostic capacity within endoscopy and radiology also impacted on April and May performance

Mitigating Actions

- Local communication has been undertaken, encouraging patients to attend GP practice if they have symptoms
- NUH is continuing to use the Spire for CTC and day-surgery, TC and now Woodthorpe for endoscopy. Waits for endoscopy are reducing and many patients now have dates
- June is expected to meet performance target

Assurances

The main issue causing falling performance and increasing backlogs is the reduction in diagnostic capacity, especially endoscopy and CT, due to COVID infection control measures. The Trust is required to use endoscopy suites with ventilation and scanners ring fenced for COVID patients. Both endoscopy and CT facilitates require cleaning down in between patients.

Diagnostic capacity will be more severely tested when 2ww referral rates return to normal levels and Trusts start to address their elective care backlogs.

There is growing momentum at a national and regional level to address the imaging and endoscopy under-capacity which will be detrimental to the restoration and recovery of cancer and non-cancer services. NUH and SFH, along with the CCG are engaging with the East Midlands Cancer Alliance and regional teams on diagnostic initiatives such as community diagnostic centres, regional diagnostic networks and diagnostic boards.

Gaps in Assurance

The amount of capital attached to these initiatives is not known at this stage and the capacity of the mobile diagnostic solutions market is not well understood. Both factors make it difficult to forecast the additional diagnostic capacity Nottinghamshire will be able to access.

The speed at which solutions can be implemented will be dependent on how quickly funding comes down to Trusts and the capacity of the market to supply at pace.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	Cancer—28 day FDS	Waiting Times against the 28 Fast Diagnosis cancer standard	Simon Castle	CCG Acute Providers

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance - Twenty Eight Day FDS												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 70%	81.43%	78.36%	77.31%	78.58%	79.25%	81.36%	81.16%	77.13%	82.08%	79.73%	61.53%	77.66%	↑
NUH														⇔
SFH														⇔

Please note: The release of NUH & SFH data has been delayed due to the response to the COVID-19 pandemic. This table will be updated as soon as the data is available.

Root Cause
The new Faster Diagnosis Standard is intended to ensure that all patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. This standard was introduced in April 2020. The data is available at CCG as reported above, however data release has been delayed at provider level due to the COVID 19 pandemic.

Hospitals began recording data in 2019, which has enabled baseline performance to be captured prior to the indicator being formally introduced by NHSE. This has enabled Cancer Alliances to identify where improvements need to be focused at an earlier stage.

This new standard is designed to:

- Reduce anxiety for patients who will be diagnosed with cancer or receive an ‘all clear’ but do not currently hear this information in a timely manner;
- Speed up time from referral to diagnosis, particularly where faster diagnosis is proven to improve clinical outcomes;
- Reduce unwarranted variation in England by understanding how long it is taking patients to receive a diagnosis or ‘all clear’ for cancer across the country.

There are three main factors that require consideration by providers in order to deliver the Faster Diagnosis Standard. They are:

1. Time to first seen and test - This requires alignment of 2 week wait demand and diagnostic capacity
2. The volume of tests required to confirm or rule out cancer
3. Method of communication—this is often face to face, however telephone clinics are increasingly being utilised

The performance level for the Nottingham and Nottinghamshire CCG was 77.66% in May 2020, which is above the national standard of 70%. Performance within the twelve months prior was consistently above the national standard and in five of those months, performance was above 80%.

Mitigating Actions
The COVID 19 Pandemic has impacted capacity for diagnostic procedures, largely due to the increase in infection control requirements. Providers are required to protect the capacity within endoscopy suites with ventilation and scanners for COVID 19 patients. However, as COVID 19 demand begins to reduce the dedicated capacity can be released to other patient groups.

The FDS standard requires the use of the ‘letter sent date’ to be recorded. However, use of telephone clinics could reduce FDS waits by 7-10 days.

SFH are reviewing all tumour sites to review methods of communication used for FDS. Moving to telephone clinics where possible to reduce the number of days patients are waiting for outcomes.

Assurances
Collecting the data from April 19 has enabled a more granular understanding to be reached around the key areas for improvement at local providers which include the level of Outpatient and Diagnostic capacity as well as timely methods of communication.

System wide dialogue continues to take place around the recovery and restoration of services.

Gaps in Assurance
Patient choice remains a risk with some patients currently choosing to decline appointments due to COVID fears.

In addition to comparison against the national standard, provider benchmarking is a useful resource against which to assess provider performance. However, this is not currently possible for 28 day FDS as a national decision has been taken to delay the publication of provider level FDS data until at least the end of Q1 2020/21.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	Cancer—31 Day	Waiting Times against the 31 day wait cancer standard	Simon Castle	CCG Acute Providers

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance - 31 Day												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 96%	96.60%	92.87%	96.79%	92.82%	94.73%	92.94%	94.38%	89.90%	95.37%	94.96%	94.53%	92.79%	↓
NUH		93.85%	91.98%	94.58%	92.90%	93.14%	91.71%	93.16%	88.87%	94.55%	94.29%	94.34%	94.36%	↑
SFH		97.60%	94.44%	100%	94.44%	97.06%	96.43%	95.80%	90.00%	99.10%	96.90%	96.20%	88.75%	↓

Root Cause

- COVID-19, lockdown and restriction of movement continues to impact on NUH performance.
- Higher than normal non-attendance through patient choice due to COVID-19
- 31 Day Performance for May 2020 was static at 94.4%. (April 94.3%)
- Impacted by lack of surgical capacity in skin and Breast
- Skin - recent increased demand continues to impact on capacity

Mitigating Actions

Skin

- Skin continues to be fragile, with increased demand through TC impacting on capacity
- Use of Spire Hospital to help reduce backlog.

Patient Choice

- CNSs are continuing to contact 'non-attending patients' – engaging with them to build confidence / encourage them to attend.
- Standardised information being added to website for patients, to encourage attendance

Assurances

The main issue causing falling performance and increasing backlogs is the reduction in diagnostic capacity, especially endoscopy and CT, due to Covid infection control measures. The Trust is required to use endoscopy suites with ventilation and scanners ring fenced for Covid patients. Both endoscopy and CT facilitates require cleaning down in between patients.

Diagnostic capacity will be more severely tested when 2ww referral rates return to normal levels and Trusts start to address their elective care backlogs.

There is growing momentum at a national and regional level to address the imaging and endoscopy under-capacity which will be detrimental to the restoration and recovery of cancer and non-cancer services. SFH, along with the CCG are engaging with the East Midlands Cancer Alliance and regional teams on diagnostic initiatives such as community diagnostic centres, regional diagnostic networks and diagnostic boards.

Gaps in Assurance

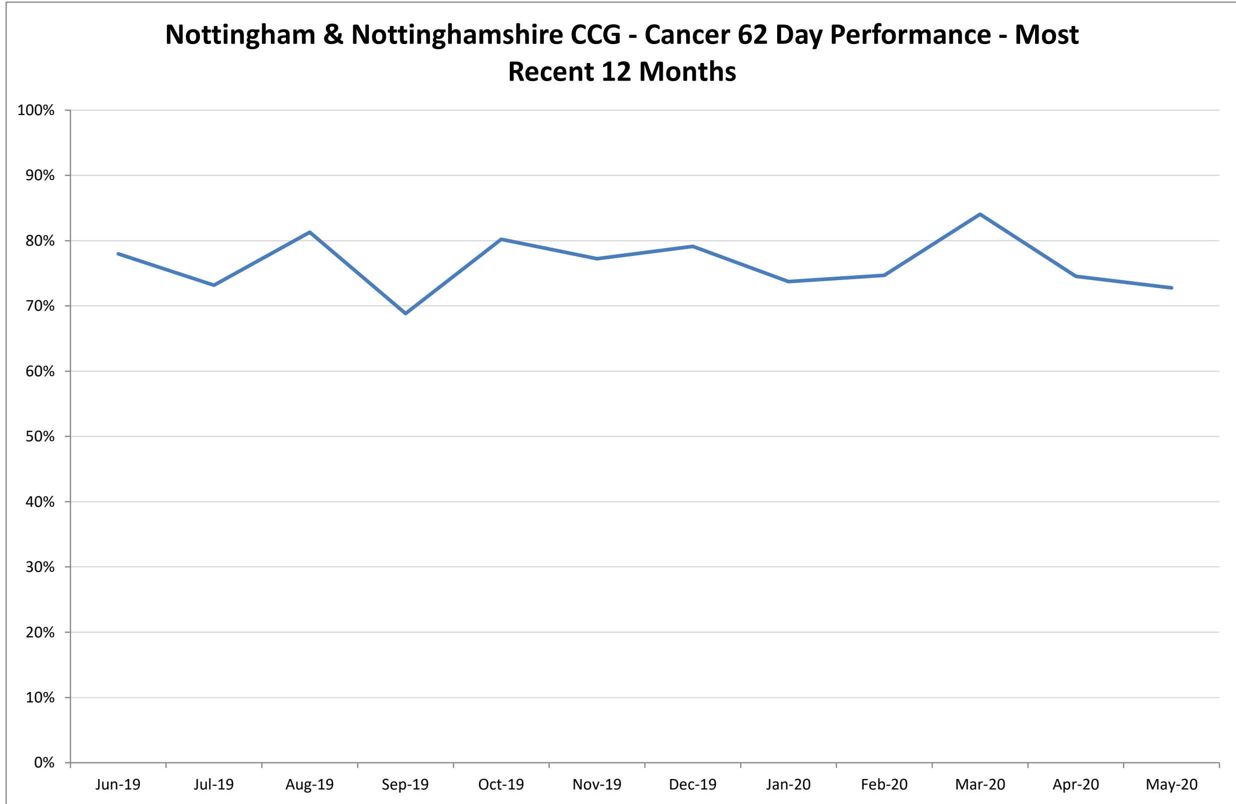
The amount of capital attached to these initiatives is not known at this stage and the capacity of the mobile diagnostic solutions market is not well understood. Both factors make it difficult to forecast the additional diagnostic capacity Nottinghamshire will be able to access.

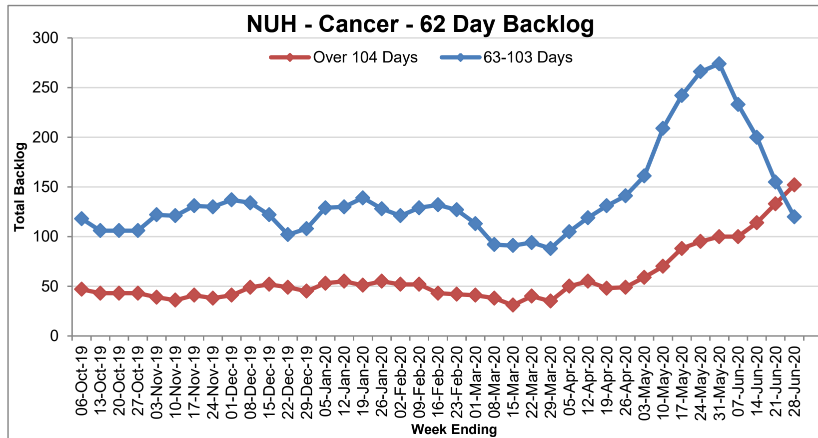
The speed at which solutions can be implemented will be dependent on how quickly funding comes down to Trusts and the capacity of the market to supply at pace.

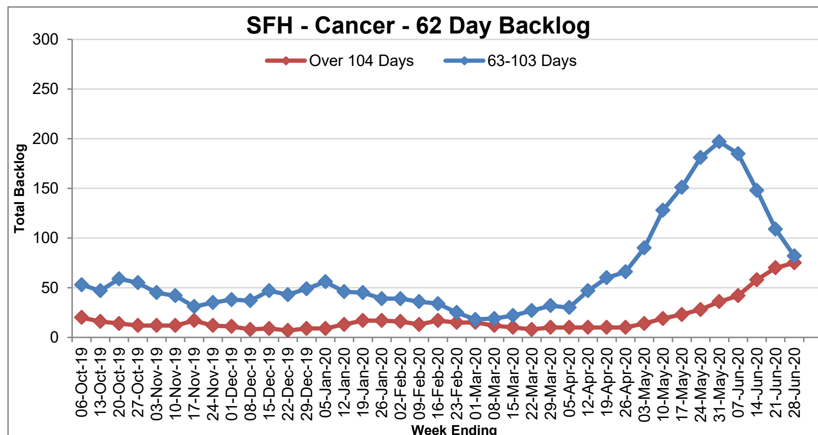
Theme	Indicator	Indicator Overview	CCG Lead	Focus
Planned Care	Cancer—62 Day	Waiting Times against the 62 day wait cancer standard	Simon Castle	CCG Acute Providers

Nottingham and Nottinghamshire
Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance - 62 Day												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than	77.97%	73.16%	81.30%	68.84%	80.20%	77.24%	79.13%	73.73%	74.68%	84.05%	74.53%	72.78%	↓
NUH	or equal to	75.50%	70.51%	80.15%	77.72%	80.34%	78.30%	74.32%	78.07%	75.81%	85.54%	74.01%	69.69%	↓
SFH	85%	68.07%	76.39%	82.22%	77.27%	76.12%	74.27%	86.02%	67.26%	76.43%	80.66%	72.73%	72.48%	↓







Sherwood Forest Hospitals Performance Focus

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Root Cause

- SFH's 62 day performance is almost static, 72.5% in May compared to 72.7% in April. There were 15 breaches for 54.5 treatments.
- Breaches were spread across breast (4), gynaecology (3.5), upper gastrointestinal (2.5), and urology (2).
- The 62 day backlog peaked at the end of May at about 275. By 7th July it was down to 184 due to an increase in diagnostic activity as well as the reduction in 2ww referrals in April.
- Lower gastrointestinal remains the specialty with the largest backlog. This also peaked at the end of May but is now decreasing due to increased endoscopy activity.
- The breast backlog is increasing due to the number of patients waiting for surgery. National Cancer Waiting Times (CWT) guidance states that patients who have hormone treatment as a temporising treatment, whilst awaiting surgery must remain on the PTL.
- The number of patients waiting over 104 days stood at about 50 at the end of May and continues to be impacted by reduced diagnostic and treatment capacity.
- The number of colonoscopies and gastroscopies procedures carried out is increasing. The endoscopy waiting list is correspondingly decreasing.
- The CT waiting list peaked in the middle of June and has subsequently decreased from about 140 to about 60 at the beginning of July.
- The need for 2 week self-isolation prior to surgery is impacting treatment numbers.

Mitigating Actions

- SFH run one cancer surgery list per day. Capacity is constantly reviewed by the Surgery Division.
- Patients who require their treatments with the Tertiary providers are transferred via Inter Provider Transfer (IPT) , which is in line with the established process. These patients are then prioritised by the Tertiary Provider and listed for surgery accordingly.
- The Gynaecology service is outsourcing some surgery where clinically appropriate to The Park Hospital.
- SFH Clinical Cancer leads are prioritising patients in accordance with the Clinical Guide for the Management of Cancer Patients during the Coronavirus Pandemic, which has been produced by NHSE/I.
- Welfare calls are being made to patients with anxieties regarding attending during the Pandemic
- Robust clinical triage is in place for endoscopic procedures. Patients are tested based on urgency/suspected symptoms in line with national guidance.

Nottingham University Hospitals Performance Focus

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Root Cause
- COVID-19, lockdown and restriction of movement continues to impact on NUH performance.
- Performance for May 2020 fell again to 69.7% from 74% in April
- Treatment numbers fell to 127, as activity reduces. Note that April was 177
- Breaches fell to 38.5 from 46 last month. Driven by:- UGI 8, Breast 6.5, H&N 6, Lung 5, LGI 4
- 62 day Backlog is starting to reduce and is 260 patients as of 30th June. Reducing by approx. 10% every 2 weeks (Backlog was 346 on 2/6/20) LGI continues to have the largest percentage of the overall backlog
- 104 day patients – Numbers continue to increase, and will do for the next 2/3 weeks, before any improvement is seen. (154 as of 24th June) Overall numbers continue to be driven by LGI, which accounts for over 50% of the total

CTC
- Capacity issues continue with CTC
- 15 CTC per week being delivered by Spire Hospital – 50% of normal capacity. 6 week wait for CTC

Endoscopy
- 650 slots a week required for all endoscopies, including routines – current average is 350
- Cancer patients have been allocated dates given within 2-4 wks.
- Numbers not back to pre-COVID levels yet. Approximately 1,300 routine non-cancer patients waiting for endoscopies at NUH.
- Continuing ventilation issue within endoscopy suite at NUH means no patients going through it - leaving capacity gap

Surgery
- Surgical capacity is robust; however 2 week self-isolation pre surgery is also impacting on numbers. 2-4 wk. waits for surgery
- Few patients are waiting for surgery dates on the PTL (Patient Tracking list) however with high number of patients waiting to be diagnosed in LGI this is likely to rise.
- Chemotherapy and Radiotherapy continues to manage well. Referrals have fallen slightly however treatment times remain robust

Mitigating Actions
Patient Choice
- Patients continue to choose not to attend appointments due to concerns about COVID-19
- CNSs are continuing to contact 'non-attending patients' – engaging with them to build confidence and encourage attendance.
- Standardised information being added to website for patients, to encourage attendance

Surgery
- Majority of patients are attending surgery date
- The Park undertaking Colorectal surgery

Independent Sector
- NUH is continuing to use the Spire for CTC and day-surgery. The Treatment Centre and now Woodthorpe are both being used for endoscopy. Waits for endoscopy are reducing.
- National agreement to utilise Independent sector has now been extended until August.
- Successfully running 4 lists per day at the Park. NUH is supporting with staff, equipment and PPE where necessary.
- 290 cancer patients in May, were treated in the independent sector.

CTC
- 15 ctc per week being delivered by Spire Hospital, although this is less than 50% of normal capacity.

Endoscopy
- Utilising day surgery unit at TC for endoscopy
- Endoscopy continues to be provided at Woodthorpe Hospital.

Urology
- Robotic surgery has commenced – Urology has 4 lists a week at The Park and 4 lists at City Hospital.

Continued from previous page

NHS
Nottingham and Nottinghamshire
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Assurances - NUH and SFH
The main issue causing falling 62 day performance and increasing backlogs is the reduction in diagnostic capacity, especially endoscopy and CT, due to COVID infection control measures. The Trust is required to use endoscopy suites with ventilation and scanners ring fenced for COVID patients. Both endoscopy and CT facilitates require cleaning down in between patients.

Diagnostic capacity will be more severely tested when 2ww referral rates return to normal levels and Trusts start to address their elective care backlogs.

There is growing momentum at a national and regional level to address the imaging and endoscopy under-capacity which will be detrimental to the restoration and recovery of cancer and non-cancer services. SFH, along with the CCG are engaging with the East Midlands Cancer Alliance and regional teams on diagnostic initiatives such as community diagnostic centres, regional diagnostic networks and diagnostic boards.

Gaps in Assurances - NUH and SFH
The amount of capital attached to these initiatives is not known at this stage and the capacity of the mobile diagnostic solutions market is not well understood. Both factors make it difficult to forecast the additional diagnostic capacity Nottinghamshire will be able to access.

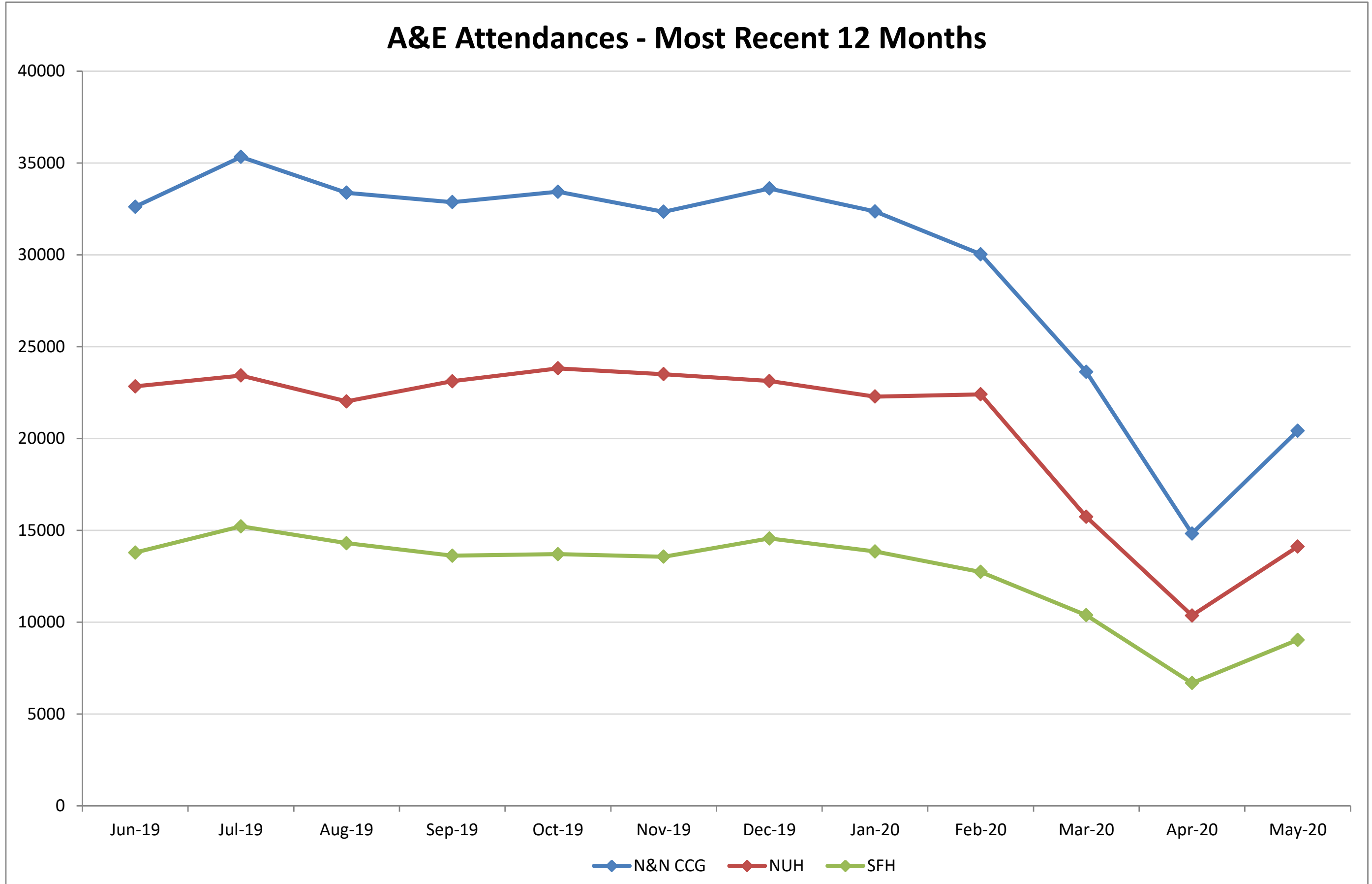
The speed at which solutions can be implemented will be dependent on how quickly funding comes down to Trusts and the capacity of the market to supply at pace.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Urgent Care	A&E—4 hour Wait	The percentage of patients waiting under 4 hours in A&E departments	Caroline Nolan/Lisa Durant	Acute Providers CCG

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 95%	78.11%	77.80%	78.33%	76.95%	75.67%	75.09%	73.25%	76.48%	75.73%	76.77%	84.31%	88.17%	↑
NUH		Reporting suspended due to trial of new indicators												↔
SFH		94.67%	88.95%	89.22%	90.25%	91.53%	88.29%	87.01%	89.65%	89.61%	87.72%	96.50%	97.55%	↑

Organsation	Standard	Most Recent 12 Months - Attendances												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	N/A	32614	35332	33379	32868	33433	32340	33611	32360	30032	23622	14823	20416	N/A
NUH		22838	23429	22017	23113	23814	23498	23125	22279	22405	15731	10356	14111	N/A
SFH		13783	15212	14300	13617	13697	13557	14553	13844	12728	10378	6678	9026	N/A



Root Cause

NUH
4hr wait performance is not applicable to NUH.

For June, NUH ED attendances are starting to rise and are now showing a daily average of 508. Likewise, the UTC on London Road has also seen a steady rise in daily attendances. Patient cohort wise, an increased volume of Mental Health presentations to ED continues to be seen.

SFH
For June, the Trust achieved a performance standard of 95.74%. Throughout June the Trust has seen a continuing increase in overall attendance (circa 10% increase from May) however this increase is not linear, as daily attendance continues to fluctuate. No patient cohort or injury/illness trend has been identified for this increasing attendance figures.

Streaming, there has been an increase in the numbers being streamed to PC24 with an average of 53 daily attendances in June. The streaming position in June was 18.61% and this has continued to increase.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Mitigating Actions

For SFHFT front door services, community are redeploying staff back to admission avoidance services whilst ensuring the continuing staffing of the D2A cell. SFHFT continue to review breaches to identify issues learnt that can then be used to avoid further 4hr delays e.g. identifying areas to improve processes to speed up attendance to admission,

CCG, A Nottinghamshire wide Demand Avoidance Group has been set up to maintain the reduction in attendances seen in ED during the Covid-19 period. This group has a clinical lead and includes EMAS representatives who will work to maintain the reduction in ambulance conveyances to ED seen over the last 3 months.

Assurances

The performance level of SFH and NUH ED departments is reviewed in detail by the A&E delivery Boards for Mid Nottinghamshire and Greater Nottingham as part of their role ensuring effective delivery of services and improvement in the associated access and performance standards. The delivery boards have executive level multi organisational membership to enable urgent care system issues to be addressed.

System wide telephone calls take place on a daily basis, which enable partner organisations from the urgent care system to discuss the latest performance levels and work collaboratively to address urgent issues.

Daily data is received from SFH and NUH in the form of a SitRep, which includes data for the previous calendar day on around 60 metrics, including A&E performance, Ambulance Handovers, Long waiting patients and Available bed stock. These metrics enable granular monitoring of the ED pathway and provide a common snapshot of performance that can be discussed on the daily system calls.

Gaps in Assurance

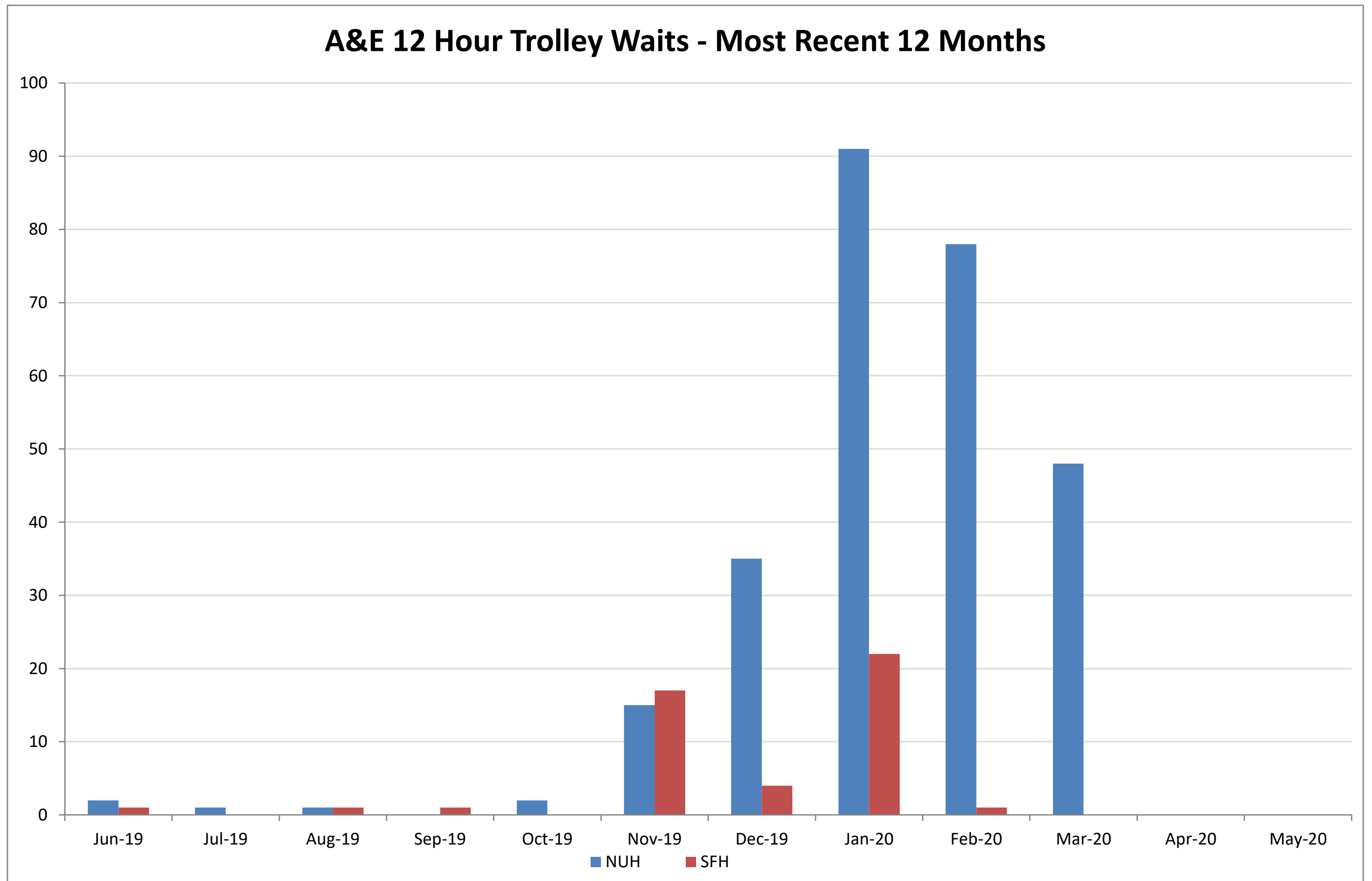
The demand avoidance group has formed and is currently developing a series of plans. The phasing of planned scheme impact is not yet finalised. Therefore, there may be a continued rise in ED attendances for a number of months until the schemes beginning to deliver.

Monitoring the effectiveness of plans to avoid demand will require care and granular analysis. It will be challenge to accurately calculate the delivery level of a individual scheme given that patients can be members of multiple cohorts. Therefore a single patient can be the focus of a number of schemes. Assignment of a prevented attendance to a scheme will require careful consideration when developing the monitoring approach.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Urgent Care	A&E—12 Hour Trolley waits	Period from the decision to admit to formal admission to an emergency inpatient bed	Caroline Nolan/Lisa Durant	Acute Providers CCG

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months - Attendances												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	⇔
NUH		2	1	1	0	2	15	35	91	78	48	0	0	⇔
SFH		1	0	1	1	0	17	4	22	1	0	0	0	⇔



Root Cause
There were zero 12 hour breaches at NUH in May for patients of Nottingham and Nottinghamshire CCG. There were also no breaches for NUH and SFH at Total Trust level.

Mitigating Actions
On a routine basis, patients approaching the 12 hour trolley wait are escalated to senior managers to discuss whether any appropriate action can be taken to prevent the breach. All breaches are reported to the CCG.

Assurances
All 12 hour breaches are investigated by the provider and a Root Cause Analysis (RCA) document is produced to summarise the findings.

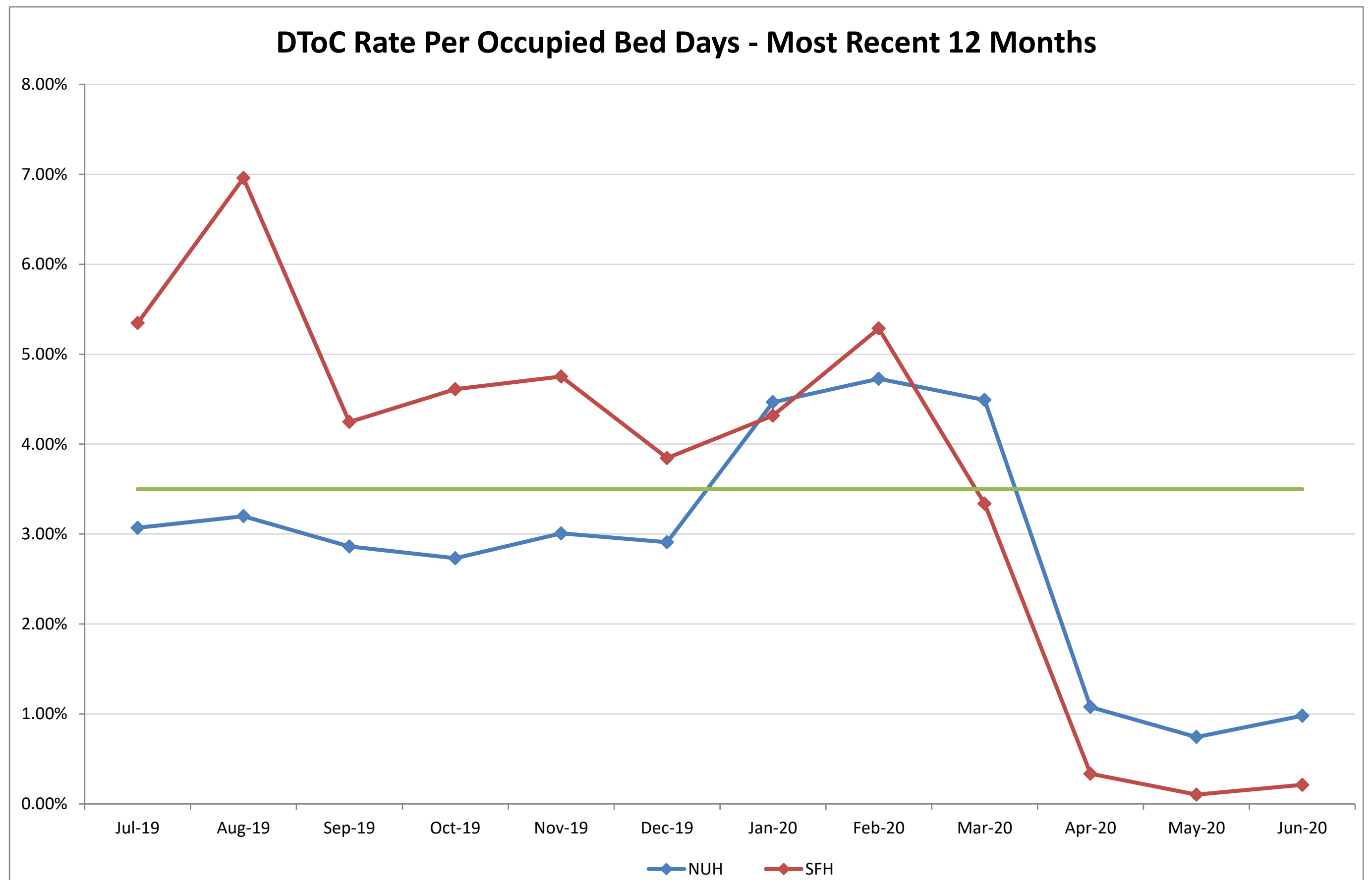
Gaps in Assurance
Gaps in assurance will be included where identified from the review of a breach RCA document.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Urgent Care	Delayed Transfers of Care	Rate of delayed transfers of care per occupied bed days	Caroline Nolan/Lisa Durant	Acute Providers

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	
NUH	DToCs less than 3.5%	3.07%	3.20%	2.86%	2.73%	3.01%	2.91%	4.47%	4.73%	4.49%	1.08%	0.74%	0.98%	↓
SFH		5.35%	6.96%	4.25%	4.61%	4.75%	3.84%	4.32%	5.29%	3.34%	0.33%	0.10%	0.21%	↓

Organsation	Standard	Most Recent 12 Months - Attendances												Performance Direction
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	
NUH		1349	1406	1217	1243	1325	1324	2033	2013	2044	474	338	431	↓
SFH		908	1182	698	771	769	643	722	827	558	54	17	34	↓



Root Cause
Note that the DTOC national standard has been paused due to the COVID 19 Pandemic. However, local data continues to be collected and reported for SFH and NUH. Based on data provided within the daily SitRep, NUH are reporting a DTOC rate of 0.98% in June. SFH are reporting a position of 0.21% for the same period.

Mitigating Actions
There is a focus on discharge to free up bed capacity at SFH, which is based on Government guidelines released. These impose a pathway 0-3 Discharge to Assess approach which has been rolled out at scale across the Trust.

Assurances
Daily calls continue to be in place to actively manage the Medically Safe For Transfer (MSFT) list to expedite the transfer of patients out of hospital into an appropriate care setting when clinically ready to do so. Daily targets have been set for the transfer of patients deemed Medically Safe For Transfer. There has been a reduction in the daily MSFT patient volume from over 200 pre COVID 19 pandemic to the following in the 7 days up to 21st June 2020:

42 at NUH against the trajectory of 37
17 at SFH against a trajectory of 22

Gaps in Assurance
It is not currently clear how quickly and to what extent demand for urgent care services will increase following the relaxation of lockdown restrictions. A rapid rise in urgent care demands, particularly for older people could create issues.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Urgent Care	Ambulance Response Times	Time taken for ambulances to respond to 999 calls	Caroline Nolan/Lisa Durant	Nottinghamshire Division (includes Bassetlaw)

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Indicator	Measure	Standard	Most Recent 12 Months Performance												Performance Direction
			Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
Cat 1 – Life threatening illnesses or injuries	Average	00:07:00	00:06:55	00:06:47	00:06:29	00:06:37	00:06:35	00:07:12	00:07:01	00:06:34	00:06:43	00:07:09	00:05:59	00:06:00	↓
Cat 2 – Emergency calls	Average	00:18:00	00:23:47	00:27:29	00:24:53	00:23:22	00:26:01	00:27:55	00:34:25	00:23:52	00:23:09	00:24:43	00:13:41	00:12:19	↑
Cat 1 – Life threatening illnesses or injuries	90th Centile	00:15:00	00:12:07	00:11:25	00:11:04	00:11:00	00:11:05	00:12:38	00:12:01	00:11:19	00:11:37	00:12:12	00:10:23	00:10:29	↓
Cat 2 – Emergency calls	90th Centile	00:40:00	00:46:14	00:54:35	00:50:06	00:46:07	00:51:49	00:54:42	01:11:25	00:47:36	00:44:42	00:48:09	00:26:05	00:23:03	↑
Cat 3 – Urgent calls	90th Centile	02:00:00	02:38:27	03:47:49	03:19:45	02:57:41	03:37:56	04:09:11	04:43:56	02:41:19	02:57:35	04:08:31	01:04:49	00:51:58	↑
Cat 4 – Less urgent calls	90th Centile	03:00:00	02:54:05	02:47:49	03:29:21	02:33:59	03:25:49	03:49:51	03:43:14	02:49:23	03:30:06	04:11:40	01:09:06	01:08:05	↑

Root Cause
During the COVID period, ambulance response time performance has significantly improved across Nottinghamshire due to reduced demand.

A significant contributory factor for the performance in Newark and Sherwood and Rushcliffe localities is the rural geography which has, historically, resulted in poorer performance in comparison to other areas. This is due to the increased time it takes an ambulance to travel from their base to the patient's location.

Mitigating Actions
As part of the ambulance service recovery and restore process, plans have been developed to continue the service improvements that have contributed to improved performance. This is aligned to the previous 4 pillar improvement plan focussing on the below areas;

- Reducing Demand
- External Efficiencies - Pre Hospital Handover Delays
- Internal Efficiencies
  - Reducing Avoidable Conveyance
  - Post Handover times
- Resourcing – recruitment and output hours

For the Newark and Sherwood and Rushcliffe localities, this will include increasing use of clinical advice and navigation to reduce time on scene and release capacity from a reduction in conveyance to hospital to respond to jobs.

Assurances
The recovery and restoration work reports into the Strategic Delivery Board – the regional group with responsibility for overseeing delivery of the EMAS Ambulance Service contract.

In addition, the local Nottinghamshire divisional plan on conveyance will report to the A&E Delivery Boards through the Demand Avoidance Cell.

This will ensure regional and local commissioners have oversight of the delivery of both the regional and local elements.

Gaps in Assurance
It is not clear how quickly and to what extent demand for Ambulance services will increase going forward as the lockdown is further relaxed. Therefore, there is a risk that as demand increases, there is a consequential reduction in performance.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Improving Access to Psychological Therapies	Performance information for patients undergoing IAPT treatment	Maxine Bunn	CCG

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Patients Entering Treatment—2019/20 (% target)

Organsation	Standard	Most Recent 12 Months Performance - Patients Entering Treatment (Rolling Three Months)												Performance Direction
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
N&N CCG	Rolling Three Months Performance	5.28%	5.49%	5.44%	5.26%	4.88%	4.62%	4.71%	5.11%	5.29%	5.63%	5.48%	5.70%	↑
	Standard	4.94%	4.94%	4.94%	5.13%	5.13%	5.13%	5.31%	5.31%	5.31%	5.50%	5.50%	5.50%	N/A
	Patients Entering Treatment	5785	6020	5965	5770	5345	5065	5160	5600	5800	6170	6010	6250	↑
	Additional Patients Required	N/A	N/A	N/A	N/A	281	561	664	224	24	N/A	22	N/A	↑

Patients Entering Treatment—2020/21 (Numerical target)

Organsation	Standard	Most Recent 12 Months Performance - Patients Entering Treatment (Rolling Three Months)												Performance Direction
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
N&N CCG	Patients Entering Treatment	5370												⇔
	Additional Patients Required	933												⇔
	Standard	6303	6303	6303	6575	6575	6575	6848	6848	6848	7121	7121	7121	N/A

Recovery Rate

Organsation	Standard	Most Recent 12 Months Performance - Recovery Rate (Rolling Three Months)												Performance Direction
		May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	
N&N CCG	Greater than or equal to 50%	52.50%	52.51%	52.14%	52.49%	53.24%	53.25%	52.03%	51.51%	51.96%	53.47%	53.29%	52.92%	↓

Waiting Times—6 Week Standard

Organsation	Standard	Most Recent 12 Months Performance - Waiting Times - First Treatment Within 6 Weeks												Performance Direction
		May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	
N&N CCG	Greater than or equal to 75%	70.69%	69.42%	70.47%	75.20%	81.90%	80.80%	86.07%	85.09%	84.98%	84.10%	83.78%	82.45%	↓

Waiting Times—18 Week Standard

Organsation	Standard	Most Recent 12 Months Performance - Waiting Times - First Treatment Within 18 Weeks												Performance Direction
		May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	
N&N CCG	Greater than or equal to 95%	97.84%	98.35%	97.32%	98.00%	98.64%	98.00%	99.59%	99.56%	98.90%	99.58%	98.65%	99.06%	↑

Root Cause
NB The access target has changed from April 2020 to be numbers of patients rather than a percentage.

Access:
COVID-19 has significantly impacted on referrals to IAPT. Over the 3 month period March - May, referrals reduced by 45% on the 12 month average. Providers have been using the capacity to ensure patients on the waiting list access treatment faster.

The access standard was being achieved at a CCG level in March 2020. Performance in April 2020 is below target, even within localities that had continually met the access standard in 2019/20.

Recovery:
The 50% recovery standard has been met at an overall CCG level in April 2020, recovery rates remain below target in Nottingham City and Mansfield and Ashfield. Local data for May shows an improvement in recovery rates across all localities. The impact of waiting times (for second appointments) and deprivation / wider determinants of health are being assessed as part of a deep dive into performance and variation.

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Mitigating Actions
To increase access, IAPT services have been promoted by the CCG and providers, including communications throughout Mental Health Awareness Week and increased promotion of services through GPs, Pharmacists and social media. A webinar for Primary Care is planned during quarter 2 2020 as a way of raising awareness of IAPT, what the service offers and how it can be accessed.

A deep dive into performance, including analysing and understanding the causes of variation in locality performance and individual providers is being undertaken in quarter 2 2020, to fully understand the impact of COVID -19 on activity and to plan for the predicted increase in demand, as per national guidance.

Assurances
System wide recovery plans, including required investment, have been developed and submitted to NHSE /I.

The system has identified IAPT as a high priority area, due to national modelling that indicates there will be increased demand for Psychological therapies.

Providers continue to report that referrals have increased through May and June and recovery rates are improving. This performance report shows a decrease in recovery for the ICS of around 0.5% since pre-COVID. Unvalidated local data for May is showing an increase in recovery rates in all localities.

The recruitment process for IAPT trainees has progressed despite the pandemic , it is anticipated that 26 training places will be filled in October 2020, and 20 training places will be filled in March 2021, this will help to increase the local workforce.

Gaps in Assurance
Waiting times have remained above target in April 2020, however it is anticipated that they will increase if there is an increase in demand due to COVID-19. It is anticipated that performance against the access standard will decline further in the short-term, and will not improve until referrals increase to pre-COVID levels.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Dementia Diagnosis Rate	The rate of dementia diagnosis against the estimated prevalence	Maxine Bunn	CCG

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Organsation	Standard	Most Recent 12 Months Performance - Dementia Diagnosis Rate												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 66.7%	76.59%	76.73%	76.94%	76.94%	76.65%	76.60%	75.79%	75.43%	75.06%	74.65%	73.15%	71.56%	↓

Organsation	Indicator	Most Recent 12 Months Performance - Memory Assessment Service												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Ave. Waiting Time From Referral to Assessment	8.0	8.0	9.1	9.2	9.3	9.0	9.9	10.0	10.3	11.6	15.2	17.9	↓
	Max of Weeks To Assessment	38	38	32	35	34	35	37	37	40	44	48	49	↓
	Patients Waiting for Assessment	458	458	511	491	538	562	613	631	649	677	688	688	↔

Root Cause
The ICS continues to meet the Dementia Diagnosis Rate despite the suspension of the Memory Assessment Service (which was in accordance with NHS England guidance).

Waiting times for the memory assessment service were identified as a significant concern pre-COVID-19, as a result of increasing demand over time without increased capacity. This has resulted in a growing waiting list, further exacerbated by the suspension of services during the pandemic (memory assessment services were suspended as required by national guidance). Funding for an interim model to reduce waiting times was agreed, however this was delayed due to the service being suspended.

In addition, reduced CT scanning capacity as a consequence of COVID-19 is expected to cause further delays to the assessment and diagnosis process.

Mitigating Actions
A business case has been approved by the Prioritisation & Investment Committee in June 2020 which will increase the capacity within the Memory Assessment Service, including a dedicated MDT. In the new model people will be assessed and diagnosed within 6 weeks as per the Memory Services National Accreditation Programme standards. An Implementation plan will be finalised by the CCG in Mid August, this will be informed by a plan from NHT which will include a trajectory to reduce the waiting list backlog , and a timeline for when the service will achieve the 6-week diagnosis standard.

As part of the new model implementation planning , clinical leads have been reviewing how to improve efficiency and pathways. Actions agreed include guidance to improve history taking in general practice, to support GP diagnosis and improve referrals to the specialist memory assessment service and advice and guidance to support GP diagnosis. Due to the impact of COVID, which has reduced CT scanning capacity ,the local clinical network has been engaged to inform local plans for targetted scanning, to reduce reliance on CT scans for diagnosis.

A webinar for GPs will also be developed and take place in quarter 2 to support diagnosis of less complex cases, within primary care.

Assurances
As part of recovery planning and implementing the new service model, the CCG is finalising an implementation plan, which will detail milestones from quarter 2 when the service restarts (service is suspended until August 2020). The implementation plan will be informed by a restart plan and a trajectory to reduce the backlog which is being submitted by the provider by the end of July 2020.

Gaps in Assurance
Waiting times are estimated to be significantly affected by the COVID-19 pandemic.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Perinatal Mental Health Services	% of Population Birthrate	Maxine Bunn	CCG

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Organsation	Measure	Most Recent Rolling 12 Months Performance - Perinatal Mental Health												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	% of Population Birthrate	6.82%	6.91%	6.92%	7.06%	7.21%	7.31%	7.45%	7.40%	7.63%	7.42%	7.61%	7.69%	↑
	Patients	812	822	824	843	866	877	894	888	916	891	914	923	↑
	Standard	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	6.4%	6.4%	N/A

Root Cause
The ICS continues to meet the access standard with an ongoing upwards trajectory.

Mitigating Actions
Continued monitoring of performance.

Assurances
LTP non-recurrent transformation funding was used to enhance new ways of working to include improved collection of outcomes and some specific research around inequalities.

Gaps in Assurance
None identified.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	PHSMI	Physical health checks for people with a SMI	Maxine Bunn	CCG

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Organsation	Standard	Most Recent 12 Months Performance - Physical Health Check for people with a SMI												Performance Direction
		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	
N&N CCG	Greater than or equal to 60%	34.0%	34.0%	34.0%	34.0%	34.0%	31.0%	36.0%	36.0%	36.7%	37.5%	36.5%	31.1%	↓

Root Cause
At the end of quarter 4 2019/20 performance remained above the regional (34.0%) and national (35.8%) average but below the national target of 60%.

COVID-19 has impacted on the number of healthchecks being completed in primary care, and performance has declined in May 2020. In addition, activity undertaken within secondary mental health care has not had the expected level of impact, and further exploration during quarter 2 is being undertaken fully understand the reason behind this.

Mitigating Actions
An action plan to improve performance has been developed, and key actions for quarter 2 2020 are:

- The recruitment of 6 Health Improvement Workers across the ICS as part of the Community Mental Health Transformation. These roles will support patients to access physical health checks across primary and secondary care and improve performance against the standard
- The Mental Health Clinical leads will support GP practices to ensure there are effective recall systems in place for patients who have not had all 6 checks. This will mirror recall systems already in place for physical health conditions.
- Engagement is being undertaken at PCN level and performance will be shared with PCNs and GP practices in order that localised support can be offered and GPs can learn from higher performing areas.
- Analysis of the NHT data set to understand why there hasn't been the expected impact in the number of healthchecks completed in secondary care

Assurances
Oversight of delivery of the standard is being integrated into the community transformation programme, the steering group has been reviewed and the membership will now include GP clinical leads to ensure there are focused actions in primary care to improve performance.

Gaps in Assurance
The HIW roles will not be in post until quarter 3. However, work with GP Practices and PCNs will continue in July 2020.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Out of Area Placements	Out of Area Occupied Bed Days	Maxine Bunn	Mental Health Trust

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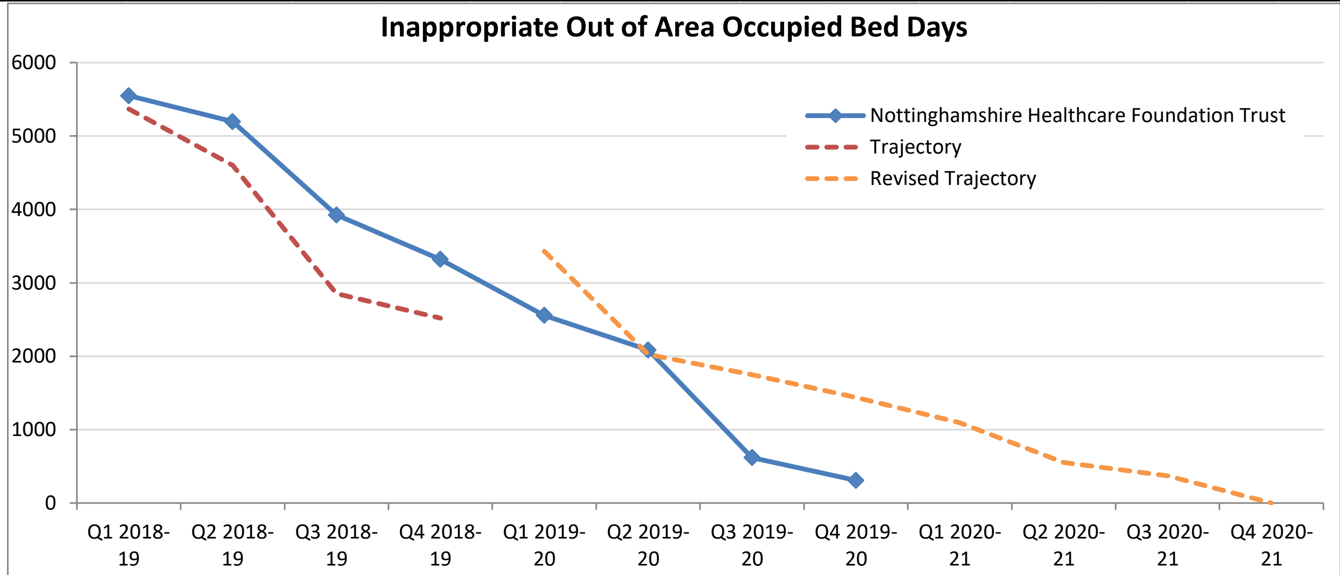
Organsation	Measure	Quarterly Performance - Inappropriate Out of Area Occupied Bed Days											
		Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21
Nottinghamshire Healthcare Trust	NHFT Actual	5549	5197	3925	3319	2555	2085	618	306				
	Original Trajectory	5369	4600	2852	2520								
	Revised Trajectory					3432	2024	1748	1440	279	184	0	0



Root Cause
The trajectory for quarter 4 2019/20 was achieved and the number of out of area placements had continued to decrease. However from April performance has this has been impacted by COVID-19 due to the requirement for isolation beds to ensure compliance with COVID 19 guidance. Patients have been placed in out of area PICU beds as local bed capacity had been reduced. Increased demand for female PICU beds contributed an increase in OAPs in April, alongside delays in discharging people from out of area beds and repatriating to Nottinghamshire due to COVID-19 isolation requirements.

There is a discrepancy in the CCG level data, reported nationally by NHSD and data provided locally by NHT, the NHSD data shows a higher number of OAP occupied bed days than local data. The CCG is currently reviewing the data to understand and resolve the discrepancy. Initial review indicates that patients are either being placed by out of area mental health trusts and not contacting the local bed management team at NHT before doing so, or patients are incorrectly allocated to Nottinghamshire.

Mitigating Actions
Performance against the trajectory was on plan up to the end of quarter 4 2019/20. The local plan to increase PICU subcontracted beds (3 additional female beds) was delayed due to COVID-19, but has now been in place since from the end of May; this will support a reduction in OAPs.

Actions are underway to understand and resolve the data discrepancy with support from NHSE/I and NHS digital, with a process in place locally going forwards to ensure the data aligns.

The transformation of the Crisis and Urgent care pathway and Community pathways has recommenced. Crisis Teams are now delivering 24/7 home treatment and a Crisis line is in place for self- referral to urgent mental health support.

Assurances
Actions that had been agreed in 2019/20 had delivered improvements in performance and the quarter 4 trajectory had been achieved.

Regular OAP steering groups have recommenced, all actions within the recovery action plan, including review of the personality disorder pathway and transformation of community mental health teams are being reviewed to ensure they are implemented at pace, due to the impact COVID-19 has had on local inpatient and community team capacity and OAP performance.

Gaps in Assurance
The ongoing requirement, due to COVID-19, to have isolation areas continues to reduce local capacity, resulting in the use of out of area beds. The recovery action plan is being reviewed to ensure all actions to improve performance are being implemented at pace.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	EIP	Early Intervention in Psychosis Waiting Times	Maxine Bunn	CCG

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Organsation	Measure	Most Recent 12 Months Performance - EIP Waiting Times (Rolling Three Months)												Performance Direction
		May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	
N&N CCG	Started treatment in 2 weeks	71.6%	77.9%	81.4%	81.4%	76.5%	68.0%	61.5%	73.1%	64.3%	71.4%	60.7%	68.3%	↑
	Standard	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	60.0%	N/A

Root Cause
Overall at an ICS level the standard has been consistently met, there is local variation in performance in localities.

From review of exception reports underperformance relate to DNAs or capacity within teams to see the patient within 2 weeks. Further analysis of performance in NNE locality is underway due to the decline in performance.

Mitigating Actions
Additional funding for EIP was agreed for quarter 4 2019/20 to develop and implement an interim model that can deliver the National Standards across the ICS, prioritising the areas that will have the greatest impact on the standards. Recruitment in line with the above model has continued. The transformation plans for moving EIP to standalone service and increasing NICE compliance continue, were delayed by prioritising services and service capacity to respond to COVID- 19. Transformation programmes are now being restarted and actions will be progressed from quarter 2 2020.

Exception reporting on breaches of the access standard is included in the EIP monthly activity reports, this enables review of exception reports to identify any themes and enables actions to be agreed to with the objective of improving performance . Previous analysis has indicated that breaches are due to patient DNAs and capacity in teams to meet the 2 week standard due to high caseload sizes this will be addressed through the change to the service model, planned for 2020/21.

Assurances
EIP Transformation meetings with the NHT have recommenced following COVID-19 which focus on the delivery of actions outlined in the Recovery Action Plan.

Gaps in Assurance
Nationally it is reported that there is likely to be an increase in EIP referrals due to COVID-19, as it is reported that there is a delay in people seeking help. In addition some of the EIP specific interventions were postponed due to COVID-19. Demand and capacity modelling has undertaken and has been submitted by the system for national funding to meet the predicted demand due to COVID-19.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Children & Young People Eating Disorders	Access and waiting times for Children & Young People Eating Disorder treatment	Maxine Bunn	CCG

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Children & Young People Increasing Access

Organisation	Total number of CYP with a diagnosible mental health condition	CYP with 2+ Contacts 2019/20	MHSDS 12mth Rolling (Mar 20)	2019/20 Target	2018/19 SDCS Collection
N&N CCG	19931	5515	27.7%	34.0%	25.3%

Children & Young People Eating Disorders Waiting Times—Rolling Four Quarters Performance

Organsation	Standard	Most Recent 12 Quarters Performance - Routine Complete (Rolling 4 Quarters)												Performance Direction
		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	
N&N CCG	95% Under 4 Weeks	45.71%	48.39%	33.33%	37.50%	63.16%	57.69%	66.67%	75.51%	75.00%	82.76%	85.00%	85.48%	↑
		35	31	18	16	19	26	42	49	52	58	60	62	N/A

Organsation	Standard	Most Recent 12 Quarters Performance - Urgent Complete (Rolling 4 Quarters)												Performance Direction
		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	
N&N CCG	95% Under 1 Week	8.33%	16.67%	12.50%	23.08%	38.46%	36.36%	38.46%	63.64%	66.67%	85.71%	100%	100%	↔
		12	12	<10	13	13	11	13	11	<10	<10	<10	<10	N/A

Children & Young People Eating Disorders Waiting Times—Rolling Four Quarters Performance

Organsation	Standard	Most Recent 12 Quarters Performance - Routine Complete (Latest Quarter)												Performance Direction
		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	
N&N CCG	95% Under 4 Weeks	16.67%	60.00%		40.00%	77.78%	50.00%	81.25%	91.67%	75.00%	83.33%	88.89%	92.86%	↑
		<10	<10	<10	<10	<10	12	16	12	12	18	18	14	N/A

Organsation	Standard	Most Recent 12 Quarters Performance - Urgent Complete (Latest Quarter)												Performance Direction
		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	
N&N CCG	95% Under 1 Week	0.00%	25.00%		33.33%	66.67%	0.00%	50.00%	100%	100%		100%		↑
		<10	<10	<10	<10	<10	<10	<10	<10	<10	<10	<10	<10	N/A

Root Cause
CYP Access:
Full year performance at Quarter 4 2019/20 was 27.7% against a target of 34%. (Please note to contribute to the target two contacts with a service are required, per child or young person).

There are a number of factors impacting performance, including referral numbers and their conversion into treatment, as well as underperformance in cproviders, some of which is impacted by staffing vacancies. Other factors include data not flowing all allowable ADHD/ ASD activity data as per NHSE/I guidance.

During covid-19 all providers continued to provide a service to CYP via F2F, virtually or via phone support.

CYP Eating Disorders:
In Quarter 4, the standard for urgent cases (95% receiving first treatment within one week) was achieved with performance at 100%.

Performance for routine cases remained below target (Quarter 4 – 92.9% receiving first treatment within four weeks against a target of 95%). Rolling months remained stable at 85% receiving treatment within four weeks.

Local exception reporting shows that for Quarter 4 < 5 young people did not meet the access and waiting time standard of four weeks. This was due to patient choice and capacity within the service (sickness and annual leave within the team). This has been addressed by the service to ensure capacity is maintained.

To note, the technical reporting guidance does not allow for the clock to be ‘paused’ in respect to patient choice, and with small numbers accessing the service, there is a continued risk of underperformance against the national target when young people choose to wait for treatment.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Mitigating Actions
CYP Access:
From 2020/21 new services will be flowing data to the MHSDS which will contribute to the access target. Work is taking place during quarter 2 with NHSE/I to support new providers (NUH, SFH and Family Action) to submit data to the MHSDS, as well as identifying additional data support to existing provider to improve the quality of their submissions.

Additional services have been commissioned as below, contributing to increased access:
Family Action Small Steps Service, starting June 2020 - first submission expected July 2020.
BEH service will be delivered by Nottingham City Council from April 2020 - the service are currently reconfiguring their local system to enable flow to the MHSDS. It is anticipated that flow will be established by November 2020. Local data will be provided in the interim period.
Three further mental health support teams (providing increased capacity to the system) will be operational from August 2020.

CYP Eating Disorders:
Exception reports are provided which enables any actions to improve performance to be agreed.

Commissioners are working with the regional Clinical Network and NHS Digital to ensure data flows reflects patient choice, which is impacting on performance due to the small numbers that access the service.

Assurances
From quarter 2 2020/21, system capacity is due to significantly increase, and the access rate is forecast to increase.

NHS Improvement were scheduled to deliver a 2-day diagnostic visit on 18/19 March 2020, which was due to enable pathway and data quality improvements to be identified. This has been postponed in response to COVID-19 but is being re-scheduled for 2020.

Analysis of provider contribution to the access target is taking place to inform potential stretch targets for individual providers, analysis will be finalised in quarter 3 2020. Public Health England has indicated that there is evidence of increased levels of anxiety, depression and lower well-being across the population. The CCG has worked alongside service providers to formulate plans for the additional capacity required to meet the predicted demand due to the impact of COVID-19. The outline assumptions (based on a 5- 20% increase in activity); including staff requirements have been submitted to NHS England. This includes additional capacity across all children and young people services.

Gaps in Assurance
CYP Access:
The optimisation site visit with NHS Improvement will ensure any new areas for improvement are identified and have actions in place. during 2020

CYP Eating Disorders:
It is anticipated that performance will continue to show as ‘underperforming’ during 2020/21 if young people and families/ carers should choose to delay treatment.
However, exception reporting will continue to demonstrate impact of patient choice on performance and highlight any potential issues with capacity within the service., to enable actions to be agreed

Nottingham and Nottinghamshire
Clinical Commissioning Group

Glossary

Acronym	Meaning	Acronym	Meaning
A&E	Accident and Emergency	KMH	Kings Mill Hospital
A&E DB	Accident and Emergency Delivery Board	LD	Learning Disabilities
ACS	Accountable Care System	LoS	Length of Stay
ADD	Attention Deficit Disorder	LTWB	Let's Talk Well Being
ADHD	Attention Deficit and Hyperactivity Disorder	MHST	Mental Health Support Team
ANP	Advanced Nurse Practitioner	MN	Mid Nottinghamshire
ASD	Autism Spectrum Disorder	MOU	Memorandum of Understanding
BAU	Business As Usual	NEL	Non-Elective
CBT	Cognitive Behavioural Therapy	NEMS	Nottinghamshire Emergency Medical Services
CCG	Clinical Commissioning Group	NHCT	Nottinghamshire Healthcare NHS Trust
CETR	Care Education and Treatment Review	NHSE	NHS England
CFIDD	Community Forensic Intellectual and Development Disability Service	NHSI	NHS Improvement
CHC	Continuing Health Care	NNICS	Nottingham & Nottinghamshire ICS
CoP	Court of Protection	NICE	National Institute for Health and Care Excellence
CQUIN	Commissioning for Quality and Innovation	NUH	Nottingham University Hospitals NHS Trust
CT	Computed Tomography	OAPs	Out of Area Placements
CV	Contract Variation	OBD	Occupied Bed Days
CYP	Children and Younger People	OP	Outpatient
DCO	Director of Commissioning Operations	PCN	Primary Care Network
DST	Decision Support Tool	PHE	Public Health England
DToC	Delayed Transfers of Care	PICU	Pyschiatric Intensive Care Unit
DTT	Diagnosis to Treatment Times	PID	Project Initiation Document
EBUS	Endobronchial Ultrasound	POD	Point Of Delivery
ED	Emergency Department – often referred to as A&E	PTL	Patient Targeted List
EIP	Early Intervention in Psychosis	QIPP	Quality Innovation Productivity and Prevention
EMAS	East Midlands Ambulance Service NHS Trust	QMC	Queens Medical Centre
EMCA	East Midlands Cancer Alliance	RAP	Remedial Action Plan
EOL	End of Life	RTT	Referral to Treatment Times
G&A	General & Acute	SFHFT	Sherwood Forest Hospitals NHS Foundation Trust
GI	Gastro-Intestinal – often referred to as either Upper GI or Lower GI	SLA	Service Level Agreement
GN	Greater Nottingham	SLAM	Service Level Agreement Monitoring
HEE	Health Education England	SOP	Standard Operating Procedure
HFID	Home First Integrated Discharge	SRO	Senior Responsible Officer
IAPT	Improving Access to Psychological Therapies	STP	Sustainability and Transformation Plan
IBN	Information Breach Notice	TCP	Transforming Care Partnership
ICATT	Intensive Community Assessment and Treatment Team	UEC	Urgent & Emergency Care
ICP	Integrated Care Paertnership	UTC	Urgent Treatment Centre
ICS	Integrated Care System	YOC	Year Of Care
IR	Identification Rules	YTD	Year To Date

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	System Quality Assurance	**Paper Reference:**	**GB 20 067**
Sponsor:	Rosa Waddingham - Chief Nurse	**Attachments/ Appendices:**	Integrated Nursing & Quality Report
Presenter:	Rosa Waddingham - Chief Nurse		

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

This report is intended to update Governing Body members on information, insights and activities in relation to key quality, safety and clinical areas across the NHS Health Economy during the Covid-19 pandemic.

In summary the key headlines for board to consider;

- **Nottinghamshire Healthcare Trust (NCHT)** - continued quality oversight and establishment of a system Quality Assurance Group, attendance at NHCT committees and increased engagement are all indicating positive improvements, a full quality review is being undertaken and will report back to committee in September.

- There are currently eleven **Care Homes and Home Care** providers under enhanced surveillance with associated action plans. Plans are being developed for recovery and restoration including quality assurance monitoring. Support is being provided through the care homes team and the system Enhanced Care and Response Team.

- Safeguarding Teams have been working to ensure that cohort of **asylum seekers** now residing in Nottingham City Hotels that are being used by the Home Office as Initial Accommodation Centres (IACs) have safe and appropriate care, a regional review of the issues surrounding the IACs is being undertaken.

- **Continuing Healthcare** remains suspended. There will be a back log of reviews accrued during the respond to the pandemic. The CCG is working with local authorities to agree recovery and restoration, this includes prioritisation, understanding workforce, and resource requirements.

- **Learning Disability and Autism** - CCG inpatient numbers have risen above trajectory, the Covid-19 pandemic has caused a reduction in discharges, as community providers struggle to mobilise, recruit staff and develop readiness to accept new residents. Revised trajectories are to be agreed with NHS England/Improvement. The Learning Disability Annual Health Check position for end of Q4 is 69% (target 75%). However 2020/2021 is not on track due to the practicalities of conducting assessments during the pandemic. Targeted work to ensure recovery is underway.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☒	Procurement and/or Contract Management	☐
Strategic Planning	☐		

Conflicts of Interest:
☒ No conflict identified

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this item

Risk(s):
Relevant risks are identified in the main report

Confidentiality:
☒No

Recommendation(s):
The Governing Body is asked to: 1. **RECEIVE** and **NOTE** the report for information and assurance of the approach outlined.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Quality & Performance Committee

Integrated Nursing & Quality Report

July 2020

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PURPOSE

The purpose of this paper is to provide intelligence from Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) in relation to key Quality, Safety, and Clinical areas across the NHS Health Economy during the Covid-19 pandemic and business as usual. The paper will draw together a summary of:

- Themes generated from CCG Incident Control Centre (ICC) Quality, Safety & Clinical Cell (QSC)
- Headlines from system quality colleagues and the continuation of routine monitoring (such as Serious Incidents) across the main providers
- Trust Board published reports and Provider SitReps where available
- Care home summary identified challenges
- Primary Care overview
- Safeguarding oversight and themes
- Updates from work programmes and statutory functions including: Transforming Care (including LeDeR), Maternity, Infection Prevention and Control and Continuing Healthcare (CHC)

EXECUTIVE SUMMARY

To ensure that there is a continued oversight and understanding of the current quality and safety concerns during COVID19 the Nursing & Quality Team have compiled a report based on information and intelligence throughout the response to the pandemic. This report has been compiled to illustrate the current climate highlighting the current challenges and issues whilst detailing progress on specific programmes of work.

Since the last report there has been no escalation or request for support from the Acute, Independent Sector, Community, or Mental Health. Activity and demand is manageable however showing a steady increase in all areas, and there has been significant focus on staff returning to substantive roles from redeployment and staff well-being. The Urgent Care sector has been stable with activity increasing although still not yet back to pre-COVID levels. Bed occupancy within the Acute sector remains steady fluctuating between 65% and 72% across the Midlands. The system is in the second phase of the response with providers working through recovery and restoration plans whilst maintaining oversight of capacity and quality across all sectors.

Surveillance and support continues for Nottinghamshire Healthcare Trust plus a close monitoring of 12hr breaches once Emergency Department (ED) attendances start to increase.

Nottinghamshire Healthcare Trust continue to support people back to local beds whilst balancing the COVID-19 risks, Sherwood Forest Hospitals Trust have developed a process for identifying and capturing potential harm resultant from Covid-19 pandemic which will be used going forward as part of mortality reviews.

The Primary Care performance data has shown practices continue to struggle with achieving the target for cervical screening and bowel screening target; this is likely to deteriorate further with the disruption to screening due to the COVID-19 pandemic.

The Care Home and Home Care sector have provided twice weekly updates that clearly show bed occupancy and vacancy rates broken down by accepting and not accepting COVID positive patients, this has been invaluable in discharging patients to the correct place, first time. There is now a programme of work to increase the use of the NHS capacity tracker. There are currently 9 care homes under enhanced surveillance and two home care agencies with associated action plans. COVID-19 has led to positive enhancements in the care home and home care sector. There are examples of matrix working across health and social care, greater information sharing, positive links and working with the acute sector in relation to discharges and much greater intelligence, understanding and support for the sector.

Continuing Healthcare has been suspended during the pandemic, teams have been concentrating on reviewing patients and planning for the recommencement of CHC. Work has been undertaken with local authority colleagues in relation to market management, ensuring the market is stable and manageable after the pandemic.

CCG Quality Transformation and Oversight programmes (Local Maternity and Neonatal System, Learning Disability and Universal Personalised Care) were largely paused during COVID 19 with some notable exceptions relating to Transforming Care, LeDeR and Link Workers. All programmes are undertaking recovery planning to restart workstreams in order to continue to deliver key programme outcomes. It is anticipated that COVID will have an impact on delivery and performance of these programmes and planning will comprise of risk assessment and mitigation.

For Learning Disability and Autism, CCG inpatient numbers have risen slightly above trajectory, the COVID 19 pandemic has caused a reduction in discharges, as community providers struggle to mobilise, recruit staff and develop readiness to accept new residents. NHSE inpatient numbers remain significantly above trajectory with a significant rise in CYP admissions this will remain a challenge throughout 2020/21 with numbers remaining static.

The Special Educational Needs Service (SEND) has recently been and audited by NHSE & DFE and the initial feedback for both LA & CCG was that Nottingham and Nottinghamshire are performing highly and leading by example evidencing consistent areas of good practice.

The Looked After Children services at both NUH and SFHFT have highlighted concerns in relation to the completion of outstanding physical health assessment that were not carried out due to the COVID restrictions. This has led to a backlog across the system of approx. 70 children requiring this element of their assessment being delayed. Clearing the backlog will undoubtedly impact on the services ability to meet its target as new referral are made and children continues to require assessments. The providers have raised this internally as a risk and the CCG is working with them to identify a solution for this cohort of children.

Work is also underway to around the development of Safeguarding Guidance for health professionals using remote consultation methods to treat children and young people. This will be followed up in a Webinar on the 15th July which is to be delivered to Primary Care Safeguarding Leads where they will be able to discuss and explore this issue with the Designated Doctors and Named GP for the CCG.

The Safeguarding Teams have also been working alongside commissioner to ensure that Cohort of Asylum Seekers now residing in Nottingham City Hotels that are being used by the Home Office as Initial Accommodation Centres. Approx 300 now have access to Primary Care Services in a timely and coordinated manner.

PLEASE NOTE: The Nursing & Quality team continue to work with the BI and Transformation Team in order to ensuring integrated reporting aligned to the Quality Strategy and Quality & Performance Committee work plan

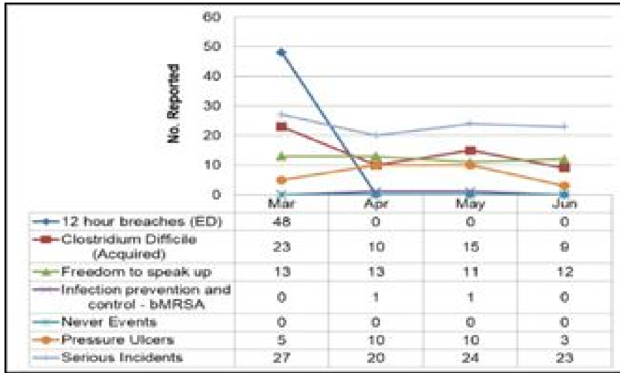
PART ONE: PROVIDER QUALITY & SAFETY METRICS AND INTELLIGENCE

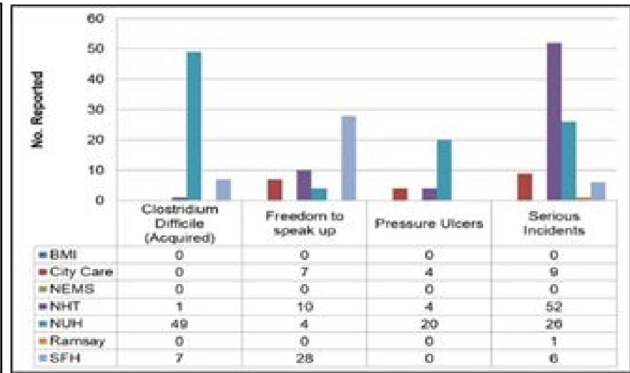
SAFE TODAY METRICS – DURING COVID-19

JUNE 2020

AUTHOR: LINDA SHIPMAN

KEY QUALITY INFORMATION





KEY QUALITY INSIGHTS

Serious Incidents continue to be reported running at a slightly lower total each week again correlating with the current activity within providers. 94 SIs have been reported from 15 March to 30 June 2020.

- 65% of SIs have been reported by Nottinghamshire Healthcare Trust with the most common categories being : unexpected/potentially avoidable death; unexpected/potentially avoidable injury causing serious harm and; disruptive / aggressive / violent behaviour
- 13% have been reported by CityCare (mostly attributed to medication incidents)
- 13% reported by Sherwood Forest Hospitals: unexpected / potentially avoidable death, maternity / obstetric and sub-optimal care of the deteriorating patient

There are no immediate themes however investigations continue. No Never Events have been reported.

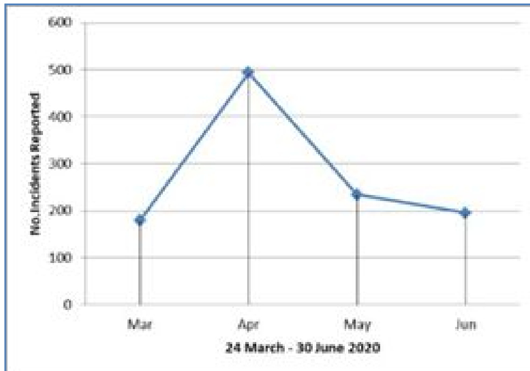
It is noted that during the pandemic Sherwood Forest Hospitals have reported 21 Freedom To Speak Up concerns, of these associated to Covid-19 with the overarching themes being: staff safety during Covid19; attitudes and behaviour; and leaders culture

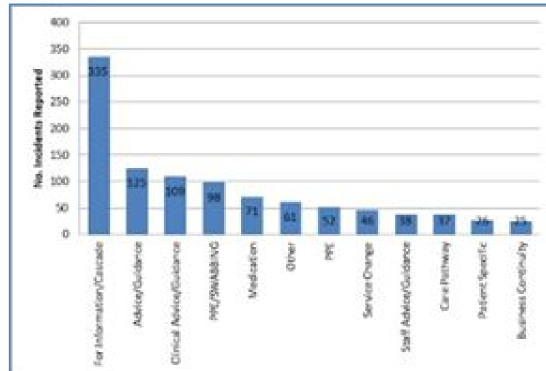
QUALITY FOCUS & ACTIONS

→ Further work is underway with all providers to understand FTSU activity and themes.
→ Providers are actively working to understand harms both directly attributable to COVID plus where COVID may have had played a contributory factor
→ Safe Today Quality & Safety metrics to be reviewed as part of Recovery & Restoration of the Quality Assurance function
→ Thematic review of SIs to be conducted with a plan to update Q&P Committee (September 2020)
→ Continue to link with Derby commissioners around the progress as the 'early adopter' for the Patient Safety Incident Response Framework (PSIRF) which will replace the current SI framework proposed for April 2021.

CCG ICC QUALITY, SAFETY, & CLINICAL CELL – DURING COVID-19	JUNE 2020
	AUTHOR: LINDA SHIPMAN

KEY QUALITY INFORMATION





KEY QUALITY INSIGHTS

Between 27 March 2020 and 30 June 2020 the CCG QSC Cell received 1102 incidents. As expected there has been a steady decline in the activity since the early phase of the COVID19 response.

Of the incidents received into the quality, safety and clinical support cell the top 5 themes of concern/query/action:

- 30% Information/Guidance Cascade
- 11% General Advice
- 10% Clinical Advice
- 9% PPE/Swabbing
- 7% Meds Management

Since 1 June 2020 there have been 195 incidents with the request to cascade information/guidance as the leading theme (48%), followed by Clinical Advice (17%), PPE/Swabbing (12%) and Staff Advice/Guidance (7%), Other 7%, Service Change 4%, the remaining 5% (very small numbers) covered workforce, business continuity, safe guarding and clinical incidents.

Analysis of the originating enquirer indicates the majority of queries came from within the CCG or NHSE/I.

- CCG 29%
- NHSE/I 24%
- Council 15%
- Primary Care 14%
- Care Homes 12%
- Other 6%

QUALITY FOCUS & ACTIONS

→ The identified incidents to the cell continue to be reviewed and completed as required. Support is requested from Subject Matter Experts in order to respond appropriately. The cell remains while the NHS is dealing with the pandemic

→ Analysis of the cell incidents continues with timely completion. The QSC cell is operating a slimmed down rota to reflect the reduction in activity and is only operating Weekdays 9-5pm

→ Monitor activity through the cell and in line with the ICC. A subsequent full rota is in place for a 7 day 8-8pm service should a second wave occur

COMMUNITY & MENTAL HEALTH SERVICES

JUNE 2020
AUTHOR: SUE BARNITT

KEY QUALITY INFORMATION

Nottinghamshire Healthcare Trust (NHCT)

- **Mental Health (MH) Inappropriate Out of Area Placements** (*see Integrated Performance Report*)

Female PICU has seen increased need and complexity. Movement between wards currently does not support infection control initiatives. Trust have a number of beds protected for COVID-19; these stand empty and have an impact on bed capacity.

Immediate Actions: NHCT actively supporting people back to local beds whilst balancing the COVID-19 risks. Where possible, the option to enable patients to be discharged directly home rather than transferring between hospital sites is in place. There is a broad COVID 19 related risk regarding managing the demand on MH services on NHCT Board Assurance Framework (BAF)

- **Physical Health Assessments** (*see Integrated Performance Report*)

Capacity issues within some community physical health services due to redeployment of staff and increased sickness levels attributed to COVID19. Sickness levels excluding COVID-19 reasons show the Trust's position at 4.1% (marginally above internal target of 4%). Annual reviews recent performance will have been significantly affected by COVID19 however have been on a downward trend since Sept 2019. Indicators significantly affected by COVID.

Immediate Actions: Actions and risk reflected on the Trust BAF, on-going assurances and updates planned

- **Workforce** (Turnover = 13.5%; Annual Reviews = 69.0%; Sickness = 6.5%)

Therapy staff continue to be redeployed to support discharges (Discharge to Assess) although referrals are increasing for routine pre COVID therapy services which is starting to impact on the overall resource and capacity. Local Integrated Care Teams have had additional staff (COVID 19 response) redeployed to their substantive posts which has meant the services are now back to carrying vacancies which impacts on capacity.

Immediate Actions: Daily staffing SitReps. Waiting lists being monitored and triage utilised where appropriate. Working with system partners to consider actions required as part of recovery and restoration

KEY QUALITY INSIGHTS

Nottinghamshire Healthcare Trust

- A spike in serious self-harm was noted by the Trust and further investigation identified this related to a small number of patients and there was no apparent trend in violence and aggression. It is however anticipated that these incidents may increase in the future due to the effects of COVID-19 on the population's mental health.
- System call have identified an increase in call outs to EMAS however many of these do not result in conveyance to the Emergency Department as patients reported to not consider this beneficial to their care.
- Joint working in progress with the Trust and EMAS to explore reasons for increase in activity, EMAS call outs and response and community support available and any shortfalls in provision.
- Significant work on-going re BAME within the Trust which includes:
  - Monitoring absence information to review impact on staffing.
  - Increased membership at NHCT staff BME network with members helping to shape trust COVID19 responses.
  - Work on developing a parallel mentoring programme has commenced

Cygnet – Cedar Vale

- On-going monitoring of provider improvement plan and virtual review of service improvements/documents.
- Weekly touch point meetings in place with registered manager particularly as admissions to unit now occurring.
- Stakeholder meeting with other commissioners held and improvements reported by many.
- Residents are settled and no incidents have occurred recently that require CCG oversight

QUALITY FOCUS & ACTIONS

Nottinghamshire Healthcare Trust

→ Quality Assurance (QA) activity and programme (recovery and restoration mapping) with providers to agree QA reporting arrangements going forward
→ Triangulation of quality intelligence relating to Lings Bar Hospital (NHCT) due to a notable increase in incidents
→ Progression of provider Quality Account statements
→ Quality Assurance Group Inaugural meeting (30 July 2020)
→ Continued oversight of overarching Quality Improvement Plan
→ Oversight of harms and SIs

CityCare

→ Impact of increase of Freedom To Speak Up champions within CityCare which may increase the number of notifications from staff due to increased publicity

Cygnet

→ Host Commissioner Quality Assurance Arrangement in place

ACUTE NHS TRUSTS & INDEPENDENT SECTOR	JUNE 2020
	AUTHOR: LINDA SHIPMAN

KEY QUALITY INFORMATION

NOTTINGHAM UNIVERSITY HOSPITALS

- **Hospital Standardised Mortality Ratio (HSMR 111.7)** HSMR for 12-months ending February 2020 (latest data) is outside the expected range.
  The pneumonia pathway analysis has been completed. The key findings indicated:
  - Patients admitted to the QMC campus compared to the City Hospital campus cohort were at higher risk of mortality and ITU admission. This is due to the location of the Health Care of the Older Person wards, ITU and ED being at QMC.
  - Patients admitted to QMC were more likely to be admitted from nursing/residential homes.
  - On both sites opportunities exist to improve antimicrobial stewardship.
  - Early senior review is important to support community acquired pneumonia (CAP) diagnosis and management plans.
  - Urgent clinical decisions, including initial categorisation, observation intervals, use of guidelines, and choice of pathway depend on the handover of accurate, complete and up-to-date information at each interface, starting even before admission.
  - Factors including frailty, complexity of disease, comorbidities and diagnosis being less apparent on admission for patients admitted to QMC are inter-related.

  NUH key recommendations includes using the national CAP CQUIN (commissioning for quality and innovation) as an opportunity to optimise the timely management of patients confirmed as having CAP, applying a care bundle approach. *Update expected : CAP - August 2020*

- **Falls (per 1,000 occupied bed days - May 2020 = 1.07)** *Target ≤0.98 (local)*
  Analysis at Divisional level suggests the increased rate is driven through the Medicine and Surgical Divisions. The key interventions in place: A monthly Falls Learning Group continues with Divisional, Therapy, and Pharmacy and Nursing representation. An on-going medicine optimisation and quality improvement focus on reducing the risk of medicine related falls in older adults. Bladder and /or bowel dysfunction have been highlighted as contributory factors following falls related investigations. Continence training has been delivered at multiple nursing forums and is included within Divisional programmes of training in CAS, Medicine and Surgery. The Falls Prevention Checklist and process of implementation has been further developed.

  Immediate Actions: Information and Insight Team further triangulating Medically Safe for Discharge (MSFD) data aligning to inpatient falls. *Update expected : August 2020*

- **Venous Thromboembolism (VTE) assessment (May 2020 = 94.4%)** *Target 95%*
  In the last 12 months NUH have been >95% for three of the 12 months. Compared to one in the 12 months before. NUH's rate of Hospital Acquired Thrombosis (HAT) remains favourable versus peers. Transfer of the VTE assessment into Nervecentre is currently in test, prior to moving this from NOTIS in late June 2020

- **Friends and Family Test (FFT) (May 2020 = 0.8% Maternity Response Rate)**
  Launch of new FFT requirements is on hold nationally until further notice. NUH have resumed feedback collection in Inpatient Wards only, using iPad devices.

  Immediate Actions: Scoping is underway for longer term feedback collection options

SHERWOOD FOREST HOSPITALS

- **Eligible patients asked case finding question, or diagnosis of dementia or delirium (May 2020 = 29.1%)** *Target ≥ 90%*
  New electronic screening method was introduced during 2019. Clinical lead for dementia identified to provide additional leadership; Recruitment to support/coordinate Q4 2019/20; Assessments stood down due to Covid-19 April 2020.

  Immediate Actions: Assessments to be re-introduced and agreed process to be decided and communicated across the Trust

- **Care Quality Commission (CQC) Inspection Actions**
  SFH met all CQC timescales in response to the three 'must do' actions for Newark Hospital end of life by 12 June 2020. The full action plan to be submitted to the Trust internal quality committee on July 15th after which it will then be shared with the CCG for on-going support and monitoring against plan

- **Hospital Standardised Mortality Ratio (HSMR - February 2020 is 109.7)**
  SFH will continue to monitor the Trust HSMR position on a monthly basis through the Mortality Surveillance Group given the continued statistical significance.

  Immediate Actions: In conjunction with Dr Foster they will complete a deep dive analysis around each of the four key HSMR diagnosis groups – specifically a focus on Gastrointestinal Haemorrhage and Liver disease, alcohol related given that these two groups are also statistically significant within the Summary Hospital Mortality Indicator (SHMI). In conjunction with Dr Foster they will complete further analysis both locally and utilising the Hospital Episode Statistics based benchmarking to further understand the spike in the standardised mortality during September 2019. Review Palliative Care coding and provision given the potential impact on the HSMR

KEY QUALITY INSIGHTS

Nottingham University Hospitals

- Restoration and recovery of clinical services has commenced in order of clinical priority and is being managed through three steering groups (emergency and urgent care; elective inpatient; and ambulatory care and diagnostics). The recovery steering groups meet weekly and report to the Operational Leadership Team.
- A process has been established to consider and approve small scale service restarts in order to maintain oversight whilst reducing delays and bureaucracy. During the restoration and recovery phase NUH are working to retain and embed new ways of working that were rapidly developed during the first phase of the pandemic e.g. shift in out-patient activity to non-face to face either by telephone or video-conferencing.
- Continuation of System Connect Meetings
- Review of Quality Schedules
- Monitoring NUH ED for 12hr breaches as activity increases

Sherwood Forest Hospitals

- Restoration - 50 Specialty and Service restoration plans have been developed since the start of May, 44 have been agreed and implemented and the remaining 6 are expected to be agreed by the end of June 2020. Of the plans agreed and implemented a review of actual activity against plan commenced on 22nd June. A review of plans will continue into the next phase of recovery to ensure they remain aligned with any changes to national guidance.
- Continuation of System Connect Meetings
- Review of Quality Schedules

Independent Sector Providers - Nil concerns by exception to report

QUALITY FOCUS & ACTIONS

Nottingham University Hospitals

→ Quality schedule to be agreed with the Trust building on work completed during contract preparations for 2020/21.
→ Work-plan to be developed from the agreed quality schedule to inform quality assurance meetings
→ Quality assurance meetings to be scheduled between commissioners and the Trust
→ NUH setting up MDT review for very small cohort of COVID 19 positive patients who were in ITU in order to confirm efficacy of British Thoracic Society guidelines. Shortness of breath pathway and one stop shop MDT will be in place for three months.

Sherwood Forest Hospitals

→ Quality schedule to be agreed with the Trust building on work completed during contract preparations for 2020/21.
→ Work-plan to be developed from the agreed quality schedule to inform quality assurance meetings

- → Quality assurance meetings to be scheduled between commissioners and the Trust
- → Continued review of patients impacted by the pandemic through reduced clinical activity and their experience of care.
- → Continued review of impacts on workforce

Additional Actions

- → Restoration of the CCG Quality Assurance programme and approaches
- → To continue to monitor quality indicators and collate updates
- → Consider SFH approach to understanding harms and work with NHS providers to share good practice and approaches

PRIMARY CARE (GP)	JUNE 2020 AUTHOR: ESTHER GASKILL

KEY QUALITY INFORMATION

Q4 (2019/20) Primary Care Quality Dashboard

- 65% (84/103) practices achieved an overall 'Green *' or 'Green' rating
- 46 practices achieved an overall 'Amber' rating
- No practices received an overall 'Red' rating

Clinical Outcomes Domain – Screening: 83 practices continue to struggle with achieving the 80% target for cervical screening and 14 with the 52% bowel screening target. This is likely to deteriorate further with the disruption to screening due to the COVID-19 pandemic. 30 did not meet the 70% breast screening target.

Patient Experience Domain: Improvement from Q3 in the number of practices achieving the '% of list size recorded as a carer' and '% of patients on the end of life register who have their preferred place of death recorded' indicators

Anticipated that the volume of learning disability annual health checks and health checks for those with a mental health condition will decrease significantly as a result of practices having to postpone all routine work

Immediate Actions: The CCG's cervical screening checklist is available for practices to undertake and identify actions they can implement to help reach the 80% marker. A similar bowel screening checklist is ready to share with practices as and when the national screening programmes resume. Work is on-going with PCNs and Commissioning Team to address the annual health checks

CQC Outcomes (as of 1 July 2020)

- 15% (19) rated 'Outstanding'
- 81% (105) rated 'Good'
- 2% (3) rated 'Requires Improvement'
- 1% (2) rated 'Inadequate'
- 1 'Not rated'

KEY QUALITY INSIGHTS

Continued working with locality and IPC colleagues to support restoration of face to face appointments where required & enablement of recovery phase

Vulnerable Risk Assessment (Staff): Risk assessment of all BAME staff working in general practice underway to understand implications and ability to deliver face to face services – many appointments continue to be conducted via telephone / video

2 practice closures: RHR – all patients transferred to the new Broad Oak Practice, Radford Medical Centre (Dr Phillips) – patients transferred to several neighbouring practices

QUALITY FOCUS & ACTIONS

→ Review of practice returns in relation to preparedness and IPC compliance, providing support and guidance where required

→ Recall / review of vulnerable patient cohort to be undertaken as part of phase 2 plans and local authority undertaking safe and well checks. Guidance issued to practice managers to support approach for patients with long term conditions and medicines reviews

CARE HOME & HOME CARE SECTOR

JUNE 2020
AUTHOR: JEAN GREGORY

KEY QUALITY INFORMATION

Nursing Homes & Care Homes Under Enhanced Surveillance: The homes below are under enhanced surveillance with associated action plans for improvement. Further information can be found in the Appendix.

Mid Notts ICP	
Red Oaks CH Community & Red Rose Care Community	Requires improvement
The Sycamores and The Four Seasons (Evedale) Ltd (FSHC)	Requires improvement
Parkside Nursing Home Monarch Consultants Limited	Inadequate
Millington Springs	Requires improvement
Lancaster Grange Barchester Healthcare Homes Limited	Inadequate
Nightingale - Jasmine HealthCare Limited	Requires improvement
South Notts ICP	
Charnwood	Requires improvement
City ICP	
Connect House	Requires improvement
Seely Hirst House (in administration)	Requires improvement
Nottingham & Nottinghamshire Overall	
7 Homes	Requires improvement
2 Homes	Inadequate
Home Care Agencies	
Agincare	Overall good
Nurture Care	Requires improvement

Quality Concern Themes	Frequency Cited
General care	7
Leadership	5
Environmental issues	2
Medicines management	2
Pressure care/wound care	2
Training	2
Care records	1
Safeguarding	1
Workforce levels	1

One System Data Set: As a system we have been collating data across all care home providers this is updated twice a week and attached below. The first tab shows the summary, the second is the same information in graph form and the third tab shows each care home. This data has been used by the urgent care team to facilitate discharges and to give assurance during COVID-19. A dashboard is being developed for home care and a support metrics is in development to show which homes have received which part of the toolkit training from the Enhanced Care Response Team (ECRT) team.

KEY QUALITY INSIGHTS

- Regular and reactive quality assurance audits were suspended by Local Authority, CQC and CCG during the Covid pandemic because of the lockdown and possible risk of contamination and spread of infection to vulnerable people in care homes or those receiving care at home.
- Some homes are still anxious in relation to accepting patients who are Covid positive well after the 14 day isolation period. The IPC team have been able to provide support to these homes using Public health England guidance.
- Children's home care contract review and procurement to open up to new providers. The current contract of 7 providers has been approved for a 24 month contract extension (new expiry date of 30th September 2022). A written

offer for the contract extension will be sent to the providers, along with an amendment to the third party payments which needs to be agreed by all providers for it to be included in the contract. Following this agreement from the current providers, procurement will take place to increase the number of framework providers over the next 2 years. A full re-procurement will need to be undertaken prior to the expiry of the contract extension.
- Review of action plans that have been delayed due to Covid-19 pandemic.
- Establishment of quality link with SFHT discharge team to provide support
- Established robust clinical support to the testing cell.
- Provided support to the Market management subgroup and CHHC operational group
- Support re fit testing
- Quality team supported re compilation of Covid-19 compliant homes list.
- Continuations of support to the NUH discharge team.
- The quality team remains supportive of the Covid response via the QSC cell

What is going Well?
- Weekly meeting taking place with County Local Authority to share information and coordinate responses.
- City Local Authority have re-established their QUIF information sharing meetings
- Homes supported by the recently established ERCT team and the quality team.
- All homes have been offered PPE training 36% took up the offer and 100% of those homes have received it. There are fewer quality concerns in relation to PPE coming through.
- Virtual provider meetings now taking place.
- Meetings held with City & County Local Authority to review quality assurance approaches in the light of the Covid – 19 Pandemic.
- Strong links made with the discharge teams at NUH and SFHT to support discharges to care homes and address any difficulties at an early stage.
- List of Covid compliant homes in use by both discharge teams and proving useful.
- CCG Mental Health and LD Quality manager in place and working in partnership with the Local Authorities to supporting in relation these homes.
- Care homes Tracker one version of the truth shared with the wider health system twice a week.
- Support re the toolkit and updating in relation to discharge process

The quality team works in partnership with Local Authorities, CQC and Healthwatch. The quality concerns listed above are an example of the quality issues in the area. These are addressed via:
- Information sharing meetings (Virtual)
- Risk summits
- Action plan development/ reviews
- Participation in provider meetings (via virtual platforms during the pandemic)
- On-site audits with LA. (only one undertaken during the pandemic)
- Regular contact with providers via telephone, email
- Partnership working with LA and CCG safeguarding teams
- Reactive approach to quality concerns

Actions being taken to assure and improve quality generally
- Development of an Enhanced Care Response Team (ECRT) to deliver quality elements of training following a tool kit that can be accessed here
- NHS Quality monitoring audits
- e-healthscope dashboard
- promotion of a shared LA and NHS quality concerns template
- 6 weekly newsletters to all nursing homes focusing on quality.
- Care homes forums had been established across all ICPs prior to the pandemic. There is now a virtual forum which is held fortnightly and attendance is increasing. Care home managers and staff encouraged to attend.
- Whatsapp group for providers which have proved effective Care homes are encouraged to engage with LPZ, EnRich and Optimum.

QUALITY FOCUS & ACTIONS

- → Programme of quality assurance of Children's Home care agencies.
- → Agree quality assurance processes going forward for both Nursing Homes & home care services for adults.
- → Work with both Local Authorities to identify those homes that because of quality concerns require an on-site visit to complete an audit and provide assurance.
- → Establish links with the Locality Directors.
- → To plan for restoration and recovery.
- → To develop the operational group into business as usual.
- → To ensure the care homes and home care team are linked into other CCG wide pieces of work for example demand management.
- → Providing support to the development of Enhanced Care Response Team and workforce plans
- → Further development of a support metrics to identify homes that have received specific training.
- → Work with the Enhanced Healthcare in Care homes team and primary care to develop and support the EHCH DES.
- → Continue to assess homes for the IPC compliance checklist

PART TWO: CCG STATUTORY RESPONSIBILITY/FUNCTION

SAFEGUARDING – LOOKED AFTER CHILDREN (LAC)	JUNE 2020 AUTHOR: KATHRYN HIGGINS

KEY QUALITY INFORMATION

Statutory Health Assessments
During the COVID-19 pandemic no changes have been made to statutory guidance relating to health assessments for LAC but in line with the COVID-19 Bill all 3 providers (NUH, SFHFT and NHCT) have risk assessed and completed all statutory health assessments remotely without physical assessment/growth. A review of Initial Health Assessments highlighted:

- NUH – 62 (62%) of the 100 consultations affected between 16.03.20 and 03.06.20 still require face to face review. In addition 26 referrals have been received since 03.06.20 where we do not yet have a clear answer regarding the proportion requiring an examination. If a similar percentage this will add 16 further children.
- SFHFT – 50 of the consultations affected have required an additional face to face review. At the time of writing 9 (18%) of those 50 consultations still require face to face with 49 completed in the last 4 – 6 weeks.
- NHCT – At the time of writing it was not possible to identify the total number of Review Health Assessments (RHA) completed virtually, however only 12 have been risk assessed as needing revisiting face to face

An audit of 10 RHAs completed remotely was undertaken by the Designated Nurse for LAC and the service lead and indicated good quality assessments with the growth element and/or developmental assessment missing for some (many reported by carers or self-reported). Each provider has had differing issues in relation to buildings and staffing impacting on their recovery plans.

NUH are recommencing face to face mid-July
SFH recommenced early June and had extra support within the team to facilitate this.
NHT recommenced face to face on 29.06.20

Immediate Actions: Both NUH and SFHFT teams have raised concerns internally, advising their LAC service is added to the provider risk register. LAC Designated Nurse & Doctors are working towards a solution to support providers with the backlog that has built due to COVID restrictions. All 3 providers have differing situations in regard to facilities and staff and therefore will having differing recovery dates and it will be impacted upon by any changes in Government directive. Provider contract meetings are being resumed in September and activity and performance will be discussed.

KEY QUALITY INSIGHTS

Continued focus on recovery. Further assurances gained from the LAC CAMHS service in both City and County in relation to their recovery plans. Papers will be submitted to the Safeguarding Assurance Group on 08.07.20

QUALITY FOCUS & ACTIONS

→ Continue to support and monitor provider recovery
→ Continue to link in with regional and national LAC forums/NHSE in regard to recovery
→ Work with providers to support them with backlog recovery plans

SAFEGUARDING – CHILDREN & YOUNG PEOPLE	JUNE 2020 AUTHOR: VAL SIMNETT / SANDRA MORRELL

KEY QUALITY INFORMATION

GP participation in Initial Child Protection Conferences (ICPC)* data 2019/2020 Q4		
	No of ICPCS	% of GP participation (either attendance or submission of a report)
City	*Under Development*	
County	110	28%

** An ICPC is a meeting to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child and determine whether the child needs to be made subject to a child protection plan.*

GPs should be routinely invited to all ICPCs and are requested either to attend the meeting or submit report summarising key information in relation to the subject child, and make recommendations on the nature of any risks identified. As can be seen by the performance figures, GP contribution remains significantly low. This is compared to attendance by other partners such as the police (77%) schools (87%) Health visitor (89%). This issue continues to be complex and GP audits undertaken have identified a number of issues including: Invitations not being sent promptly or to the right individual; Internal GP practice administrative issues resulting in delays or negative responses; GPs claiming that lack of notice and/or time constraints are prohibitive. During the Covid incident, the LA have initiated virtual IPCS via MST, and anecdotal evidence suggests this has improved GP participation.

Health involvement in strategy discussions in compliance with Working Together 2018		
	No. of discussions	% involving health professional
Nottm. City	313	60%
Nottm. County	143	8.5%

Working Together 2018 Statutory Guidance requires local authority children's social care to convene a strategy discussion to determine a child's welfare and plan rapid future action if there is cause to suspect they are suffering or is likely to suffer significant harm. Health professionals should be consulted as part of this process. As can be seen from the performance data, there are significant shortfalls in this requirement. **Immediate Actions:**

- Established electronic communication pathways between LA and GPs
- Raising the issue at GP safeguarding lead workshops
- Developing a CP conference report template and guidance for GPs
- Local NHS providers have agreed for the MASH health teams to be the first port of call to contribute to strategy discussions
- Work is underway to review MASH pathways to enable access to key health information from across health systems to enable effective contribution to strategy discussions.
- A cross Authority working group is in place and progress is being monitored by the LSCP Business Management Group in the City and the Safeguarding Assurance and Improvement Group in the County.
- The Operational teams for City and County MASH are reviewing processors in conjunction with the review to establish alignment across the ICS footprint
- The City LA in conjunction with Partners are reviewing compliance due to recording anomalies

Further Planned Actions: The benefits of virtual MST meetings need to be analysed to identify whether this has improved GP participation. Multi Agency Audit needs to be undertaken to identify any barriers or issues emerging from the electronic invitation process to inform next steps. Further work within the City between partners to review attendance and identify barriers. Exploration of the Care Coordinator role

KEY QUALITY INSIGHTS

- Working with the Safeguarding Team to develop risk and recovery plans and identify emerging trends in relation to release of Covid 19 lockdown
- Monitor MASH referral data and provider safeguarding performance reports to ensure services meet identified needs of vulnerable children.
- Link to the Asylum seeker work as referenced in the Adult Safeguarding report to prioritise children and pregnant people for health assessments.
- Development of Safeguarding Guidance for health professionals using remote consultation methods to treat children and young people.

QUALITY FOCUS & ACTIONS

→ Establishing webinar sessions for GP Safeguarding Leads and to evaluate as alternate model for meetings. The evaluation will be key in establishing a future model for the delivery of PLT events in conjunction with good practice shared from a national level during the COVID crisis.

SAFEGUARDING – ADULTS	JUNE 2020 AUTHOR: NICK JUDGE

KEY QUALITY INFORMATION

S42 Care Act Enquiries: The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. The LA's has delegated this duty to the CCG **85** times in last 12 months. The majority of referrals were for incidents that have taken place in care homes involving residents that we are fund through Continuing Health Care. The main themes include:

- Pressure Ulcers
- Falls
- Unsafe discharges from hospital
- Failure to identify a deteriorating resident
- Unknown cause of injuries
- Medication Errors

For the first two months of the Covid-19 lockdown there was a reduction by a third in Adult referrals in to the local authority and the section 42 enquires ceased. From May to the end of June referrals into the LA increased by 80%. In comparison to Jun 2019 referrals have increased 55%. This increase in referrals does suggest that we are likely to see an increased demand on CCG to respond to section enquiries from Social care over the next couple of months. Learning from these enquires had been shared through the care home managers forum prior to COVID –10 incident. **Immediate Actions:** The MASH Health Team and the CCG Safeguarding Team are actively recruiting to the team as we have vacancies in the designated and practitioner roles. Continue to share learning across partners

Court of Protection Cases: Court of protection (21a) = 8; Court of protection (Welfare) = 6
The Court of Protection continues to operate via virtual hearings and there are currently 8 active cases where there is a dispute in relation to either placement or restrictions within the care plan. There are also 6 cases where CCG funded care arrangements are being scrutinised by the Court. Currently contact within care homes and supported living is still restricted so we have to work with continuing Health care colleagues to ensure that these patients are monitored and care plans amended were required. No immediate action/ concerns. Virtual Court is working well. All cases are progressing according to plan.

Deprivation of Liberty in the Community: Authorisation of Community deprivation of liberty safeguards is an area for concern. Following the integration of the 6 Nottingham and Nottinghamshire CCGs there is a level of inequality in relation to getting these deprivation authorised via the Court of protection Re:X process. The Mid-Nottinghamshire area does not have a community DoLS process in place. **Immediate Actions:** The Mid-Nottinghamshire Continuing Care Team has identified individuals who are potentially at risk of an unauthorised deprivation. An initial plan was to review care plans and records to assure the CCG that care arrangements and any restriction imposed on the individual were proportionate. This has approach has been impacted and delayed by the Covid-19 pandemic. Senior Nurses have scheduled to meet mid-July to discuss possibilities and options for extending greater Notts approach to Re:X authorisations across CCG footprint. Preferred solution to be agreed by 31st July 2020. All identified community DoLS to be authorised in the court of protection by March 2021

PREVENT (77.4% WRAP Level 1 – NUH Underperformance): The fall below the expected target for level 3 WRAP training is due to the three yearly cycle coming to an end. NUH have e-learning packages for staff to complete linked to their role, this is mandatory and it is linked to progression through pay gateways reviewed in appraisals and 1-1's. They also provided a filmed version of Prevent delivered by the adult safeguarding team that can be used to deliver Prevent training in a classroom setting where these are being facilitated; this training meets the mandatory requirement also.
Immediate Actions: NUH has registered this as a risk on their Risk Register and and a recovery plan has been implemented. The Trust will now report into the CCG on a monthly basis until they reach compliance with which is 85%.

New Statutory Reviews (Domestic Homicide Reviews = 0, Safeguarding Adult Reviews = 1): Despite local and national intelligence suggesting that DV is increasing during lockdown there have been no new recent cases of Domestic Homicide. On-going contribution to statutory Reviews

KEY QUALITY INSIGHTS

This month's focus has been on the court of protection:

- The safeguarding adults' team as continued to progress all applications to the court of Protection and respond to relevant orders and provide required evidence in line with court imposed timescales.
- A draft court of protection standard operating procedure has been developed as an aid and guide to all staff arranging

or commissioning individual patient care packages. This will ensure that restrictive or potentially contentious care is personalised, least restrictive, in the individual's best interest and as such can be sanctioned by the court of protection.

- Addressing and resolving the inequity in community DoLS applications and authorisation across the CCG footprint.

Asylum Seekers Contingency Accommodation: The commissioning of Primary Care services to carry out the immediate health and care services has been concluded to support Asylum Seekers who have been placed in Nottingham City Hotels. The main challenges initially were information sharing between Home Office and CCG in order to identify the most vulnerable and also gaining assurance around IPC within the hotels. We now established a communication network and escalation processes so all parties are aware of their roles and responsibilities in relation to the cohort of people.

QUALITY FOCUS & ACTIONS

→ DHR/SAR Action plans and learning
→ Community Court of Protection Cases
→ Section 42 referrals
→ Safeguarding Adult Team recruitment
→ PREVENT
→ The business of the boards is beginning to recommence using virtual meetings

SAFEGUARDING – SPECIAL EDUCATION AND NEEDS DISABILITY (SEND)	JUNE 2020 AUTHOR: MICHELLE SHERLOCK

KEY QUALITY INFORMATION

Department of Education (DFE) and NHSE/I national SEND reviews undertaken to obtain an overview of impact of COVID 19 and to collate information for analysis with a view to share elements of good practice across the regions.

Response provided as part of the SEND review:

- DCO working towards enhancing how we obtain assurance form health providers around meeting the needs of CYP with SEND
- There has been no Impact on temporary changes in legislation as service providers have continued to deliver on and meet requirements for EHC assessment process.
- DCO developed a pathway for escalation, to support assessors if a health-related risk presented. To date have not had any incidents of concern escalated from either LA.
- Community Health service delivery for CYP with SEND did experience an initial challenge due to community paediatricians and Speech and Language Therapists being deployed to acute settings to support frontline workforce. This was time limited and services resumed to normal duties, albeit with alternative arrangements for working being implemented, to consider the guidance from DFE for social distancing
- DCO working towards gaining assurance in relation to SEND audits and assurance tools from NHS Trusts
- DCO has good working relationships with LA partners, providers commissioners and parent/carer forum, although still building those links for Nottingham City LA

Immediate Actions

- DCO has obtained support from Designated Safeguarding Leads to establish appropriate escalation and governance routes. This has resulted in requesting and ensuring SEND is now included on a quality schedule.
- Commissioners are also reviewing contracts and are working towards ensuring key performance indicators and exception data is included to be reported on.
- By establishing the above routes this should mitigate risks identified in relation to adhering to SEND statutory duties and provide assurance to that effect. It will improve systems and process when trying to establish communications routes around updates or providing returns for NHSE SEND assurance in the future
- Following the inception of Nottingham & Nottinghamshire CCG the DCO has been aligned to the CCG Safeguarding team.
- The DCO regularly participates in work development groups and co-production with partners and parent/carers forum

KEY QUALITY INSIGHTS

- Initial feedback from the SEND review for both LA was that Nottingham and Nottinghamshire are performing highly and leading by example, have identified areas of good practice and want to share that work regionally and nationally.
- Outcomes remain to be determined as the analysis needs to be collated by DFE, Ofsted, NHSE and formulated to be shared nationally
- Health service providers will circulate their current local offer to stakeholder and be available for parent carers through appropriate communication systems. DCO and LA are to ensure information is available for school bulletins
- As communication links are established to address quality assurance and the impact of COVID on service provision for CYP with SEND.

QUALITY FOCUS & ACTIONS

→ NHSE restoration for children's community health services has been published and services are considering this for their business recovery plans, most services are resuming to business as usual.
→ NHSE restoration for children's community health services has been published and services are considering this for their business recovery plans, most services are resuming to business as usual.
→ The DCO to work with Assistant Director for nursing & Safeguarding to establish clear strategic leads in the NHS Trusts for SEND in conjunction with Quality Team leads.

CONTINUING HEALTHCARE

JUNE 2020
AUTHOR: JANE GODDEN

KEY QUALITY INFORMATION

No performance data available due to suspension of CHC service since 19.3.2020. CCGs are not being held to account on the NHS CHC Assurance standards.

Early estimate is that by 30 Sept 2020 there will be a backlog of around 1,000 CHC assessments

Immediate Actions: Planning in place to define recovery

KEY QUALITY INSIGHTS

Recovery: Planning for CHC Recovery – there is no update yet on the Covid 19 guidance issued on 19th March 2020 when the CHC service was suspended. Therefore all packages of care arranged to facilitate hospital discharge or avoid admission continue to be funded by the NHS. Discussions have commenced with both Local Authorities regarding the assessments that will be required to ensure all Covid 19 funded individuals are moved to the appropriate funding stream once the NHS funding comes to an end. This will result is a significant number of CHC assessments and have an impact on available resources to comply with the National Framework. It is expected that the CCG will receive a higher than normal number of appeals against CHC eligibility decisions and this will need to be taken account of within our planning

CHC Reviews: The Covid 19 guidance stated that CCGs should take a proportionate approach to CHC reviews whilst CHC remains suspended. Due to CHC Nurses being re-deployed to other areas of the NHS, no reviews were completed during March-May. From June 2020, reviews of those individuals in receipt of NHS CHC (i.e. fully funded NHS care) have re-commenced. From July 2020, reviews of people in receipt of funded nursing care (FNC) will recommence. There is a back-log of other reviews: joint funded and s117 packages and a pragmatic approach to managing this back-log needs to be agreed with the Local Authorities.

Finances: In recognition of the recent FNC uplift applied by the government (9% back-dated to 1.4.19 and a further 2% from 1.4.20), a proposal has been submitted to Prioritisation & Investment Committee to uplift CHC rates in nursing homes by 11% back-dated to 1.4.20. This will retain the differential between local authority rates and CHC rates in recognition of the higher health care needs of individuals who are eligible for CHC. The paper highlights the challenges the care sector has been facing during Covid 19 and the CCG's expectations under their contracts. The proposal is cost neutral as it is off-set by the reduced CHC expenditure since the service was suspended.

Children's Continuing Care: Discussions have been taking place regarding the Children's continuing care service which was also suspended with the caveat that the CCG would approve urgent funding requests to maintain complex care packages or enable new ones to commence to facilitate discharge or avoid admission.

QUALITY FOCUS & ACTIONS

- → **Recovery:** Next meeting between CCG and the Local Authorities – 23.7.2020. The plan is to agree a set of principles regarding the assessments required, such as cohorting the individuals and having a lead agency for each cohort, and stream lining the process given that the majority of assessments may need to be carried out virtually but still working within the requirements of the National Framework. The principles also need to address when CHC referrals should be made and to develop an alternative approach for Local Authorities to apply for joint funding.
- → **Reviews:** Reviews of CHC and FNC to continue during July/August in order to reduce the back-log as far as possible before the reinstatement of the CHC service
- → **Finances:** Paper to be considered at Prioritisation & Investment Committee on 8.7.2020. If approved, notification to be issued to all nursing homes and the back-dated funding applied to budgets for payment in August.
- → **CYP Continuing Care**: Re-start Children's continuing care service from 1st July 2020 with panels to re-commence from 7th July. Evaluate how the Children's panel works using MS Teams as a model for re-introducing adult CHC panels at the appropriate time.

INFECTION PREVENTION AND CONTROL (IPC)

JUNE 2020
AUTHOR: IPC TEAM

KEY QUALITY INFORMATION

MRSA June 2020		
CCG	Plan	Actual
Nottingham /Nottinghamshire	0	1
Mansfield & Ashfield	0	1
Newark & Sherwood	0	0
Nottingham North & East	0	0
Nottingham West	0	0
Rushcliffe	0	0
City	0	0
Nottingham University Hospitals Trust (NUHT)	0	0
Sherwood Forest Hospitals Trust	0	0

- 1 County pre 48hr case of MRSAb undergoing a post infection review (PIR) to determine any learning for future prevention
- Post infection review is underway to determine any learning for future prevention
- A revised national ambition is in place to reduce all healthcare associated cases by 25% by 2021/22.
- The 50% reduction is now required by 2023/24, this reflects the complexity of these infections.

C. difficile June 2020	Plan	Actual				
		COCA	COIA	COHA	HOHA	TOTAL COUNT
N&N CCG	41					38
Mansfield & Ashfield	8	4	0	2	0	6
Newark & Sherwood	4	2	1	1	1	5
Nottingham City	5	2	1	0	3	6
Nottingham North & East	2	2	1	0	0	3
Nottingham West	1	0	0	1	0	1
Rushcliffe	3	1	1	0	3	5
NUH	12			1	8	9
SFH	6			3	0	3

C.difficile cases reported during June 2020 are identified above. All cases are reviewed to identify any learning both in primary and secondary care. There is a delay in determining learning and lapses due to prioritisation of essential work and IPC significant workload from supporting with COVID-19.
Use of antibiotics is likely to have increased across both primary and secondary care from use in managing respiratory infections and this may be contributory to an increase in cases – detail unknown at this stage and will be reported once available. No new objectives have been released for 2020-21 so the plan is based on 2019 objective.

- Newark and Sherwood 5 cases against a plan of 4
- Nottingham City 6 cases against a plan of 5
- Nottingham North and East 3 cases against a plan of 2
- Rushcliffe 5 cases against plan of 3

E.coli BSI June 2020	Plan 10% reduction 2016 baseline	Actual (June 2020)
N&N CCG	94	87
Mansfield & Ashfield	15	12
Newark & Sherwood	10	11
Nottingham City	22	21
Nottingham North & East	12	13
Nottingham West	7	4
Rushcliffe	8	11
NUH	17	13
SFH	3	2

- Rates of *E.coli* BSI are higher in Nottinghamshire than the national rate. However, after rising rates each year up to 2016 a slight reduction is now evident.
- Gram negative reduction targets are expected to be introduced after April 2020 but have yet to be released.
- Due to on-going workload and IPC requirement to support COVID-19, work to review *E.coli* themes has been temporarily suspended

KEY QUALITY INSIGHTS

COVID-19 remains at the forefront of IPC work.

- Working in the IPC cell , first point of contact for providers regarding any COVID-19 related issues
- Read and translated daily guidance for local use – care homes/primary care CMC
- Communications support
- Pandemic planning - strategic advice
- Support for initiating home diagnostic team/later local swabbing response
- Review of business continuity plan/key priority areas
- IPC service maintained with modifications
- Primary Care - Recovery and Restoration of services
- Outbreak Management / Plans

QUALITY FOCUS & ACTIONS

→ IPC team work to continue support care homes with COVID-19 zoning and management of outbreaks/ swabbing results and key messages regarding IPC and continued use PPE during on-going local transmission
→ On-going monitoring of homes with quality concerns
→ IPC support to primary care with COVID-19 zoning/IPC requirements and new ways of working
→ IPC support to Public Health with outbreak management plans
→ RCA reporting extended to include HCA COVID-19 clusters/outbreaks in providers with need to collate learning and themes
→ On-going swabbing in care homes staff/residents to detect asymptomatic COVID-19 carriage and early indicators of outbreak
→ Test and trace
→ Monitoring of other HCAI rates and implications of increased antibiotic use during COVID-19 (e.g. C.difficile/ E.coli BSI) against existing objectives

PART THREE: QUALITY & TRANSFORMATION

LOCAL MATERNITY & NEONATAL SYSTEM

JUNE 2020

AUTHOR: BECKY GRAY

KEY QUALITY INFORMATION

Nationally the maternity transformation programme was paused to enable systems to respond to Covid 19, this has included a pause in reporting and initiatives. The time lost during this period and the impact this is likely to have upon programme performance has been recognised on the LMNS Transformation Programme Board risk register. Restoration and recovery planning for the programme is underway.

Continuity of Carer

Programme deliverable: 35% of women achieving continuity of carer by March 2021 (local target); 51% of women achieving continuity of carer by March 2021 (national target)

Continuity of Carer LMNS performance against trajectories

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20

National Trajectory
Local Trajectory
Actual Performance (all models)
Actual performance against National definition models

NB. Spikes in performance due to caseload uplift

Teams operating to provide enhanced CoC for women at both SFH and NUH were maintained during Covid 19 (nationally this was not the case) and a further team was launched in June 2020 at SFH (performance numbers will be reflected in July reporting). Plans to launch a 3rd CoC Team at NUH have been delayed due to Covid-19 as midwives currently working in the acute sector could not be realised into the community setting in order to support safe staffing levels within the hospital environment during the pandemic. **Immediate Actions**: Initial restoration and recovery planning has identified establishing further CoC Teams in line with local targets between now and March 2021 has been identified as a programme priority. Workstream meetings are to resume in July and additional resource requirements are being considered.

Reducing Stillbirths by 50% by 2025 nationally .

Programme deliverable: Local trajectory set out in ICS LTP: 4.17 (Stillbirth rate per 1000 births) 2019/20; 3.66 (Stillbirth rate per 1000 births) 2020/21

Current LMNS performance against locally agreed trajectories in reducing still births across Nottingham and Nottinghamshire were met for 2019/20. Progress towards fully embedding all elements of the care bundle had slowed during Covid 19 and the development and implementation of a robust audit programme has been delayed. **Immediate Actions:** Work aligned to the LMNS Safety agenda has been identified as a programme priority through initial restoration and recovery planning. Work has been on-going to fully embed the Saving Babies Lives Care Bundle version 2 (SBLCBv2) across NUH and SFH during Covid 19 and continuation of this is expected to support the achievement of 2020/21 trajectory and contribute to the national ambition of a 50% reduction in stillbirths by 2025.

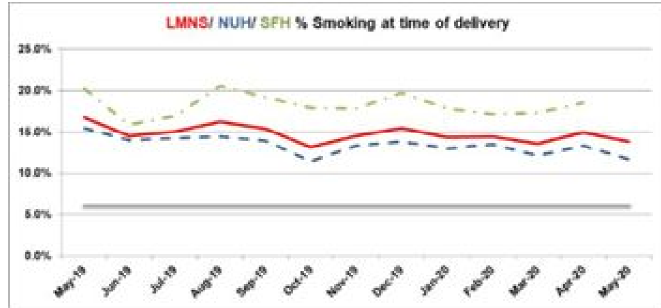
Smoking at time of delivery (SaToD)

Programme deliverable: National target to reduce SaToD to 6%; (Local target set for districts across footprint to reflect wide variation in SaToD rates)

SaToD rates across the LMNS remain significantly above the national target though some reduction within the Nottingham City area has been seen. **Immediate Actions:** There are a number of initiatives across the LMNS to support women with smoking cessation before and during pregnancy. Smoking cessation services have continued to support women during Covid though methods of service delivery have been altered to adhere to guidance on social distancing and reducing face to face contact. Appointments have been converted into telephone consultations, which have reduced the number of DNAs as women report accessing support without the need for travel has been a positive benefit.

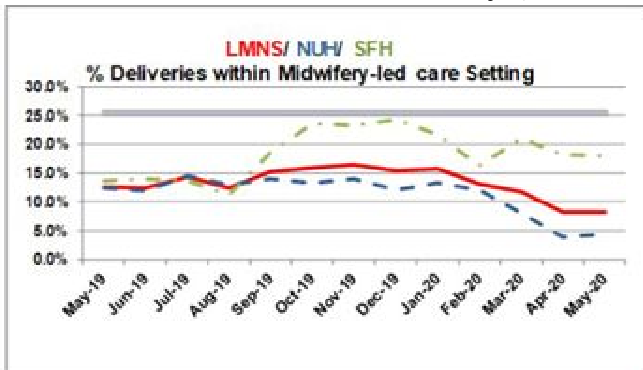
The LMNS has been confirmed as Early Implementation Site (EIS) that will 'stress test' maternity services based stop smoking services for tobacco addiction in pregnancy prior to the planned national roll out. This project and associated

funding has been delayed due to Covid and work is currently underway to understand when this is likely to come back on track



Increased % of women delivering in Midwifery Led Care settings

Programme deliverable: Local target 25.5% of deliveries in MLC settings (inc. Homebirths and alongside MLC units) March 2020; 29% of deliveries in MLC settings (inc. Homebirths and alongside MLC units) March 2021



The number of women giving birth in midwifery led care settings (including home births) across the LMNS reduced significantly from March 2020 to May 2020.

Home Births number has reduced during Covid 19 response as trusts developed local response. NUH reduced their location of birth offer due to the use of The Sanctuary (Midwifery led care) as a Covid 19 isolation unit.

Immediate Actions: Across the system there was a reduction in place of birth choices for women and families. This was in line with responses in other LMS where supporting acute services during the pandemic was prioritised.
Home births were temporarily suspended by both SFH and NUH and have since been reinstated with a case by case review to ensure appropriate and safe staffing levels. A full service reinstating was planned from the end of June 2020.
The alongside midwifery led units (AMU) at NUH have been utilised as Covid 19 isolation areas to support IPC measures which has further reduced the place of birth offer and impacted upon the number of women able to deliver in MLC settings. Reinstating the AMUs is being considered currently.

KEY QUALITY INSIGHTS

- Recovery and restoration planning for the transformation programme has been started
- LMNS PMO team started transition to BAU role during the month.
- July LMNS board was centred on restoration planning. The board acknowledged that the programme would have to take a pragmatic approach to enable restoration and has given direction that focus should be on delivering safety and Continuity of Carer.

QUALITY FOCUS & ACTIONS

→ The PMO is supporting the work stream leads to develop a more detailed implementation plan against the Board priorities whilst also looking at where programme deliverables may be supported/deliver through other work/programmes.

LEARNING DISABILITY/AUTISTIC SPECTRUM DISORDER (TRANSFORMING CARE)

JUNE 2020

AUTHOR: TCP TEAM

Nottingham and Nottinghamshire TCP Inpatient Targets

Inpatient KPI	Apr- 20	May-20	Jun- 20	Jul- 20
CCG Performance	14	13	13	14
Plus/minus target	+2	+1	+1	+2
NHSE Adult Performance	32	32	34	34
Plus/Minus Performance	+4	+5	+8	+8
NHSE CYP Performance	2	2	4	4
Plus/Minus Performance	-1	-1	+2	+2
TCP Overall	48	47	49	50

Annual Health Check

Nottingham and Nottinghamshire CCGs continued to improve the level of annual health checks delivered during 2019/20 rising from 43% in Q3 to 59% in Q4. Initiatives to continue this improvement will progress throughout 2020/21, but the restrictions in response to COVID 19 are likely to have an impact on this year's performance. NHSE regional team for LD/Autism acknowledge the challenges and feedback is awaited regarding adaptations in response to COVID.

LeDeR

	2019	2020 (Total)	2020 (COVID)	
March	4	5	0	+20%
April	4	16	11	+75%
May	5	8	4	+37.5%
Total	**13**	**29**	**15**	**+55.2%**

LeDeR Covid implications:

- **15** recorded COVID-19 deaths across the System
- **13** confirmed COVID-19 deaths, 2 are suspected and are undergoing post-mortem

April 2020 saw a 75% increase in LeDeR deaths compared to last year (April 2019). For non-COVID-19 cases there were 14 which places us on a similar footprint to last year's LeDeR deaths of 13.

- 73% of LeDeR COVID-19 deaths occurred in the Acute setting, the remaining 27% occurred in a care home
- 67% were male compared to 33% female
- 100% had White British ethnicity
- 100% had underlying health conditions- the most common was Epilepsy affecting 40% of the LeDeR COVID-19 deaths

Immediate Actions: Business continuity plans have been developed to ensure that CTR/CeTRs, Host commissioner arrangements, and LeDeR reviews continue to take priority throughout the COVID 19 pandemic phase. IT hardware has been requested and granted by NHSE/I and distributed to allow key clinical and expert by experience personnel to provide independent challenge to the CTR process. Close liaison is taking place with NHSE region regarding necessary adaptations that could allow annual health checks to be delivered, and feedback is awaited from NHSE national team as to how local systems could implement the changes. Liaison is taking place with primary and secondary care LD nursing teams to ensure that there is monitoring of LD care homes taking place on a PCN footprint throughout the restoration and recovery phase and beyond. NHSE have confirmed all CETR's will continue to be undertaken virtually in line with the phase 2 letter that highlights Care (Education) and Treatment Reviews should continue, using online/digital approach. The third phase letter is due to be released soon. The policy refresh work has also been delayed and the C(E)TRs Policy has been adapted to enable virtual delivery through COVID.

KEY QUALITY INSIGHTS

CCG inpatient numbers have risen slightly above trajectory, the COVID 19 pandemic has caused a reduction in discharges, as community providers struggle to mobilise, recruit staff and develop readiness to accept new residents. NHSE inpatient numbers remain significantly above trajectory with a significant rise in CYP admissions this will remain a challenge throughout 2020/21 with numbers remaining static. Work is required across the CCG, local authorities, NHSE and IMPACT to deliver effective and sustainable new models of care to enable the reduction in secure adult inpatient beds.

CTRs/CeTRs and LAEPS have been delivered remotely throughout the COVID 19 pandemic and have proved effective in preventing an increase in admissions.

There has been a slight increase in safeguarding referrals with the COVID 19 phase but early analysis suggests that these are not strictly COVID 19 related. Providers have risen to the challenges relating to staffing, restrictions on patient leave and movement and PPE with low levels of outbreaks generally across inpatient care.

Nottingham and Nottinghamshire ICS saw more than double the amount of learning disability deaths (55.2%) based on 2019 data which is mainly attributable to COVID-19.

QUALITY FOCUS & ACTIONS

- → Continue to coordinate LeDeR reviews
- → Regular liaison with NHSE/I via monthly MST meeting
- → Host Commissioner Responsibility - continue oversight and facilitate information sharing – meeting arranged
- → Monitor Inpatient Numbers and support Discharges – frequency reporting to region
- → Continue CTR/CeTRs - will continue to monitor virtual CTR until NHSE give go ahead that face to face can commence
- → Rapid Reviews/LeDeR Investigations for all cases - LeDeR Steering Group to lead on the recommendations and learning.
- → Weekly CCG LeDeR meetings to monitor new cases, implement any immediate learning, and escalate any concern
- → Align reporting to wider COVID19 mortality and morbidity
- → Recovery & Restoration Planning
- → TCP (LD/ASD) Executive board 30 June 2020

UNIVERSAL PERSONALISED CARE

JUNE 2020
AUTHOR: AMY CALLAWAY

KEY QUALITY INFORMATION

MOU/LTP metrics	20/21 target	Q1 performance to date
Support the recruitment of social prescribing link workers in PCNs across the STP/ICS.	39	34
Referrals to social prescribing link workers.	4,188	5,884
Promote and offer personal health budgets for people with a legal right to have a personal health budget and in priority local cohorts (as identified in the STP/ICS LTP local implementation plan).	4,350	0
Increase the number of personalised care and support plans (PCSPs) for identified cohorts in line with the standard replicable PCSP model.	21,500	not yet reported

Most of the UPC programme was paused during COVID for the team to focus on the COVID response.
The exception to this was that Link Workers were mobilised as part of the LRF response, contacting shielded and vulnerable patients with a COVID service offer focused on immediate support requirements (medicines and groceries) as well as wellbeing support.
Link Workers contacted 5,884 individuals during April – June 20.

COVID focused work was carried out on existing PHB’s (such as co-ordination of PPE) but there have been no new PHB’s created during this time (especially as CHC assessments are usually the starting point of a PHB and there have not been any of these taking place).

NHSE have stated that 20/21 targets will be reviewed in light of COVID, but we are awaiting confirmation of this. Recovery plans will analyse our anticipated performance for the remainder of the year against initial targets.

KEY QUALITY INSIGHTS

- Recovery and restoration planning for the transformation programme has been started
- UPC team started transition to BAU role 80% of time during the month (remaining 20% of time is with Business Continuity Cell).

QUALITY FOCUS & ACTIONS

→ Detailed workstream planning for restoration phase up to end of current programme in March 2021, with a focus on prioritisation and delivery expectations to March 21.
→ Commencement of workstreams with key stakeholders and agreement on workstream deliverables and outcomes

APPENDIX A – CARE HOME & HOME CARE BY PROVIDER

JUNE 2020
AUTHOR: JEAN GREGORY

MID NOTTS ICP

- **Red Oaks Care Community & Red Rose Care Community (CQC Requires Improvement) Healthcare Limited / Red Homes Healthcare Limited.** Action Plan review Feb 2020 - Improvement notice in place for both services. Red oaks restricted to 1 admission per week in line with the restrictions on the improvement notice. Red Rose - virtual action plan review in July 2020 – report pending. Red Oaks – requested Medication optimisation support which has been arranged. **Action:** CQC considering on-site visit following a number of safeguarding.
- **The Sycamores and the Poplars (CQC Requires Improvement) Four Seasons (Evedale) Limited (FSHC).** Service remains suspended. Joint service review scheduled for March 2020 with Nottscc and postponed due to current crisis. **Action:** Joint provider review meeting scheduled for July 2020 to review contract suspension
- **Parkside Nursing Home (CQC inadequate) Monarch Consultants Limited** Joint action plan review, with Notts CC, planned for March 2020 and postponed. April 2020, CQC lifted restrictions on registration. Provider requested lifting of contract suspension. Virtual provider meeting undertaken in May 2020, with Notts CC, suspension to remain in place following a review of the evidence submitted by the provider. **Action:** CQC are currently determining if an on-site visit is required. Virtual action plan meeting scheduled for August /Sept 2020
- **Millington Springs – (CQC Requires improvement)** Provider contract suspension lifted in April 2020 following a review of the submitted evidence. Improvement notice remains in place with a limit on admissions to 1 a week across both contracts. Telephone review by CCG with provider in June 2020. Information shared with LA. Only 1 admission in 4 weeks. **Action:** Improvement notice and admission limit to remain in place until further review has been undertaken in August 2020
- **Lancaster Grange (CQC Inadequate) - Barchester Healthcare Homes Limited.** Provider currently being managed by Notts CC. Provider is currently suspended. **Action:** Notts CC are currently managing the contract suspension as the CCG have no nursing contract in place. No action for CCG.
- **Nightingale (CQC Requires improvement) Jasmine HealthCare Limited** May 2020, quality concern regarding a syringe driver nursing care and appropriate training. Provider meeting held June 2020; provider contract suspended until qualified staff training and competency requirements completed. Action: Provider review by LA & CCG - July 2020.

SOUTH NOTTS ICP

- **Charnwood (CQC Requires Improvement)** Joint review of the service planned with Notts CC for March 2020, this was postponed due to the current crisis. Continuing staffing and IPC concerns since March 2020 – IPC providing support. Request from provider to review current contract suspension, in place since Sept 2018. Provider meeting held on 16th June 2020 and provider was requested to present information relating to the above concerns. Provider has, to date only submitted part of the data, despite reminders. Contract reviewed by Notts CC and CCG, contract suspension to remain in place. Further concerns raised around the merger of the two “Houses” provider does not appear to have taken on board advice regarding the merger and have not submitted the evidence requested at the provider meeting in June 2020. **Action:** Notts CC to request the information. Joint Notts CC and CCG meeting planned for July 2020. CQC are considering whether to undertake an on-site visit.

CITY ICP

- **Connect House (CQC Requires improvement)** Provider gave written assurances to the concerns raised around documentation and care provision; these have been reviewed by the CCG Quality team. City Council Early

Intervention and Provider review visit postponed due to current crisis. **Action:** Provider virtually review scheduled for July 2020.

- **Seely Hirst House (CQC- Requires Improvement) Home in administration.** This home is quality managed by Nottingham City Council. No CCG involvement.

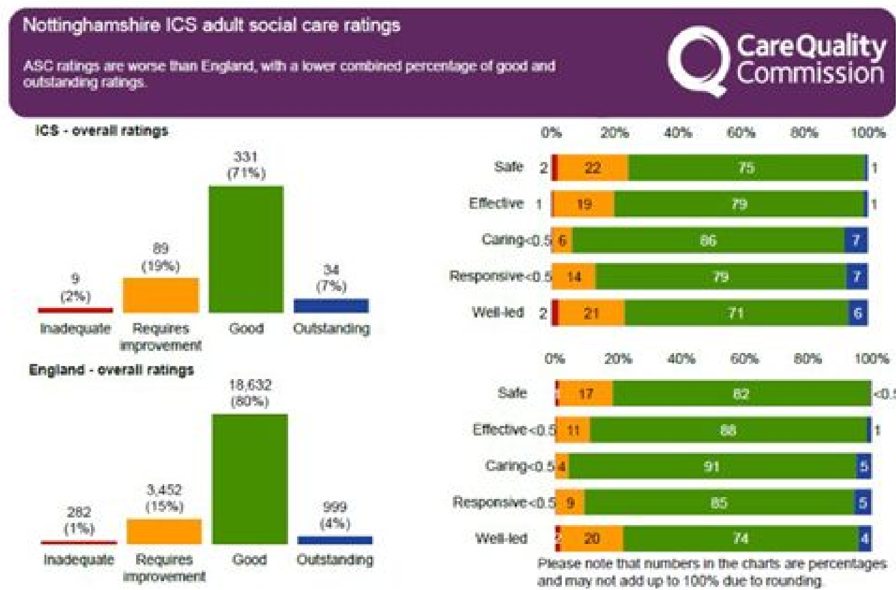
HOME CARE AGENCIES

- **Agincare (CQC rating Overall good) (Cover countywide excluding the West)** In Nottinghamshire County due to the impact of COVID-19 the 90 Day Notice to Improve has been extended for a further 6 weeks (expiring 14th August 2020). By this date the Provider will have booked in dates to complete the specialist training that is outstanding. In April 2020, Agincare became an additional provider for Nottingham City (Joint Contract with Nottingham City Council). At the meeting that was held on the 2nd July it was confirmed that the staff delivering in the Nottingham City Area are the same staff delivering in the County, and as such are not trained to deliver specialist interventions. As this was the reason for the suspension remaining in place in the County it was appropriate to issue a contract suspension in part for the City Contract. There is currently 1 health funded homecare package in the city.

  Action: Contract review August 2020

- **Nurture Care (CQC rating Requires improvement) County wide service** Quality team working in partnership with the safeguarding team and the CityCare children's CHC nurses and contracting in relation to concerns raised with a view to undertaking a virtual meeting with the provider. Nurture care contract suspended May 2020.

  Action: Meeting scheduled for end July 2020.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	06 August 2020

Paper Title:	Learning Disability Mortality Review (LeDeR)	**Paper Reference:**	**GB 20 068**

Sponsor: **Presenter:**	Rosa Waddingham, Chief Nurse Rosa Waddingham, Chief Nurse	**Attachments/ Appendices:**	Appendix A: Easy read version Appendix B: Full LeDeR Report-2017-2020

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

This report provides an update on the implementation, progress and learning from the Learning Disabilities Mortality Review (LeDeR) reviews that have been carried out following the deaths of Nottingham City and Nottinghamshire citizens with learning disabilities and/or autism.

This report forms part of the governance and assurance arrangements for this programme and it is a requirement that the easy read version of the report at Appendix A is approved by the CCG's Governing Body prior to its publication on the CCG's website. The full version of the report is appended for information/further reading only.

The Learning Disabilities Mortality Review (LeDeR) Programme was established in response to the recommendations of the confidential inquiry into the premature deaths of people with learning disabilities (CIPOLD). It has been commissioned by NHS England and Improvement and is managed by the Healthcare Quality Improvement Partnership (HQIP).

LeDeR was established to support local areas to review the deaths of people with a learning disability, identifying learning from those deaths, and to take forward the learning into service improvement initiatives. The steering group are responsible for managing those actions and representatives are at a senior level within their respective organisations to influence and support change.

This is the first annual report for LeDeR, which summarises the achievements of the programme since it began. It is a regulatory requirement for all areas to complete a LeDeR annual report.

Both versions of the report were received by the Quality and Performance Committee on 27 May 2020.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☒
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☐

<table>
<tr><td colspan="2">Strategic Planning</td><td>☐</td><td colspan="2"></td><td></td></tr>
<tr><td colspan="6">Conflicts of Interest:</td></tr>
<tr><td colspan="6">☒ No conflict identified</td></tr>
<tr><td colspan="6">Completion of Impact Assessments:</td></tr>
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<tr><td colspan="6">Recommendation(s):</td></tr>
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Nottingham and Nottinghamshire
Clinical Commissioning Group

LeDeR report (easy read)

This is the first report of the Learning Disabilities Death Review (LeDeR) programme for Nottingham and Nottinghamshire.

The report was written in April 2020.

It tells you about the deaths of people with learning disabilities. The deaths were checked in 2017, 2018 and 2019.

This report is about people who have died, who were special to their families and friends.

Thank you to all families who have taken part in the reviews.

The aims of the LeDeR programme are:

1. To help improve health and social care services for people with learning disabilities.
2. To stop people with learning disabilities dying too soon.

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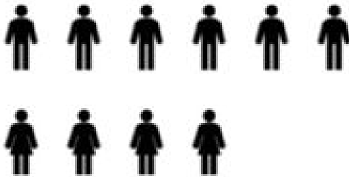
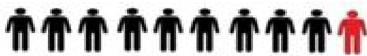
The LeDeR programme in Nottingham and Nottinghamshire has been told about the deaths of 167 people with learning disabilities since November 2017.

152 have had an initial review completed (about 9 out of every 10 cases).



6 out of every 10 of the people who died were male.

4 out of every 10 of the people who died were female.



We have found 9 out of 10 people with a learning disability in Nottingham and Nottinghamshire have received satisfactory, good or excellent care

The average age at death for people with a learning disability in Nottingham and Nottinghamshire was 62 years old.

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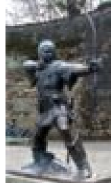
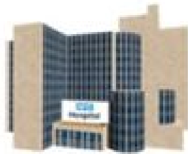
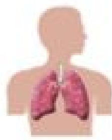


There were more deaths in Nottingham and Nottinghamshire than we expected.



More people died in hospital than we expected.

The four most common causes of death were:

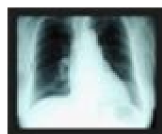


1. Pneumonia.

This is an infection in your lungs caused by bugs called 'bacteria'.

2. Aspiration pneumonia.

This is an infection in your lungs caused by food or drink going down 'the wrong way'.



3. Cancer.

This is a disease which can be in any part of your body.

4. Cardiovascular.

This is a problem with your heart.

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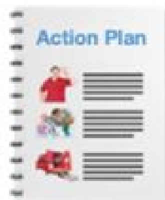
We found several things kept being said at our reviews. These were:

1. We need to try to involve family members more in the reviews.

2. Care needs to be based more around the needs of the individual person (making 'reasonable adjustments').

3. Staff who care for people with learning disabilities need more help with training and skills.

4. It is important that people with learning disabilities receive a health check every year.



We have learnt many things from our LeDeR reviews. We are writing an action plan to improve care and support for people with learning disabilities.

What do you think? Are there things we could be doing better? Please let us know.

Learning Disabilities Mortality Review (LeDeR) Programme

March 2020 (covering the period from November 2017)

Nottingham and Nottinghamshire

Nottingham City Council Nottinghamshire County Council NHS
Nottinghamshire
Transforming Care Partnership

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

EXECUTIVE SUMMARY

People with a learning disability often have poorer physical and mental health than other people. We know that we need to understand why so that we can make a difference to people's lives. One way we are doing this is by looking at why people die. This is called the Learning Disabilities Mortality Review programme or LeDeR for short. To help this national programme make the most difference we need to know about as many deaths of people with a learning disability, autism or both as possible.

In this report, covering November 2017 to March 2020, 167 LeDeR referrals have been received and 152 have had an initial review completed (91%).

The age range of LeDeR deaths for Nottingham and Nottinghamshire reflects the national trend for learning disability deaths. The median (middle) age of death is 62.5 years which is slightly higher than the national median age for learning disability deaths at 59 years. This however, is still considerably lower than the mortality rate within the population. Our work going forwards must seek to end this inequality for people with a learning disability.

Analysis of the LeDeR reviews has highlighted a number of key themes that need addressing in people's care.

- We are seeking greater involvement of family members in the reviews, so we can better understand people's lives and the care and support they receive.
- We are looking to ensure better uptake of reasonable adjustments for people's care.
- We need to work with health and care organisations, in the public sector, private sector, and the voluntary and community sector, to improve staff training, their understanding, awareness and skills.
- We need to continue to increase the number of annual health checks provided for people with learning disabilities and overcome the barriers preventing people accessing Primary Care services.
- In conjunction with the local STOMP/STAMP steering group, we need to idenitify and address the over-reliance of long term psychotropic medication for people with learning disabilities and autism where there is no justified clinical indication, which can increase the risk factors for long term conditions.

Our steering group for Nottingham and Nottinghamshire will use the insights being gained through the national and local LeDeR programmes to ensure care, support and outcomes improve year on year. Our strategic action plan for the next 12 months will see a focus on clinical conditions (pneumonia, cancer and sepsis) and system changes (learning and development and reasonable adjustments) and we will continue to monitor progress and keep partners and system leaders abreast of developments.

INTRODUCTION

The report covers the journey of the Nottingham & Nottinghamshire LeDeR programme from its inception in November 2017 to March 2020. It reviews the progress, challenges and achievements of the LeDeR programme. It will then make recommendations 2020-21 as well as providing assurance regarding the progress of the programme against nationally agreed outcomes.

The LeDeR Programme is led by the University of Bristol and is commissioned by NHS England and Improvement (NHSE/I). Research has found that people with learning disabilities on average die 15-20 years earlier than the general population. Some of these deaths have been identified as potentially avoidable if there had been earlier assessment, diagnosis and treatment of common conditions. Improving the care for people with learning disabilities has been identified as one of the four national Government priorities over the next 10 years.

The LeDeR programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and change and improve care and services as a result.

Through the completed reviews taking place across the country, evidence is being used to develop staff skills and awareness and improve access to services and support. The aim is to enable people with learning disabilities to receive equitable health and social care to that of the general population, and reduce the life expectancy gap.

OVERVIEW OF THE LEDER PROGRAMME

The Programme is coordinated by the newly formed Nottingham and Nottinghamshire CCG, following the merger in April 2020 of the six previous local CCGs.

Within the CCG we have a Primary Local Area Contact (LAC) and a LeDeR Administrator who are responsible for the day-to-day management of the programme. The LAC also oversees the quality assurance process of the reviews and collates the data along with conducting analysis of the outcomes themes and trends. This is then overseen by the steering group.

THE STEERING GROUP

NHS Nottingham and Nottinghamshire Clinical Commissioning Groups (CCG) LeDER local steering group which was established in November 2017. The steering group provides oversight, support and governance to the local delivery of the programme.

The steering group has representation from the CCG, NHS (primary care, community and acute) organisations, local authorities, GPs, medical directors and carers by experience. There is discretionary membership to representatives from public health, medicines management, the Care Quality Commission and the Child Death Overview Panel.

The steering group is facilitated by the CCG and Chaired by the Primary LAC. An action plan has been developed by the steering group which addresses the learning and themes arising from completed reviews. The steering group have been working on many areas such as the ReSPECT guidance, easy read documentation, improving uptake for annual health checks and screening programmes, including the influenza vaccination. The steering group have been fundamental in cascading the purpose of LeDeR and promoting referrals into the programme. LeDeR has also informed changes to organisational policies and practice when incidents have been reviewed.

The steering group has developed two working groups in the past six months – one focusing on LeDeR learning and the other on quality assurance processes.

REVIEW COMPLETION PERFORMANCE

A number of local clinical reviewers were trained to undertake LeDeR reviews between November 2017 – December 2019 but there proved to be challenges with capacity to undertake reviews alongside their existing roles.

In order in ensure reviews and learning was developed the CCG commissioned an external consultancy in January 2019 to complete all of the reviews. By December 2019, 89% of reviews were completed. Since the programme launched in November 2017, 152 reviews have been completed, 15 remain in progress or on-hold due to other statutory processes, leading to an overall completion rate of 91% which above the national target.

The table below provides an overview of our completed reviews per calendar year:

	Open	Closed	Total	% Complete
2017 (November-December)	9	0	9	0%
2018 (January- December)	66	4	75	5%
2019 (January- December)	81	126	147	89%
2020 (January- March)	11	22	158	91%
Overall total	167	152	167	91%

Nottingham City Council | Nottinghamshire County Council | NHS Nottinghamshire Transforming Care Partnership

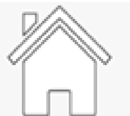
NHS Nottingham and Nottinghamshire Clinical Commissioning Group

SUMMARY OF REVIEWS IN NOTTINGHAM AND NOTTINGHAMSHIRE

167 LeDeR referrals have been received since November 2017

152 have had an initial review completed (91%)

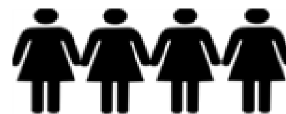
56% of people died in local hospitals (this is 9% above the national



32% of people died in their usual place of residence

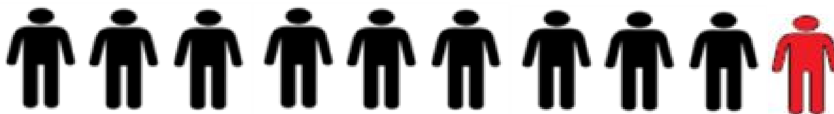
Six in every 10 deaths were males

Four in every 10 deaths were females



141 reviews have completed a grading of care.

This demonstrates that **9 out of 10** people in Nottingham and Nottinghamshire with a learning disability have received satisfactory, good or excellent care



Nottingham City Council · Nottinghamshire County Council · NHS Nottinghamshire Transforming Care Partnership

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

LINKS TO OTHER ORGANISATIONS AND REVIEWS

When a death of a person with learning disabilities occurs, a number of processes need to be considered and organisations informed. These include:

- Safeguarding adult reviews
- Child death reviews (CDOP)
- Coroner's inquests
- Police, prison and probation ombudsman report

LEDER NATIONALLY

The national LeDeR programme produced its first annual report in 2016 and the latest report was published in May 2019 (covering July 2016 to December 2018).

The annual report states:

- 4,302 deaths had been notified into the programme
- Approximately 86% of the total number of deaths for people with a learning disability had been referred into the programme
- By December 2018, the review process had only been completed for a quarter of these deaths
- The proportion of deaths notified for people from Black, Asian and Minority Ethnic (BAME) groups was lower at 10% than that of the population of England as a whole (14%). The findings for Nottingham and Nottinghamshire are that this is significantly lower at 2% - an issue being examined by the steering group.

BACKLOG PROJECT

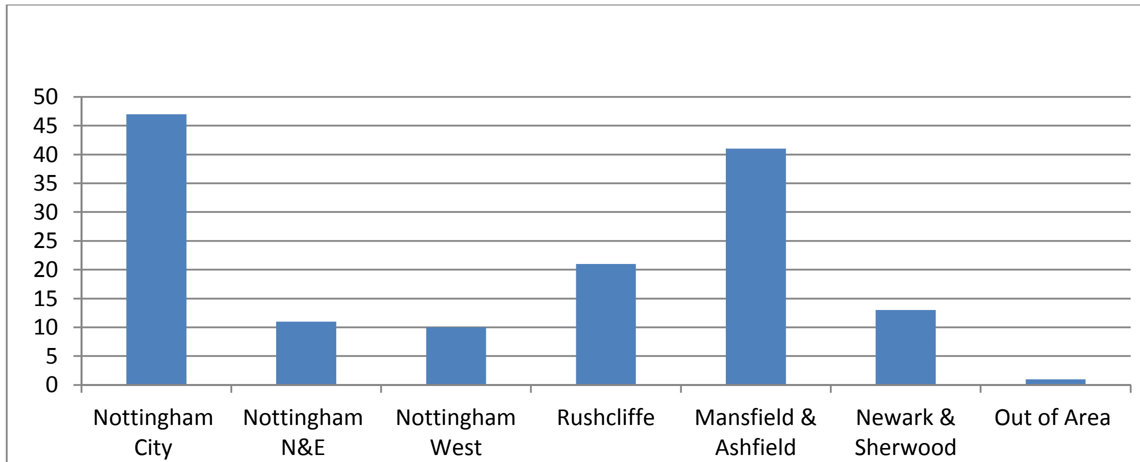
Nationally, NHS England and Improvement has provided an additional £5 million to fund reviews. At the time of the funding announcement, there remained between 2,700 and 3,000 incomplete reviews.

In June 2019 approximately 50 reviews in Nottingham and Nottinghamshire had been completed and 30 were in progress. The target for completed reviews was 20 per month and there was a robust approach to achieving this with the consultancy company.

The backlog project started in September 2019 by which time the majority of these reviews had been completed and only 11 went into our final trajectories. The funding achieved from the backlog project has now been received by the CCG but has not as yet been spent. The steering group will determine where this funding should be prioritised based on the findings from the reviews.

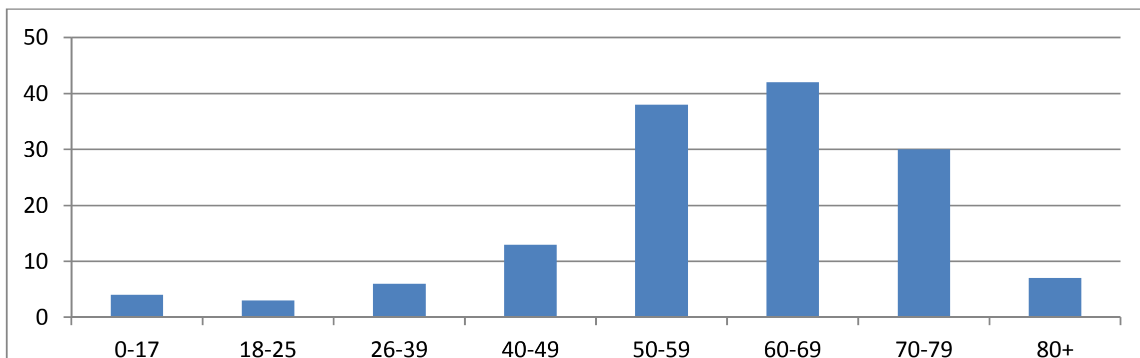
LEARNING FROM DEATHS IN NOTTINGHAM AND NOTTINGHAMSHIRE

Chart 1- Review status by responsible CCG area 2017-20



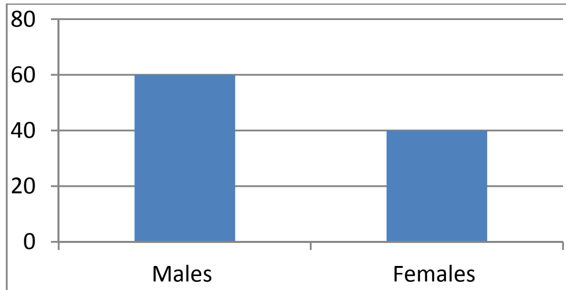
A total of 31% of LeDeR reviews have been from Nottingham CCG. The remaining 69% came from Nottinghamshire CCGs (Nottingham North and East, Nottingham West, Rushcliffe, Mansfield and Ashfield, and Newark and Sherwood). Census data 2018 shows Nottingham City has a population of 331,100 and Nottinghamshire has a population of 823,100. The origin of our LeDeR notifications, as per responsible CCG, does largely reflect the local population data.

Chart 2 - Review status by age range 2017-20



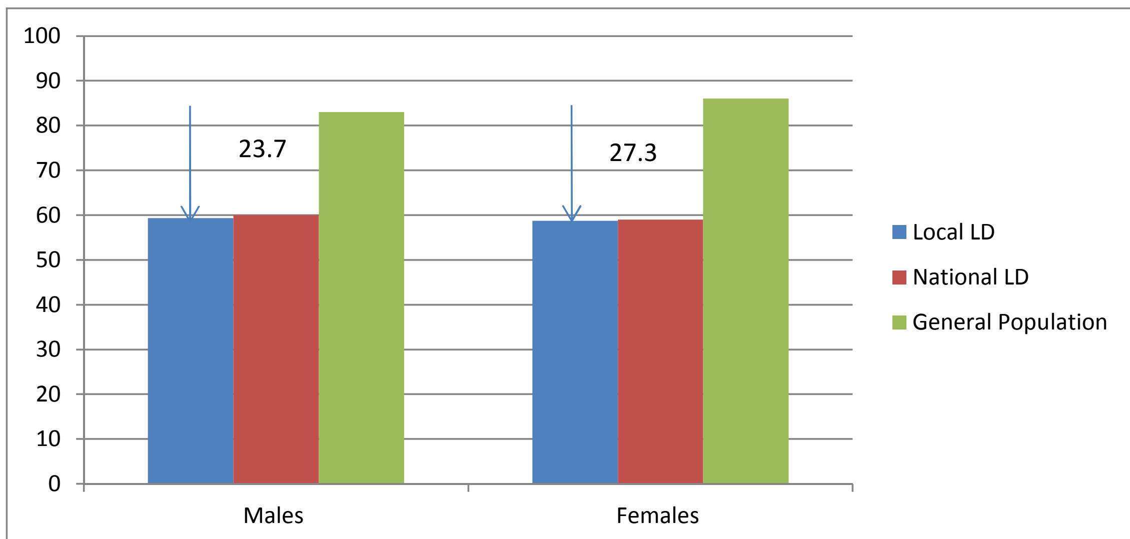
The age range of LeDeR deaths for Nottingham and Nottinghamshire reflects the national trend for learning disability deaths. The median (middle) age of death is 62.5 years which is slightly higher than the national median age for learning disability deaths at 59 years. This is still much lower than the national population.

Chart 3 - Review status - male versus female 2017-20



Our local LeDeR data demonstrates a higher number of deaths in males (60%) compared to females (40%). This is in line with the national trend for learning disability deaths of 58% male deaths compared to 42% female deaths.

Chart 4 - Average age of death for males and females - local versus national

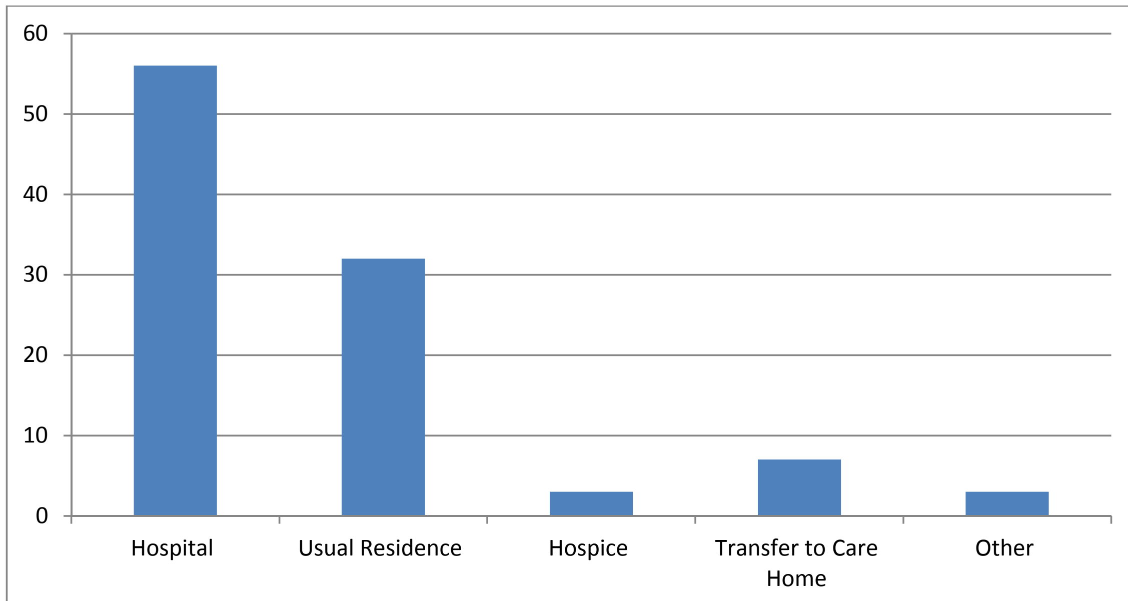


Our local data is comparable with LeDeR data nationally. It shows we have much to achieve to reduce the life expectancy gap for people with a learning disability in Nottingham and Nottinghamshire. 2020-21 will be the first financial year that the LeDeR steering group will have produced strategic priorities aiming to reduce this life expectancy gap.

Chart 5 - Review status - place of death 2017-20

Nottingham City Council Nottinghamshire County Council NHS
Nottinghamshire
Transforming Care Partnership

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group



The number of hospital deaths for Nottingham and Nottinghamshire is currently at 56% (and has been as high as 64%). This is lower than the national average for learning disability deaths which shows that 62% occur in hospital. This is much higher than in the general population where 47% of deaths occur in hospital.

Many of the deaths reviewed through LeDeR show that people with learning disabilities were admitted as an emergency due to an unpredictable and acute onset of a clinical condition. LeDeR can evidence that many hospital admissions could have been avoided if people had an adequate level of care at home or by their care placement provider. There is evidence of a lack of end-of-life care planning. The LeDeR process currently does not take into consideration a person's preferences regarding end of life care which can make it difficult to determine the grading of care if it cannot be benchmarked.

The number of deaths which occur in a person's 'usual place of care' (or usual place of residence) for Nottingham and Nottinghamshire is currently at 32%. The national average for the general population is 23.5%. This reflects positively for our area as the majority of people wish to die in their usual place of care and this demonstrates that barriers are generally being overcome to facilitate this preference.

Nottingham City Council Nottinghamshire County Council NHS
Nottinghamshire Transforming Care Partnership

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Chart 6 - Cause of death (Nottingham and Nottinghamshire CCGs) 2017-20

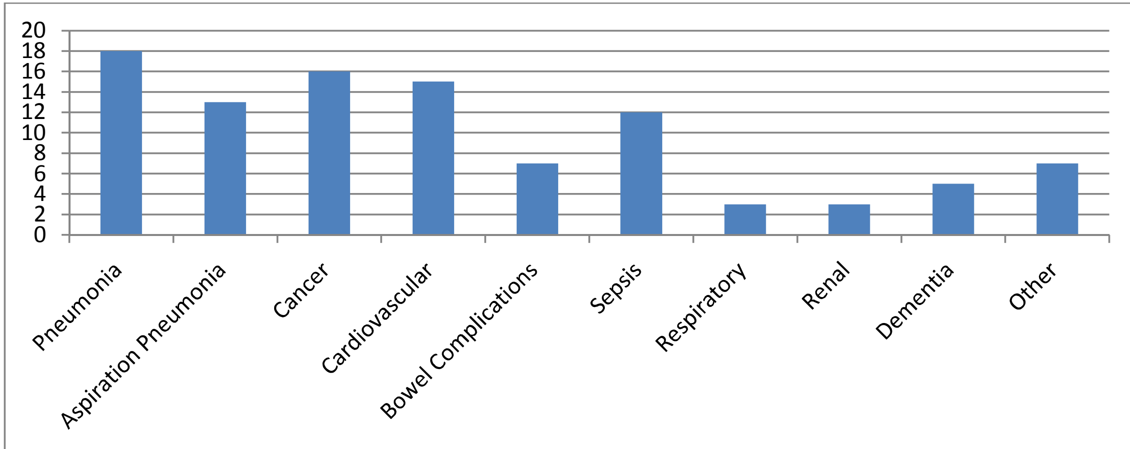


Chart 7- Cause of death - local versus national

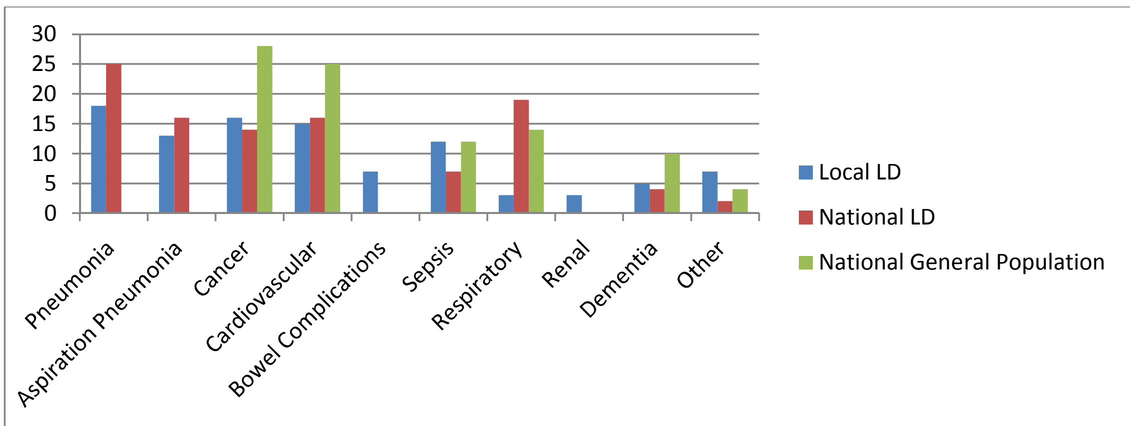
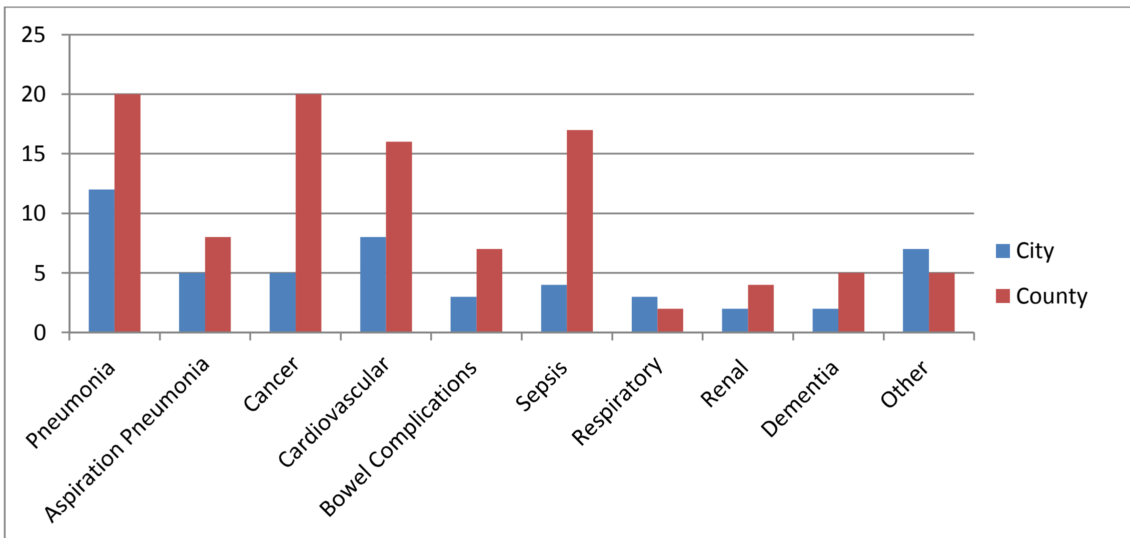


Chart 8 - Cause of death - Nottingham CCGs versus Nottinghamshire CCGs



The highest cause of death for learning disability deaths in Nottingham and Nottinghamshire is pneumonia (to include aspiration pneumonia). This accounts for about one-third of our total deaths (31% compared to 41% nationally). The figure is twice as high in the city as it is in the county. This indicates that care and treatment to prevent and manage complications of pneumonia (and aspiration pneumonia) is more effective in the county compared to the city. This will need to be strategic priority for the LeDeR steering group during 2020-21, to understand if the geographical difference is consistent with the general population for pneumonia or specifc to LD, and if so what can be done to address this.

Cancer and cardiovascular deaths have similar rates for Nottingham and Nottinghamshire. Cancer is the second highest cause of death for Nottingham and Nottinghamshire (16%) although it has been as high as 28%. LeDeR has been unable to identify any trends in the types of cancers that people with a learning disability are dying from. Cancer screening has been identified as an issue in 69% of our completed reviews although only one review could be linked directly to a death from not receiving appropriate screening. Nottinghamshire residents have elevated cancer death rates (80%) compared to the Nottingham residents (20%). It is expected that cancer will be a strategic priority for the LeDeR steering group during 2020-21.

Although cardiovascular is consistently the third highest cause of local learning disability deaths, comparisons with national general population deaths (25%) and national learning disability deaths (16%), our cardiovascular death rate (15%) is less of a priority for LeDeR.

Sepsis is the fourth highest cause of learning disability deaths for Nottingham and Nottinghamshire (12%). This is equal to the number of sepsis deaths for the general population. The national number of learning disability deaths for sepsis is 7%. As our data is 5% higher this could demonstrate that we have further learning to undertake in terms of recognising the signs for sepsis and educating staff. Sepsis should be a strategic priority for the LeDeR steering group in 2020-21.

Deaths from bowel complications, dementia, renal disorders and other causes were relatively low for Nottingham and Nottinghamshire. Our data is consistent with national learning disability averages. On the basis of this evidence these conditions will not be covered directly through the LeDeR steering group’s strategic priorities during 2020-21.

KEY THEMES FROM REVIEWS

Family participation in reviews

The top key theme from reviews has been a consistent lack of family participation in sharing information with the reviewers. In 38% of our completed reviews this was identified as an issue. This was highest in quarter one (April to June 2019) where

68% of families did not engage with the process. In quarter four (January to March 2020) this reduced significantly to only five reviews not receiving any contribution from family (23%). Family have been approached over the phone and via letter and accompanying leaflet. It is likely that family participation rates have been improving per quarter as reviews have been allocated closer to a person's date of death. It appears that families are more willing to talk to reviewers sooner after the death. This is understandable in many cases as talking about their deaths can make families and carers revoke trauma and distress.

Reasonable adjustments

Another top key theme from reviews has been in relation to a lack of reasonable adjustments made across all sectors, not isolated to health. It has been estimated that reasonable adjustments could have been improved in 52% of our reviews. Approximately half of all people with a learning disability may not be having services individualised to their needs in a way in which they can understand. This should be considered as a strategic priority for 2020-21. Providing reasonable adjustments for people with disabilities or individualised needs is covered by the Equality Act (2010) and the steering group needs to invest time and resources to improving this.

Workforce development

Learning around reasonable adjustments should be a focus as the LeDeR Programme can evidence that this is a significant area for staff development as well as being a key priority in government and national legislation around learning disabilities and autism. In partnership with our key providers, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust and the Nottinghamshire Alliance Training Hub, members of the steering group are working to develop a bid for the Health Education England Oliver McGowen mandatory training programme. If accepted then we would be part of one of five national areas producing training resources for this. The Chair of the ICS Workforce Development Group is part of the team who are developing and writing our local bid. In the future his team's networking and professional contacts would be crucial for system-wide implementation.

Another consistent theme is the training and development of care staff who work for independent and private companies, regardless of whether they are commissioned by the NHS or local authority. In partnership with the Transforming Care Partnership, the steering group must take action to address and review current contractual agreements that the local authority, NHS and CQC have in place when performing quality monitoring visits to these placement areas in terms of LeDeR. The Transforming Care Partnership coordinates a learning disabilities and autism workforce development plan and a community of practice for local providers both inpatient and community based. The LeDeR and workforce development steering

groups will need to align priorities based on a shared understanding of where the learning and development gaps are across the system.

Annual health checks

As part of the national focus on LD/Autism within the NHS Long Term Plan it is the expectation that people aged 14 years and over with a learning disability are offered and assisted to attend an annual physical health check, with a commitment that at least 75% of eligible people will receive an Annual Health Check (AHC) by the end of March 2024. The LD AHCs are in recognition of the early mortality rate, as learning from reviews shows that a number of deaths were attributed to an undiagnosed treatable long term condition, and/or related to issues with accessing primary care services. As a result of this each CCG/ICS area is performance measured on the numbers of people with LD accessing AHCs each year as a percentage of the estimated local LD population based on the GP's LD Registers.

Nottingham and Nottinghamshire continue to improve the incidence of AHCs within the LD population and overcome the inherent access and communication issues with accessing primary care services. Efforts made to improve AHC performance include partnership working with Social Care and Continuing Healthcare to encourage support services to assist people to attend their AHC, working in conjunction with peer support initiatives and multi-lingual promotional materials, such as posters and leaflets. There remains some variation in the way that primary care are recording their AHC's as practices tend to use different templates, and nationally there is no mandatory approach.

In LeDeR, it has been identified that the number of completed AHCs is higher than our system average. The quality and meaningfulness of these can vary greatly depending on the template and the skills of the practitioner. LeDeR may demonstrate that primary care are more likely to prioritise those with pre-existing health conditions or an ageing population more than our younger LD patients, as this remains an area of focus because uptake is very low.

OBJECTIVES AND PLANS FOR 2020-21

The NHS operational planning and contracting guidance 2020-21 includes four deliverables in relation to the LeDeR programme:

1) *There is a robust CCG processin place to ensure that LeDeR reviews are undertaken within six months of the notification of death to the local area*

NHSE/I have begun benchmarking CCGs against the following criteria for completed LeDeR reviews:

- % notifications assigned within three months

- % notifications completed within six months

Expectations are that our data will consistently be above 90% to remain compliant. During 2020, data has continually been at 100% *CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility*

The chief nurse is the named lead for Nottingham and Nottinghamshire and retains strategic oversight of LeDeR with operational support from within the safeguarding team, transforming care and the quality team.

2) *CCG has systems in place to analyse and address the themes and recommendations from completed LeDeR reviews*

   The CCG contributes learning from reviews to the local steering group where themes are collated and then priorities are set for service improvements. The steering group is to develop strategic action plans for each priority theme from April 2020. In 2020-21, these themes will focus on clinical conditions (pneumonia, cancer and sepsis) and system changes (learning and development and reasonable adjustments.

3) *An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews*

The CCG has already provided a number of reports through its internal governance arrangements. This annual report will be shared in the same way and across partner agencies through local safeguarding boards.

RECOMMENDATIONS

1. NHS Nottingham and Nottinghamshire CCG to maintain timeliness of conducting reviews in order to create a continual learning culture striving to make improvements and responding to the needs of our citizens and their families/carers.

2. NHS Nottingham and Nottinghamshire CCG to remain compliant with all NHS England and Improvement operational and contracting guidance 2020/21 and continue to maintain the four deliverables in relation to the LeDeR programme. In collaboration with the Transforming Care Partnership we will focus on improving the health and wellbeing of people for all ages with a learning disability, autism or both and their families to achieve better health and care, reduced health inequalities and to ensure that reasonable adjustments are being provided so people can access services fairly. Health

and care provision should offer tailored, effective and safe services to support people to live in the community and reduce the reliance on inpatient care.

3. In collaboration with the Transforming Care Partnership, the steering group are to actively engage with ICP and PCN's to raise awareness and support to increase the number of notifications into the LeDeR programme.

4. The steering group to work in collaboration with the Transforming Care Partnership to further understand and respond to the BAME learning disability community. From our local BAME data it should be achievable to increase referrals into the LeDeR programme by 5%.

5. The steering group to work in collaboration with the Transforming Care Partnership to ensure that our processes for contacting families and carers are robust and in line with local and NHSE/I professional standards. The LAC will have overall responsibility for ensuring that standards and sensitivity is maintained when families are contacted about the LeDeR programme.

6. By working in collaboration with the Transforming Care Partnership, the steering group will continue to raise the profile of LeDeR. Although the awareness of LeDeR appears to be increasing across the ICS there appears to remain a gap in the number of notifications received from private providers and Primary Care. It is important to increase our contact with these key community providers (in line with national directives) to reduce the number of hospital admissions for LD citizens. It is important through the steering groups work with the Transforming Care Partnership that processes are improved for sharing learning across all system levels for acute, community and primary care, including the information that has arisen from this annual report. The backlog funding will be used towards a Communication campaign for LeDeR which extends across the ICS.

7. By working with commissioning quality, primary and secondary care colleagues the group will understand and address the issues with prevalence of pneumonia, cancer and sepsis to understand how these diseases are being addressed at a whole population level and ensure parity for the LD population accordingly.

8. In working with the NHSE regional and national team, aim to understand how health inequalities and prevence of such dieases is being addressed elsewhere and how access and communication issues are being overcome.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	05 August 2020
Paper Title:	Highlight report from the (virtual) meeting of the CCG's Audit and Governance Committee	Paper Reference:	**GB 20 069**
Chair of the meeting:	Sue Sunderland, Non-Executive Director	Attachments/ Appendices:	-

Summary Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Summary of the Meeting

The Audit and Governance Committee met on the 22 June 2020. Due to the current Coronavirus (COVID-19) situation, the meeting was held virtually. At the meeting the Committee:

- **APPROVED** the annual reports and accounts for the six predecessor CCGs and endorsed the signing of the letters of representation for the six CCGs, which stated compliance with accounting and auditing standards. This approval had followed scrutiny of the External Audit reports on the accounts for all six CCGs; all third party assurance reports; a report on the Better Payment Practice Code; and the Head of Internal Audit Opinion report. The External Audit opinion for all six CCGs was 'unqualified'.

- **APPROVED** the Terms of Reference for the new Health, Safety and Security Steering Group and three policies that had consolidated and aligned a number of stand-alone policies from the predecessor CCGs.
  - Health, Safety and Security Policy;
  - Fire Safety Policy; and
  - Display Screen Equipment (DSE) Use Policy

- **ENDORSED** the proposal to make a minor amendment to the CCG's Management of Conflicts of Interest Policy to change the frequency of the annual assurance exercise from bi-annual to annual. An annual assurance exercise is the national standard; however the CCG had previously chosen to increase frequency during the merger process. Now the six predecessor CCGs had become a single entity and arrangements and processes for managing conflicts of interests were aligned and embedded, a bi-annual process was considered unnecessary.

  As the policy is owned by the Governing Body, a request is made that the Governing Body **APPROVES** this amendment.

- **ENDOSED** the proposal for the CCG's Senior Information Risk Owner (Stuart Poynor) to sign off compliant 2019/20 Data Security and Protection Toolkit (DSPT) submissions for the six predecessor CCGs by the end of June 2020.

- **RECEIVED** an assurance report on the CCG's payroll processes. This request had been made at the February meeting of the predecessor CCGs' Governing Bodies. The paper provided a narrative on the issues that had arisen and actions that had been taken to reduce the risk of instances of incorrect payments. The Committee noted the processes that had been put in place to mitigate errors; however they wished to seek further assurance regarding up to date information on error rates and requested review of the performance criteria in the contract with the Commissioning Support Unit. A further report will be brought to the September meeting of the Committee.

- **RECEIVED** the final two assignment reports from the 2019/20 Internal Audit Workplan:
  - Data Quality Framework
  - Workforce and Organisational Development

  The Data Quality Framework report had received a rating of 'significant assurance'. The workforce report had not provided an opinion, as due to the merger of the six CCGs, this had been an area of considerable change and it was deemed inappropriate to provide an opinion at this time.

- **NOTED** that work in the 2020/21 Internal Audit Plan was yet to commence and raised concern that non-delivery of the Plan would impact on the end of year audit opinion. It was agreed that this would be raised at a future Executive Management Team meeting.

- **RECEVIED** the Counter Fraud Annual Report, which reported that the predecessor CCGs had maintained compliance with the NHS Counter Fraud Authority's standards throughout the course of last year.

- **AGREED** to keep a watching brief on the CCG's use of procurement cards during the response to the Covid-19 pandemic.

- **AGREED** to keep the levels of risk for the Committee's four risks at their current levels.

Key Messages for the Governing Bodies

- Positive assurance from the annual reports and accounts process.
- The importance of commencing the Internal Audit Plan for 2020/21.
- Receipt of the assurance report on payroll issues, as requested by the Governing Bodies of the predecessor CCGs.

The ratified minutes of the meeting will be received by the Governing Body on the 7 October 2020.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	05 August 2020
Paper Title:	Risk Management Policy	Paper Reference:	**GB 20 070**
Sponsor:	N/A	Attachments/ Appendices:	**Appendix A** - Risk Management Policy
Presenter:	Lucy Branson, Associate Director of Governance		

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

Executive Summary

A fundamental aspect of the CCG's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Governing Body is kept informed of the key risks facing the CCG and assured that robust management actions are in place to manage and mitigate them.

As part of the Governing Body's wider assurance arrangements, effective risk management can provide members with ongoing assurance that processes are in place to proactively identify, understand, monitor and address current and future risks; both operationally and strategically.

The Risk Management Policy has been reviewed to ensure it is 'fit for purpose' for the CCG. It has been updated to reflect new roles and responsibilities for the CCG, as well as to:

- More clearly differentiate between strategic and operational risk management processes;
- Provide further clarity in relation to the management of risk logs at a team/Directorate or project level;
- Reference the need for an annual fraud risk assessment.

A high-level review of the risk appetite statement has also been undertaken as good practice recommends this is done annually.

Risk Appetite

Good risk management is not about being risk averse, it is also about recognising the potential for events and outcomes that my result in opportunities for improvement, as well as threats to success. Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted (e.g. minim and maximum levels of risk the CCG is willing to accept reflective of the risk appetite statement).

As such, it is important that the Governing Body is in agreement with the risk appetite and risk tolerance elements outlined on page 10 of the policy.

The policy has been circulated to the CCG's Internal Audit provider (360 Assurance) and Non-Executive Directors for review prior to being presented to the Governing Body for approval. All feedback has been considered as part of this exercise.

The purpose of this paper is to present the CCG's Risk Management Policy for review and approval.

<u>Policy Summary</u>

The CCG's Risk Management Policy describes the aligned approach to the management of risk across the CCG. The policy outlines the whole risk management architecture (roles, responsibilities and reporting structure) and clearly sets out:

- The Governing Body's commitment to, and leadership of, the total risk management function.
- How risk management is integrated into organisational culture and is key to all business decision making processes.
- The roles and responsibilities of individuals and committees in respect of both operational and strategic risks.
- The processes in place to ensure the systematic identification, assessment, evaluation and control of risks; for both strategic and operational risk management, including arrangements for the Corporate Risk Register and Governing Body Assurance Framework.
- The CCG's risk appetite statement and approach to risk tolerance, including acknowledgement that well-managed risk-taking can support innovation and bring other positive benefits.
- How all staff are empowered to be responsible for risk management (through training and guidance), in a 'risk-aware' culture where senior managers lead by example.
- A description of risk management terms to ensure common understanding, along with full guidance on the risk scoring matrix.

<u>Next Steps</u>

The next steps are to:

- Publish and communicate the Risk Management Policy to all staff. Training in relation to the policy, specifically operational risk identification, management and escalation, will be offered to all Directorates/teams across the CCG.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☒
Financial Management	☒	Cultural and/or Organisational Development	☒
Performance Management	☒	Procurement and/or Contract Management	☒
Strategic Planning	☒		

Conflicts of Interest:

☒ No conflict identified

☐ Conflict noted, conflicted party can participate in discussion and decision

☐ Conflict noted, conflicted party can participate in discussion, but not decision

☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision

☐ Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report

Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report
Risk(s):				
The paper details the CCG's policy for strategic and operational risk management.				
Confidentiality:				
☒No				
Recommendation(s):				
1. **APPROVE** the Risk Management Policy (attached at **Appendix A**), with particular consideration of the CCG's risk appetite statement and approach to risk tolerance.				

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Risk Management Policy

2020-2023

Draft

Version:	2.0 DRAFT
Approved by:	Governing Body
Date approved:	*August 2020*
Date of issue (communicated to staff):	*August 2020*
Next review date:	August 2023
Document author(s):	Associate Director of Governance Head of Corporate Assurance

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Head of Corporate Assurance</td></tr>
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Chief Nurse</td></tr>
<tr><td colspan="2">Team
Corporate Assurance</td></tr>
<tr><td>Title</td><td colspan="4">Risk Management Policy</td></tr>
<tr><td>Amendments</td><td colspan="4">Policy updated to more clearly differentiate between strategic and operational risk management processes. Further guidance included in relation to the management of local risk logs and fraud risk management processes. Risk appetite slightly amended.</td></tr>
<tr><td>Purpose</td><td colspan="4">The purpose of this policy is to ensure that robust arrangements for risk management are embedded across the CCG and to ensure an agreed risk appetite and approach to risk tolerance.</td></tr>
<tr><td>Associated Documents</td><td colspan="4">• Nottingham and Nottinghamshire CCG's Governing Body Assurance Framework
• Nottingham and Nottinghamshire CCG's Corporate Risk Register
• Nottingham and Nottinghamshire CCG's Fraud Risk Register</td></tr>
<tr><td>Superseded Documents</td><td colspan="4">Risk Management Policy v1.0</td></tr>
<tr><td>Audience</td><td colspan="4">All employees and appointees of the Nottingham and Nottinghamshire CCG and any individuals working within the CCG in a temporary capacity.</td></tr>
<tr><td>Equality Impact Assessment</td><td colspan="4">Complete (see Appendix E)</td></tr>
<tr><td>Approving Body</td><td colspan="2">Governing Body</td><td>Date approved</td><td>August 2020</td></tr>
<tr><td>Date of issue</td><td colspan="4">August 2020</td></tr>
<tr><td>Review Date</td><td colspan="4">August 2023</td></tr>
<tr><td colspan="5">This is a controlled document and whilst this policy may be printed, the electronic version available on the CCG's document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.</td></tr>
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Draft

NHS Nottingham and Nottinghamshire CCG's policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Communications Team at ncccg.team.communications@nhs.net

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1. Introduction

1.1. This policy applies to NHS Nottingham and Nottinghamshire Clinical Commissioning Group, hereafter referred to as '**the CCG'**.

1.2. The CCG recognises risk management as an essential business activity that underpins the achievement of its objectives. A proactive and robust approach to risk management can:

- Reduce risk exposure through the development of a 'lessons learnt' environment and more effective targeting of resources.
- Support informed decision-making to allow for innovation and opportunity.
- Enhance compliance with applicable laws, regulations and national guidance.
- Increase stakeholder confidence in corporate governance and ability to deliver.

1.3. Risk is accepted as an inherent part of health care. Likewise, uncertainty and change in the evolving healthcare landscape may require innovative approaches that bring with them more risk. Therefore, it is not practical to aim for a risk-free or risk-averse environment; rather one where risks are considered as a matter of course and identified and managed appropriately.

1.4. This policy has been developed to ensure that risk management is fundamental to all of the CCG's activities and understood as the business of everyone. The policy has adopted the following principles of risk management as set out in the ISO 31000: 2018 standard[1].

Principle	Description
Integrated	Risk management is an integral part of all organisational activities.
Inclusive	Appropriate and timely involvement of stakeholders enables their knowledge, views and perceptions to be considered. This results in improved awareness and informed risk management.
Structured and comprehensive	A structured and comprehensive approach to risk management contributes to consistent and comparable results.
Customised	The risk management framework and process are customised and proportionate to the organisation's external and internal context related to its objectives.

[1] ISO 31000 helps organisations develop a risk management strategy to effectively identify and mitigate risks, thereby enhancing the likelihood of achieving their objectives and increasing the protection of their assets. https://www.iso.org/iso-31000-risk-management.html

Principle	Description
Dynamic	Risks can emerge, change or disappear as an organisation's external and internal context changes. Risk management anticipates, detects, acknowledges and responds to those changes and events in an appropriate and timely manner.
Best available information	The inputs to risk management are based on historical and current information, as well as on future expectations. Risk management explicitly takes into account any limitations and uncertainties associated with such information and expectations. Information should be timely, clear and available to relevant stakeholders.
Human and cultural factors	Human behaviour and culture significantly influence all aspects of risk management.
Continual improvement	Risk management is continually improved through learning and experience.

1.5. This policy demonstrates the CCG's commitment to its total risk management function. It sets out the CCG's risk architecture (roles, responsibilities, communication and reporting arrangements) and describes how risk management is integrated into governance arrangements, key business activities and culture.

2. Purpose

This policy describes the CCG's approach to the management of risk at all levels across the organisation. The purpose of this guidance is to encourage a culture where risk management is viewed as an essential process of the CCG's activities. It provides assurance to the public, patients and partner organisations that the CCG is committed to managing risk appropriately.

3. Scope

This policy applies to all employees and appointees of the CCG and any individuals working within the CCG in a temporary capacity (hereafter referred to as 'individuals').

4. Definition of Risk Management Terms

The following terms are used throughout this document:

Term	Definition
Assurance	Evidence that controls are working effectively. Assurance can be internal (e.g. committee oversight) or external (e.g. Internal Audit reports).

Term	Definition
Assurance Framework	A (Governing Body) Assurance Framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect. The Assurance Framework document is the key source of evidence that links the organisation's strategic objectives to risk, controls and assurances and the main tool a Governing Body uses in discharging its responsibility for internal control.[2]
Controls	The measures in place to control risks and reduce the impact or likelihood of them occurring.
Corporate Risk Register	A tool for recording identified operational risks and monitoring actions against them.
Current (or Residual) risk score	The numerical assessment of the risk (impact vs. likelihood) after taking into consideration any mitigating controls and/or actions.
Initial risk score	The numerical assessment of the risk (impact vs. likelihood) prior to considering any additional mitigating controls and/or actions.
Operational risk management	Risk management processes which focus on 'live' operational risks which the organisation is potentially facing. It relies upon the identification of risks, which are 'dynamic' in nature and are managed via additional mitigations. Operational risk management processes are centred around the Corporate Risk Register.
Operational risks	These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.
Risk	There are many definitions of what a risk is but this policy has adopted the definition set out in ISO 31000 in that a risk is the *'effect of uncertainty on objectives'.* The effects can be negative, positive or both. It is measured in terms of impact and likelihood.
Risk assessment	An examination of the possible risks that could occur during an activity.

[2] NHS Governance, Fourth Edition 2017 (HfMA)

Term	Definition
Risk culture	The values, beliefs, knowledge and understanding of risk, shared by a group of people with a common intended purpose.
Risk logs	Risk logs are a tool for capturing low level risks which may impact the achievement of team and/or project-level objectives.
Risk management	The arrangements and activities in place that direct and control the organisation with regard to risk.
Risk mitigation	How risks are going to be controlled in order to reduce the impact on the organisation and/or likelihood of their occurrence.
Risk profile	The nature and level of the threats faced by an organisation.
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Strategic objectives	Strategic objectives describe a set of clear organisational goals that help establish priority areas of focus. Whilst broad and directional in nature, they need to be specific enough that their achievement can be assured and progress measured. They should have direct alignment with the Governing Body Assurance Framework and the CCG's performance management processes.
Strategic risk management	Risk management processes which support the achievement of the organisation's strategic objectives. It focuses on the proactive identification of 'high level' risks which are managed by an established control framework and planned assurances. Strategic risk management processes are centred around the Governing Body Assurance Framework.
Strategic risks	Potential, significant risks that are pro-actively identified and threaten the achievement of strategic objectives.

The diagram provided at **Appendix A** summarises the differences between strategic and operational risks.

5. Roles and Responsibilities

Roles	Responsibilities
Governing Body	The Governing Body has overall accountability for risk management and, as such, needs to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Governing Body determines the CCG's risk appetite and risk tolerance levels and is also responsible for establishing the risk culture.
Audit and Governance Committee	The Audit and Governance Committee provides the Governing Body with assurance on the effectiveness of the Governing Body Assurance Framework and the robustness of the CCG's operational risk management processes. The Committee's role is not to 'manage risks' but to ensure that the approach to risks is effective and meaningful. In particular, the Committee supports the Governing Body by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging relevant managers when controls are not working or data is unreliable.
All Committees	All committees are responsible for monitoring operational risks related to their delegated duties*. This will include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Corporate Risk Register.
Accountable Officer (AO)	The AO has responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding public funds and assets.
Chief Nurse	The Chief Nurse is the executive lead for corporate governance and risk and assurance systems across the CCG. This includes promoting the CCG's risk culture within the Executive Team and wider directorates.

Roles	Responsibilities
Independent / Non-Executive Directors	As members of the Governing Body and committees, Independent / Non-Executive Members will ensure an impartial approach to the CCG's risk management activities and should satisfy themselves that systems of risk management are robust and defensible.
Associate Director of Governance (supported by the Corporate Assurance Team)	The Associate Director of Governance leads on the implementation of corporate governance and risk and assurance systems across the CCG. This includes the development, implementation and co-ordination of the CCG's risk management activities and provision of training and advice in relation to all aspects of this policy.
Nominated Executive / Strategic Leads on Partnership Boards	Executive / Strategic Leads are responsible for highlighting risks identified at meetings with strategic partners and ensuring they are captured within the CCG's own arrangements. This includes, but is not limited to, meetings in the Integrated Care System (ICS) and Integrated Care Partnership (ICP) governance structures.
Senior Information Risk Owner (SIRO)	The SIRO takes ownership of the CCG's information risks and acts as advocate for information risk on the Governing Body.
Risk Owners	Risk owners are responsible for ensuring robust mitigating actions are identified and implemented for their assigned risks.
Individuals	All individuals are responsible for complying with the arrangements set out within this policy and are expected to: • Routinely consider risks when developing business cases, commencing procurements or any other activity which could be impacted by unexpected events (undertaking specific risk assessments as necessary). • Ensure that any operational risks they are aware of are captured on the Corporate Risk Register or Directorate/Team Risk Logs as appropriate.

***** *Risks cannot always be addressed in isolation from each other. Risks may have different facets (e.g. finance and quality) and management actions may impact on different areas of the CCG. Where this is the case, a pragmatic approach will be taken and risks may be scrutinised by more than one committee.*

6. Risk Appetite

6.1. Good risk management is not about being risk averse, it is also about recognising the potential for events and outcomes that may result in opportunities for improvement, as well as threats to success.

6.2. A 'risk aware' organisation encourages innovation in order to achieve its objectives and exploit opportunities and can do so in confidence that risks are being identified and controlled by senior managers.

6.3. With this in mind, the Governing Body has agreed to the following risk appetite statement:

Nottingham and Nottinghamshire CCG's Risk Appetite Statement
The Governing Body of NHS Nottingham and Nottinghamshire CCG recognises that our long-term sustainability, and ability to improve quality and health outcomes for our population, depends on the achievement of our strategic objectives and that this will involve a willingness to take and accept risks. It may also involve taking risks with our strategic partners in order to ensure successful integration and better health services for the people of Nottingham and Nottinghamshire. The CCG will endeavour to adopt a ***mature*** approach to risk-taking where the long-term benefits could outweigh any short-term losses, in particular when working with strategic partners across the Nottingham and Nottinghamshire system. However, such risks will be considered in the context of the current environment in line with the CCG's risk tolerance and where assurance is provided that appropriate controls are in place and these are robust and defensible. The CCG will seek to ***minimise*** risks that could impact negatively on the health outcomes and safety of patients or in meeting the legal requirements and statutory obligations of the CCG. We will also seek to ***minimise*** any undue risk of adverse publicity, risk of damage to the CCG's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability. In view of the changing landscape, the CCG's risk appetite will not necessarily remain static. The CCG's Governing Body will have the freedom to vary the amount of risk we are prepared to take depending on the circumstances at the time. It is expected that the levels of risk the CCG is willing to accept are subject to regular review. *1 Good Governance Institute Risk Appetite for NHS Organisations – definition of '**mature**' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.* *2 Good Governance Institute Risk Appetite for NHS Organisations – definition of '**minimal'** is preference for ultra-safe delivery options that have a low degree of inherent risk.*

7. Risk Tolerance

7.1. Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted (e.g. it is the minimum and maximum level of risk the CCG is willing to accept reflective of the risk appetite statement above).

7.2. For operational risks rated lower than 12, the responsible committee may agree that they can be tolerated. However, this is subject to the committee being satisfied that no other actions can be undertaken and that robust management and monitoring controls are in place.

7.3. Some risks are unavoidable and will be out of the CCG's ability to mitigate to a tolerable level. Where this is the case, the focus will move to the controls in place to manage the risks and the contingencies planned should the risks materialise.

8. Strategic Risk Management

8.1. Strategic risks are high-level risks that are pro-actively identified and threaten the achievement of the CCG's strategic objectives and key statutory duties. Strategic risks are owned by members of the Executive Management Team and are outlined within the CCG's **Governing Body Assurance Framework (GBAF).**

8.2. The Assurance Framework provides the Governing Body with confidence that the CCG has identified its strategic risks and has robust systems, policies and processes in place (*controls*) that are effective and driving the delivery of their objectives (*assurances*). It provides confidence and evidence to management that '*what needs to be happening is actually happening in practice'*.

8.3. The Assurance Framework plays an important role in informing the production of the CCG's Annual Governance Statement and is the main tool that the Governing Body should use in discharging overall responsibility for ensuring that an effective system of internal control is in place.

8.4. The Governing Body approves the strategic risks (opening position) during the first quarter of the financial year, following agreement of the strategic objectives. The Governing Body reviews the fully populated Assurance Framework bi-annually (mid-year and year-end) to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risks.

8.5. The Assurance Framework is reviewed and updated by Executive Leads and the Head of Corporate Assurance Team throughout the year. This involves a review of the effectiveness of controls and what evidence (internal or external) is available to demonstrate that they are working as they should (assurances). Any gaps in controls or assurances will be highlighted at this point and actions identified.

8.6. The Audit and Governance Committee receive a rolling programme of targeted assurance reports which, over a 12 month period, covers all of the CCG's strategic objectives (the full Assurance Framework). This enables a focussed review on specific sections of the Assurance Framework and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances.

9. Operational Risk Management

9.1. Operational risks are 'live' risks the organisation is currently facing which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.

9.2. Operational risk management relies upon reactive identification of risks, which are 'dynamic' in nature. Operational risks are managed via additional mitigations and are captured on the CCG's **Corporate Risk Register**.

9.3. The Corporate Risk Register is the central repository for all of the CCG's operational risks. Whilst risks will feature across a number of the CCG's processes, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflects the CCG's risk profile.

9.4. The Corporate Risk Register contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risk to the desired level. A named individual (risk owner) is given responsibility for ensuring the action is carried out by the chosen due date. Members of the Senior Leadership Team are assigned 'risk owners' for operational risks within the Corporate Risk Register.

9.5. The majority of operational risks should have the ability to reduce in impact and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level. Major (red) operational risks (those scoring 15 or above) which are not deemed to be treatable will be highlighted to the Governing Body as part of routine risk reporting.

9.6. For operational risks rated lower than 12, the responsible committee may agree that they can be tolerated. However, this is subject to the committee being satisfied that no other actions can be undertaken and that robust management and monitoring controls are in place.

9.7. Such risks will show as 'inactive' on the Corporate Risk Register (therefore remaining within the risk profile) but will not be subject to ongoing committee scrutiny. The relevant risk lead will be responsible for highlighting any relevant changes to 'tolerated' risks (e.g. whether they can be archived or need to be reactivated). Any 'inactive' risks will be reviewed on an annual basis.

9.8. The Audit and Governance Committee receive the full Corporate Risk Register bi-annually to support their duty to provide the Governing Body with assurance on the robustness and effectiveness of the CCG's risk management processes.

9.9. Relevant extracts of the Corporate Risk Register are presented to the Governing Body's committees in line with their delegated duties. Reports will be presented monthly to those sub-committees where risks exist within their remit.

10. Risk Logs

10.1. Risk logs are used to record **project-level risks** and are held by teams across the CCG.

10.2. Risk logs can also be used to record operational risks at **Directorate and/or team-level** which are not considered significant enough to be captured on the CCG's Corporate Risk Register. Such risks are identified in line with the team/Directorate-level objectives which have been set.

10.3. Whilst a fundamental part of the CCG's risk management arrangements (ensuring and demonstrating that project-level and/or team-level risks are being actively identified and managed), risk logs do not require the same level of management as the Corporate Risk Register or Assurance Framework and, therefore, the oversight and scrutiny for team level risk logs is established at the discretion of the relevant senior manager(s).

10.4. When identified risks are considered as needing to be escalated (e.g. may directly impact the achievement of CCG objectives), these must be transferred to the Corporate Risk Register. The Head of Corporate Assurance can provide further advice on this.

11. Fraud Risk Assessment

11.1. Standard 1.4 from the *Standards for NHS Commissioners 2020/21 Fraud, bribery and corruption (version 1.2)* requires the CCG to undertake a local risk assessment to identify fraud, bribery and corruption risks and to ensure these are recorded and managed in line with the organisation's risk management policy.

11.2. A separate fraud risk register will be maintained by the CCG and reported to the Audit and Governance Committee once a year (as a minimum), to coincide with the Counter Fraud annual planning process.

12. Confidentiality

12.1. Where risks are not deemed to be in the public interest, they will be clearly marked as confidential on the Corporate Risk Register and reported to the Governing Body (or Primary Care Commissioning Committee) during their closed sessions. This should be for a time-limited period only and risk owners and committees are responsible for agreeing when confidentiality no longer applies.

13. Risk Management Processes

13.1. **Risk Assessments and Risk Identification**
Risk assessments can be undertaken at the start of any activity and provide a helpful means of anticipating 'what could go wrong' and deciding on preventative actions. For specific risk assessments relating to workplace safety (e.g. use of display screen equipment), please refer to the CCG's health and safety policies.

13.2. Operational risks (those which require adding to the Corporate Risk Register) may be identified through an assortment of means, for example by risk assessments, external assessments, audits, complaints, during meetings and through horizon-scanning. For example, any medium (or higher) risks identified within Internal Audit reports are captured within the Corporate Risk Register.

13.3. Regular meetings are held with Executive Directors and senior managers to discuss new or evolving risks within their respective portfolios/teams.

13.4. **Risk Evaluation**
Risks are evaluated by defining qualitative measures of impact and likelihood, as shown in the risk scoring matrix, shown in **Appendix D**, to determine the risk's RAG rating. Risk scores can be subjective, therefore, the scores will be subject to review and agreement by senior managers and/or the responsible committee. The Head of Corporate Assurance can also offer support and guidance regarding risk evaluation.

13.5. **Risk Treatment**
Risk treatment (also known as risk control) is the process of selecting and implementing measures to mitigate the risk to an acceptable level. Once risks have been evaluated, a decision should be made as to whether they need to be mitigated or managed through the application of controls (as described using the 'four T' risk treatment model below).

Treatment	Description
Terminate	Opt not to take the risk by terminating the activities that will cause it (more applicable to project risks).
Treating	Take mitigating actions that will minimise the impact of the risk

Treatment	Description
	prior to its occurrence and/or reduce the likelihood of the risk occurring.
Transfer	Transfer the risk, or part of the risk, to a third party.
Tolerate	Accept the risk and take no further actions. This may be due to the cost of risk mitigation activity not being cost effective or the impact is so low it is deemed acceptable to the organisation. *Risks which are tolerated should continue to be monitored as future changes may make the risk no longer tolerable.*

13.6. Management and Reporting of Risks

The following categories of risk grading provide a high-level view of management and reporting requirements. Expected management of risks at each grading has been designed in consideration of the CCG's risk appetite.

- The **Governing Body** will oversee all risks with an overall score of 15+ (e.g. any major/red operational risks from the Corporate Risk Register) at each of its meetings.
- **Committees** will oversee all risks with an overall score of 6+ (e.g. amber rating and upwards) at each of their meetings.
- The **Audit and Governance Committee** will receive bi-annual risk management updates, including the full Corporate Risk Register, which will enable any risk themes and trends to be reviewed; ensuring any multiple, similar risks of a low impact and likelihood are not ignored.

	Green	Green/Amber	Amber	Amber/Red	Red
Level of risk	An acceptable level of risk that can be managed at directorate / team level (e.g. Risk Logs, if in place).	An acceptable level of risk that can be managed at directorate / team level (e.g. Risk Logs, if in place).	A generally acceptable level of risk but corrective action needs to be taken (e.g. new risk at score 6+ or escalated from Risk Log(s))	An unacceptable level of risk which requires urgent senior management attention and immediate corrective action	An unacceptable level of risk which requires urgent senior management attention and immediate corrective action (e.g. risk score 15+)

	Green	Green/Amber	Amber	Amber/Red	Red
Add to Corporate Risk Register?	No	No	Yes, with quarterly progress updates (as a minimum)	Yes, with bi-monthly progress updates (as a minimum)	Yes, with monthly progress updates (as a minimum)
Oversight and scrutiny	N/A	N/A	Reviewed by the relevant committee(s) at each meeting	Reviewed by the relevant committee(s) at each meeting	- Reviewed by the relevant committee(s) at each meeting - Highlighted to the Governing Body

14. Performance Risks

14.1. The CCG monitors the performance of its providers against key delivery priorities via a separate, but parallel, process to the CCG's risk management arrangements.

14.2. In order to minimise duplication, failures to achieve performance standards are not routinely identified as specific risks on the Corporate Risk Register. This should not indicate its absence from the organisation's overall risk profile and poor performance from a risk perspective will be referenced as necessary when reporting externally on risks (e.g. in the Annual Governance Statement).

14.3. The consistent non-delivery of performance standards will be assessed by the Quality and Performance Committee to ensure that any specific risks this poses to the CCG's functions (e.g. a detrimental impact on health outcomes, patient safety or patient experience) are identified and captured on the Corporate Risk Register.

15. Management of Risk across Organisational Boundaries

15.1. The NHS Long Term Plan provides national direction for the delivery of the health service for the 21st century and beyond. It outlines changes which are required to the NHS service model and the infrastructure to support this.

15.2. The management of risk across organisational boundaries is complex. The system's governance model should allow each sovereign organisation to manage their own risks independently, whilst enabling a strong and holistic partnership approach to risk management to support delivery of system objectives.

15.3. Risk is an important feature within the different parts of the system architecture e.g. Integrated Care System (ICS), Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs). Partnership working can often lead to risks regarding risk ownership and accountability. As such, it is important that there are clear inter-relationships regarding the management and ownership of risks between these different elements.

15.4. Risks identified in meetings with system partners will be fed back to the CCG's Corporate Assurance Team via relevant leads. Any such risks will be considered through the lens of a strategic commissioner and included, if appropriate, within the CCG's Corporate Risk Register.

16. Communication, Monitoring and Review

16.1. The policy will be published and maintained in line with the CCG's Policy Management Framework.

16.2. The policy will be highlighted to new staff as part of the local induction process and made available to all staff through the CCG's internal communication procedures (and Internet/Intranet sites).

16.3. The CCG's Audit and Governance Committee will review the effectiveness of this policy, and its implementation, via bi-annual risk management update reports and monthly targeted assurance reports.

16.4. The CCG's Governing Body will review the risk appetite on an annual basis.

16.5. Internal Audit will report on the implementation of this policy as part of the annual Head of Internal Audit Opinion work programme.

17. Staff Training

17.1. The Corporate Assurance Team will proactively raise awareness of the policy across the CCG and provide ongoing support to committees and individuals to enable them to discharge their responsibilities. Members of the Corporate Assurance Team can be contacted for formal training at team meetings (or other forums) by email: Notts.corporateassurance@nhs.net.

17.2. Any individual who has queries regarding the content of the policy, or has difficulty understanding how this relates to their role, should contact the CCG's Corporate Assurance Team (email: Notts.corporateassurance@nhs.net).

18. Equality and Diversity Statement

17.1 NHS Nottingham and Nottinghamshire CCG pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, both as a commissioner and as an employer.

17.2 As a commissioning organisation, we are committed to ensuring our activities do not unlawfully discriminate on the grounds of any of the protected characteristics defined by the Equality Act, which are age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

17.3 We are committed to ensuring that our commissioning activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, roma and travellers.

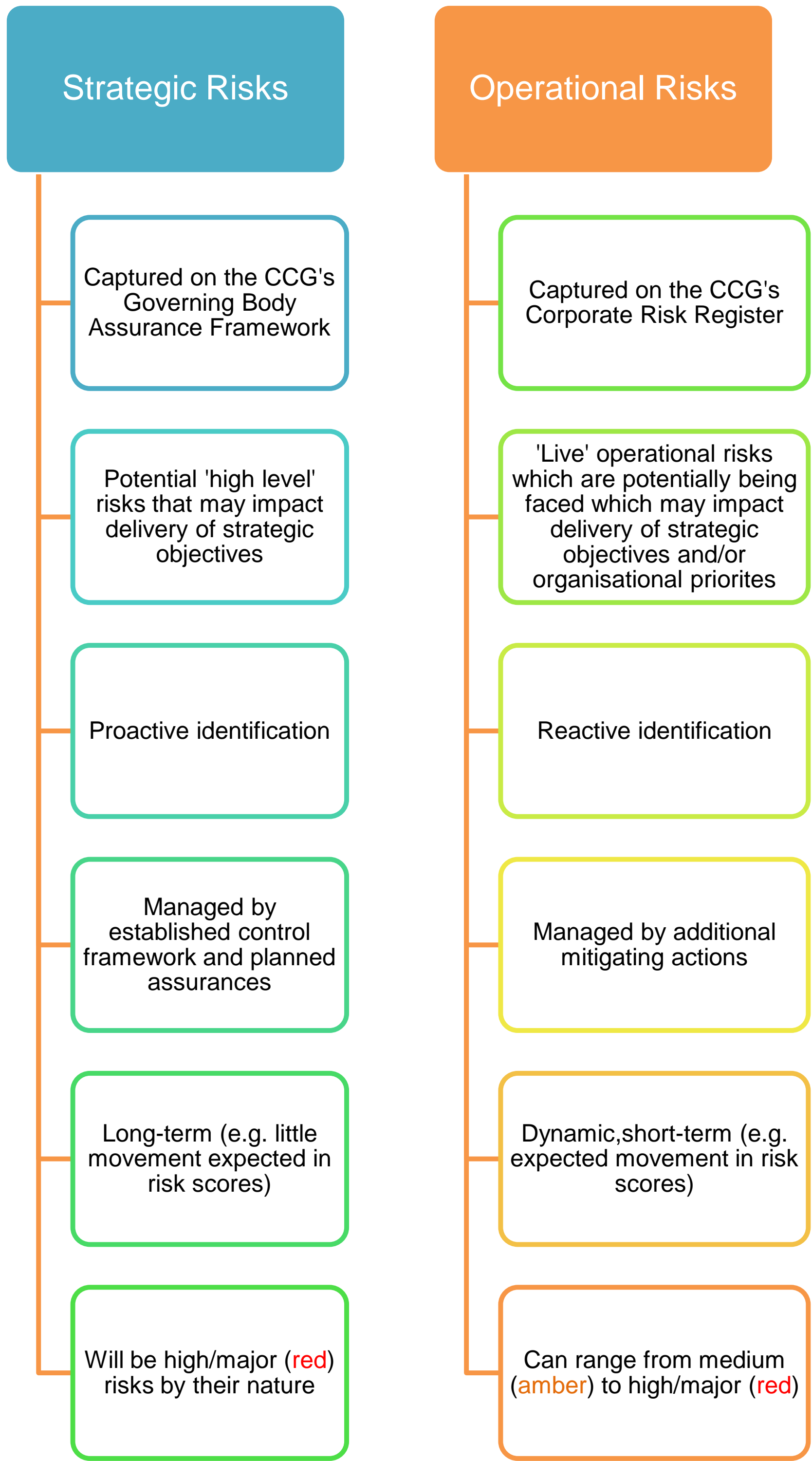
17.4 As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

17.5 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy.

19. References

- Assurance Frameworks, (2012). HM Treasury.
- A Risk Practitioners Guide to ISO 31000:2018, (2018). The Institute of Risk Management.
- Board Assurance: A toolkit for health sector organisations, (2015). NHS Providers.
- The Orange Book: Management of Risk – Principles and Concepts, (2020).
- Risk Appetite & Tolerance, (2011). The Institute of Risk Management.
- NHS Audit Committee Handbook, (2018). Healthcare Financial Management Association
- NHS Governance Handbook, (2017). Healthcare Financial Management Association
- Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking. (2012). The Good Governance Institute.

Appendix A: Characteristics of Strategic and Operational Risks



Appendix B

Risk Identification Guidance

The purpose of this form is to enable staff to report operational risks that may require entry on to the Corporate Risk Register. Further guidance on reporting risks can be provided by contacting the Corporate Assurance Team.

> The general definition of a risk is "*the effect of uncertainty on objectives"* and it is the responsibility of all staff to:
>
> - Identify risks at the conceptual stage of projects, as well as throughout the life of the project.
> - Routinely consider risk within any planning, procurement or other CCG business activities.
> - Ensure that any **operational** risks they become aware of are captured on the CCG's Corporate Risk Register.

Operational risks are defined as by-products of the day-to-day running of an organisation. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives. The objective which may not be achieved needs to be considered in the risk wording.

Good practice for articulating risks is as follows:

a) [Event that has an effect on objectives][**due to**] caused by [**cause/s]** resulting in [**consequence/s**]; or

b) [Event that has an effect on objectives][**due to**] caused by [**cause/s**]. This may result in [**consequence/s**].

Training on writing risk statements can be requested from the Head of Corporate Assurance.

Categorise the risk using the categories in **Appendix C** and use the risk scoring matrix in **Appendix D** to calculate what the risk is at the moment (before any actions have been implemented). You then need to consider the controls you have in place to manage this (e.g. contract monitoring arrangements) and any additional actions that may be needed to mitigate the risk to an acceptable level.

Depending on the risk score, you will be contacted to provide status updates on the risk as follows:

- **Red** risks – monthly
- **Amber/red** risks – bi-monthly (as a minimum)

Appendix B

- **Amber** risks – quarterly (as a minimum)

Green and **amber/green** risks do not need adding to the risk register, as these can be managed at individual/team level via a **Risk Log**.

Oversight and scrutiny processes for green and green/amber risks are at the discretion of local directorates / teams. Template **Risk Logs** are available from the Corporate Assurance team. Guidance, support and training can be provided upon request via notts.corporateassurance@nhs.net.

Appendix C

Categories of Risk

CCG Function	Description	Responsible Committee
Finance	Risks to all areas pertaining to finance and financial control. This also includes risks related to contractual enforcement issues.	Finance and Resources Committee
Quality of services	Risks in maintaining and improving quality; including the safety and effectiveness of treatment and care and patient experience (not including safeguarding or primary care services).	Quality and Performance Committee
Improved outcomes / Health inequalities	Risk of failure to ensure better outcomes for patients as a result of CCG commissioned services.	Prioritisation and Investment Committee
Safeguarding	Risks relating the CCG's statutory duties for safeguarding children and vulnerable adults.	Quality and Performance Committee
Primary Care	Risks relating to delegated commissioning responsibilities for primary care services, including quality of primary care services.	Primary Care Commissioning Committee
Compliance	Risk of failure to comply with statutory duties and other regulatory and legal requirements; for example the Public Sector Equality Duty, information governance requirements, procurement regulations and employment law.	Appropriate Committee depending on area of non-compliance
Information Governance	Risk of failure to comply with information governance regulatory and legal requirements.	Audit and Governance Committee

Appendix C

CCG Function	Description	Responsible Committee
Governance / Probity	Risk of failure to comply or to demonstrate compliance with standards of business conduct. This includes transparency in decision-making, the robust management of conflicts of interest and adherence with the CCG's policy on gifts, hospitality and sponsorship.	Audit and Governance Committee
Workforce	Risk of failure to ensure a skilled and effective workforce, incorporating issues related to staff recruitment and retention, training and development (including succession planning) and organisational morale and culture.	Finance and Resources Committee
Engagement and Partnership working	Risk of failure to engage effectively with patients, carers, the public, clinicians and all other stakeholders. Risk of working with health and social care partners. Risk of reputational damage.	Appropriate Committee depending on nature of risk.

Appendix D

Risk Scoring Matrix

Table 1 - Impact scores (I)

What is the severity of the impact?					
Impact Score	1	2	3	4	5
Descriptor	Insignificant or minor	Moderate	Significant	Very Significant	Major
Impact should it happen	No or slight impact on the CCG's objectives	Moderate Impact on the the CCG's objectives	Significant impact on the CCG's objectives	Impact on the CCG's objectives affecting delivery over several areas	Impact on the CCG's objectives requiring radical review

Table 2 Likelihood score (L)

What is the liklihood that harm, loss or damage from the identified hazard will occur?					
Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it happen?	This will probably never happen/occur	Do not expect it happen/ recur but it is possible it may do so	Possibly may happen	Highly probable that it will happen	Likely to occur

Table 3 Risk scoring = Impact x likelihood (I x L)

Very High - 5	A	A/R	R	R	R
High - 4	A	A	A/R	R	R
Medium - 3	A/G	A	A	A/R	A/R
Low - 2	G	A/G	A/G	A	A
Very Low - 1	G	G	G	G	G
	Rare - 1	Unlikely - 2	Possible - 3	Likely - 4	Almost certain - 5
			Likelihood		

G	Acceptable level of risk that can be managed at team/directorate level - does not require entry on to the organisational risk register
A/G	Acceptable level of risk that can be managed at team/directorate level - does not require entry on to the organisational risk register
A	To be entered on the organisational risk register and progress reports to be given quarterly
A/R	To be entered on the organisational risk register and progress reports to be given bi- monthly
R	To be entered on the organisational risk register and progress reports to be given monthly

Appendix E

Equality Impact Assessment

Date of assessment:	July 2020			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age[3]	No	N/A	N/A	N/A
Disability[4]	Yes	Mechanisms are in place via the Communications and Engagement Team to provide this policy in a range of languages, large print, Braille, audio, electronic and other accessible formats.	N/A	N/A
Gender reassignment[5]	No	N/A	N/A	N/A
Marriage and civil partnership[6]	No	N/A	N/A	N/A

[3] A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

[4] A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

[5] The process of transitioning from one gender to another.

[6] Marriage is a union between a man and a woman or between a same-sex couple.
Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.

Appendix E

Date of assessment:	July 2020			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Pregnancy and maternity[7]	No	N/A	N/A	N/A
Race[8]	No	N/A	N/A	N/A
Religion or belief[9]	No	N/A	N/A	N/A
Sex[10]	No	N/A	N/A	N/A
Sexual orientation[11]	No	N/A	N/A	N/A
Carers[12]	No	N/A	N/A	N/A

[7] Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

[8] Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

[9] Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

[10] A man or a woman.

[11] Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

[12] Individuals within the CCG which may have carer responsibilities.

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020

Paper Title:	2020/21 Governing Body Assurance Framework	**Paper Reference:**	**GB 20 071**

Sponsor:	Rosa Waddingham, Chief Nurse	**Attachments/ Appendices:**	**Appendix A:** Mapping of strategic and operational risks **Appendix B:** Key components of the GBAF **Appendix C**: GBAF template (including strategic risks)
Presenter:	Lucy Branson, Associate Director of Governance		

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary
At the 8 April 2020 Governing Body meeting, members approved the closing position of the Governing Body Assurance Framework (presented to the March 2020 meetings in common of the predecessor CCGs' Governing Bodies) as the opening position for 2020/21. This approach was taken in response to the impact of Covid-19 on the CCG's business as usual processes. A comprehensive review of the CCG's strategic risks has now been undertaken to ensure they align with the CCG's strategic objectives and key statutory duties. The purpose of the paper is to present the CCG's strategic risks for review and approval. The fully populated Governing Body Assurance Framework (GBAF) will be presented at the October 2020 meeting of the Governing Body in the form of a mid-year position statement.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☒
Financial Management	☒	Cultural and/or Organisational Development	☒
Performance Management	☒	Procurement and/or Contract Management	☒
Strategic Planning	☒		

Conflicts of Interest:
☒ No conflict identified

☐	Conflict noted, conflicted party can participate in discussion and decision
☐	Conflict noted, conflicted party can participate in discussion, but not decision
☐	Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report

Risk(s):
Appendix C outlines the CCG's 18 strategic risks, which may impact achievement of the strategic objectives.

Confidentiality:
☒No

Recommendation(s):
1. **APPROVE** the CCG's revised strategic risks to enable the full development of the 2020/21 Governing Body Assurance Framework; and
2. **NOTE** the next steps being taken to develop and embed Governing Body Assurance Framework reporting arrangements.

2020/21 Governing Body Assurance Framework

1. Introduction

At the 8 April 2020 Governing Body meeting, members approved the closing position of the Governing Body Assurance Framework (presented to the March 2020 meetings in common of the predecessor CCGs' Governing Bodies) as the opening position for 2020/21. This approach was taken in response to the impact of Covid-19 on the CCG's business as usual processes.

A comprehensive review of the CCG's strategic risks has now been undertaken to ensure they align with the CCG's strategic objectives, key statutory duties and core values, as well as being reflective of the CCG's transition to a single strategic commissioner. These risks will form the basis of the CCG's 2020/21 Governing Body Assurance Framework (GBAF).

The purpose of the paper is to present the CCG's strategic risks for review and approval. It is intended that the fully populated GBAF will be presented at the October 2020 meeting of the Governing Body, which will provide a mid-year position statement.

2. The role of the Governing Body Assurance Framework (GBAF)

The purpose of the GBAF is to provide the Governing Body with confidence that the CCG has identified its strategic risks and has robust systems, policies and processes in place (controls) that are effective and driving the delivery of its objectives (assurances). It should provide confidence and evidence to management that '*what needs to be happening is actually happening in practice'* and enable the Governing Body to decide what they want assurance on and how much assurance is needed.

The Governing Body Assurance Framework plays an important role in informing the production of the CCG's Annual Governance Statement and is the main tool that the Governing Body should use in discharging its overall responsibility for ensuring that an effective system of internal control is in place.

3. 2020/21 Strategic Objectives and Strategic Risks

<u>Strategic Objectives</u>

The CCG's strategic objectives are outlined below. These directly align with the ICS' triple aims which the CCG, as a system partner, has signed up to.

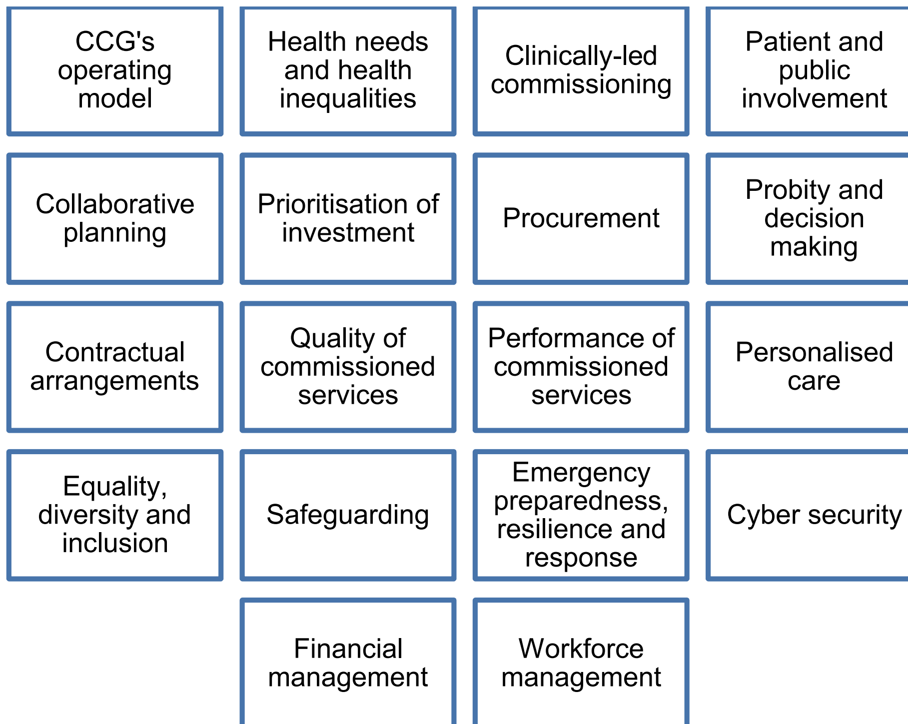
- **Improving the health and well-being of our population;**
- **Improving the overall quality of care and life our service users, and carers, are able to have and receive; and**
- **Improving the effective utilisation of our resources.**

They should have direct alignment with the Governing Body Assurance Framework and the CCG's performance management processes.

Strategic Risks

Strategic risks describe the potential risks that may prevent achievement of the CCG's strategic objectives. These have been proactively identified by taking into consideration the CCG's statutory duties and objectives, the functions of a strategic commissioner and the CCG's core values. This approach has been shared, and discussed with, Executive and Non-Executive Director colleagues.

A total of 18 strategic risks have been identified in relation to the following areas; each of which has been assigned a lead executive risk owner.



It is important to remember that the CCG's strategic risk profile is expected to be high due to the nature of the risks contained within the Governing Body Assurance Framework (i.e. if their impact rating isn't high or very high, then it is questionable whether they should be classified as strategic risks to the organisation).

Strategic vs. Operational Risks

As highlighted above, strategic risks identified for the purposes of the GBAF are potential, 'high level' risks that are managed by an established control framework and planned assurances. These differ to operational risks which are 'live' risks which the CCG is currently facing.

Operational risks may impact the delivery of strategic objectives but are required to be managed by additional mitigating actions and are captured on the CCG's Corporate Risk Register. There is an interrelationship between the two types of risks, as operational risks may indicate a 'gap' in the control framework within the GBAF.

Appendix A maps the current major (red) operational risks within the Corporate Risk Register to the relevant strategic risks in the GBAF.

4. Development of the CCG's Governing Body Assurance Framework

Subject to Governing Body agreement of the strategic risks, work will now be completed with members of the Executive Management Team to develop the Governing Body Assurance Framework to its full potential.

For 2020/21, we will ensure that the work being undertaken in relation to the CCG's organisational priorities (presented to the June 2020 meeting of the Governing Body) dovetails with the development of the GBAF. **Appendix B** illustrates the key components of the Governing Body Assurance Framework and the interrelationship with the organisational priorities.

More detailed descriptions of the strategic risks and how these map to the CCG's strategic objectives are provided at **Appendix C**.

Appendix C also outlines the Governing Body Assurance Framework template and a diagram of how to read its component parts. The template has been populated for strategic risk 1 to demonstrate how controls, assurances, 'gaps' and actions will be described.

5. Next Steps

The fully developed Governing Body Assurance Framework will be presented to the Governing Body in October 2020 (next scheduled public meeting), which will provide a mid-year position statement. The Governing Body Assurance Framework year-end position will be presented to the Governing Body in April 2020.

A rolling programme of executive-led targeted assurance reports to the Audit and Governance Committee will commence from November 2020 onwards. These reports enable a focussed review on specific sections of the Assurance Framework and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances.

6. Recommendations

The Governing Body is requested to:

- **APPROVE** the strategic risks to enable the full development of the CCG's Governing Body Assurance Framework; and
- **NOTE** the next steps being taken to develop and embed Governing Body Assurance Framework reporting arrangements.

Siân Gascoigne

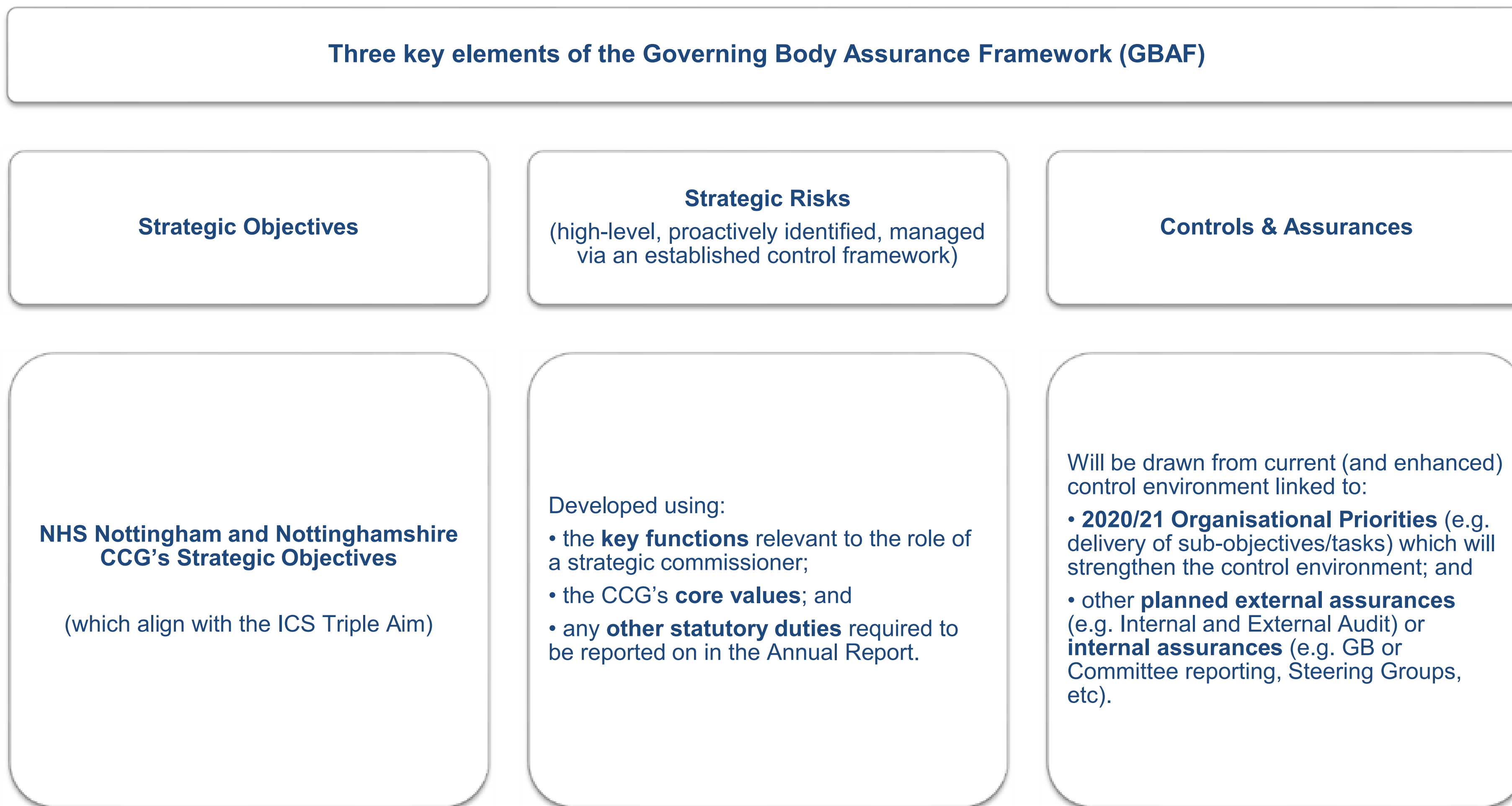
Head of Corporate Assurance

August 2020

Appendix A: Mapping of strategic and operational risks

CCG's Strategic Risks (from GBAF)	CCG's Major/Red Operational Risks (from Corporate Risk Register) *These risks demonstrate where there are already identified 'gaps' in the CCG's control environment.*
Risk 2: Assessing Health Needs and Addressing Health Inequalities The CCG may not adequately understand the current and future health needs of its population and services may not be commissioned to address identified health inequalities.	Due to COVID-19, there is a risk that the CCG may not be spending its allocation in line with commissioning intentions/priorities. This may, in turn, result in the health needs of the CCG's population not being met. *(I4 x L5) 20 Red*
	Covid-19 may exacerbate health inequalities across the CCG's population. *(I4 x L5) 20 Red*
Risk 10: Quality of Commissioned Services The CCG's arrangements for maintaining and improving the quality of commissioned services may not be effective.	Lack of assurance regarding the culture and leadership at Nottinghamshire Healthcare NHS Trust, as identified by recent Care Quality Commission (CQC) reports, alongside non-achievement of required performance targets, raises concerns regarding the quality of services provided by the Trust. This, in turn, may present a risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for members of the CCG's population. *(I4 x L5) 20 Red*
Risk 17: Financial Management The CCG's financial management arrangements may not be sufficiently robust to ensure its statutory financial duties are met.	Non-delivery of the CCG's financial duties for 2020/21 due to: • Brought forward deficit underlying positions of the six predecessor CCGs; • QIPP plans being insufficient to meet the CCG's financial plan (e.g. unidentified or undeliverable 2020/21 'cash releasing' QIPP schemes); • Potential delivery of recurrent savings schemes using non-recurrent monies; • Delays in system-wide transformation / materialisation of efficiencies; • Financial implications of COVID-19. This risk may be exacerbated given the lack of financial contingency planned. *(I4 x L5) 20 Red*
	Block payments are currently being made to NHS providers in line with a nationally calculated methodology, based on providers' M9 financial reporting. Payments are overstated when compared with what they would have been if based on the CCG's forecast spend. The above presents a risk that current rate of spend may have a detrimental impact on the CCG's overall rate of expenditure, compared to revenue resources available. This may lead to a worsening exit position for 2020/21 compared to 2019/20. *(I4 x L4) 16 Red*

Appendix B: Key components of the Governing Body Assurance Framework



Nottingham and Nottinghamshire
Clinical Commissioning Group

Governing Body Assurance Framework

August 2020

Definitions

A Board/Governing Body Assurance Framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect[1]. The document is the key source of evidence that links the organisation's strategic objectives to risk, controls and assurances and the main tool a governing body uses in discharging its responsibility for internal control[2].

Strategic risks are defined as those high-level risks that threaten the achievement of strategic objectives.

Controls are the processes/mechanisms put in place by management to help accomplish specific goals or objectives. These could include strategic CCG roles and responsibilities, governance arrangements, work streams, policies, training, etc. For the purposes of the Governing Body Assurance Framework, key controls are those on which the organisation places reliance upon.

Assurances provide the evidence or the 'avoidance of doubt' that appropriate controls are in place and operating effectively. These assurances can be internal, e.g. regular and ad-hoc management reports to the Governing Body and evidence through Committee minutes that duties are being effectively discharged; or external, e.g. independent reports/opinions from auditors, inspectors, regulatory bodies, etc.

Gaps in controls or assurance are identified where an additional system or process is needed, or where there is a lack of evidence that controls are effective.

[1] HM Treasury Guidance on Assurance Frameworks, 2012).
[2] NHS Governance, Fourth Edition 2017 (HfMA)

How to read a Governing Body Assurance Framework

Controls: What is being done to reduce the impact and likelihood of the strategic risk materialising; strategic risks will be mitigated by a number of controls.

Gaps in controls: What more can be done to control the risk and what controls could be improved.

Gaps in assurances: Where no assurances have been received or are planned to be received.

Risk score: this is the current risk rating which takes into account the controls which are in place (e.g. those remedial actions to reduce the impact / likelihood);

Target score: this is the level of risk that the CCG is prepared to accept and must be aimed for.

Risk ref:				
Strategic Risk Narrative and Risk Owner:		Risk score (I x L)	Target score (I x L)	Movement in risk score

Controls					Assurances						
Categories of control	Control Description	Gaps in Control	Action ref:		Assurance Description	I 4	E 5	+ 6	- 7	Gaps in Assurance	Action ref:
Policy / Framework											
Operational Group(s)											
Training											
Other											

Action(s):	Responsible Officer	Implementation Date

Action(s): Where gaps have been identified, these are the actions required to address them. Actions will have a named lead and target date; progress against these actions is reported to the Audit and Governance Committee.

Assurances: These are inevitably ‘bits of paper’ that act as evidence the controls are in place; assurances can be provided from within the CCG (internal) or by an independent body, such as Internal or External Audit (eternal).

Assurances can be positive (e.g. telling us that the control is working) or negative (e.g. that the control is not effective). An example of a negative assurance would be an Internal Audit report with a ‘Limited Assurance’ opinion.

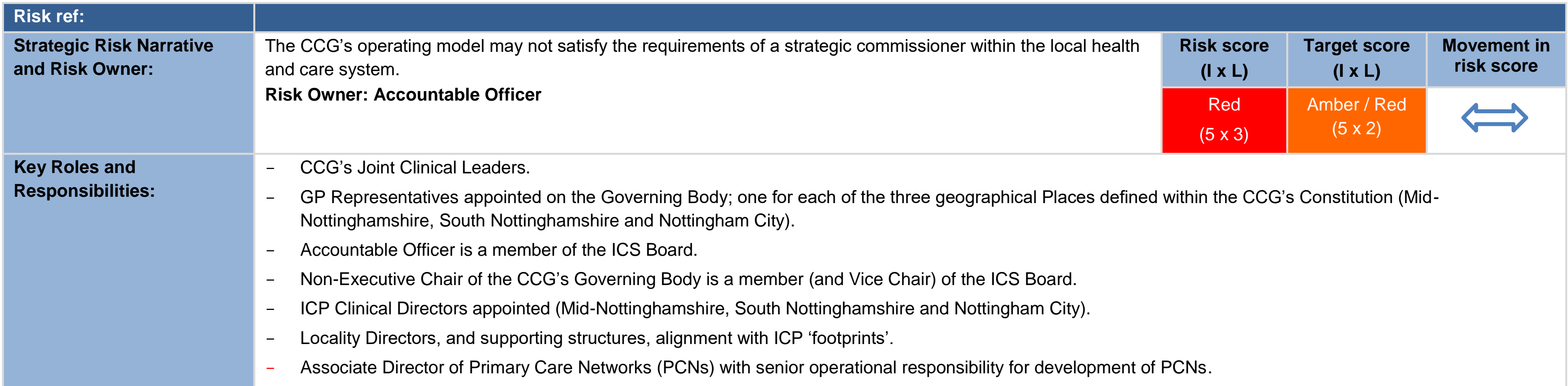
CCG's Strategic Risks (mapped against the strategic objectives and cross-referenced to the CCG's 10 Organisational Priorities for 2020/21[3])	NHS Nottingham and Nottinghamshire CCG's Strategic Objectives			Executive Lead (Risk Owner)	Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)
	Improving the health and well-being of our population	Improving the overall quality of care and life our service users, and carers, are able to have and receive	Improving the effective utilisation of our resources				
Risk 1: CCG Operating Model The CCG's operating model may not satisfy the requirements of a strategic commissioner within the local health and care system. *Organisational Priority 2: Strategic Co-ordination* *Organisational Priority 3: Empower new parts of the ICS system architecture* *Organisational Priority 10: Corporate responsibilities (OD Plan)*	✓	✓	✓	Accountable Officer	Red (5 x 3)	Red (5 x 3)	Amber / Red (5 x 2)
Risk 2: Assessing Health Needs and Addressing Health Inequalities The CCG may not adequately understand the current and future health needs of its population and services may not be commissioned to address identified health inequalities. *Organisational Priority 7: Leading system in developing new care models*	✓	✓	✓	Chief Commissioning Officer	*TBC*	*TBC*	*TBC*
Risk 3: Clinically-led Commissioning The CCG may not have robust and effective arrangements to ensure that clinical insights shape commissioning decisions and that service transformations are clinically-led. *Organisational Priority 4: Clinical leadership*	✓	✓	✓	Joint Clinical Leaders	*TBC*	*TBC*	*TBC*
Risk 4: Patient and Public Involvement The CCG may not have robust and effective arrangements to engage with its diverse population and ensure that patient and public insights inform commissioning decisions. *Organisational Priority 10: Corporate responsibilities (Insights and engagement)*	✓	✓	✓	Director of Communications and Engagement	*TBC*	*TBC*	*TBC*
Risk 5: Collaborative Planning The CCG's annual commissioning plan may not directly align to system plans and clinical strategies. *Organisational Priority 10: Corporate responsibilities (Insights and engagement)*	✓	✓	✓	Chief Finance Officer	*TBC*	*TBC*	*TBC*

[3] They key priorities will be expected to enhance the control framework and/or assurances to manage the strategic risks.

CCG's Strategic Risks (mapped against the strategic objectives and cross-referenced to the CCG's 10 Organisational Priorities for 2020/21[3])	NHS Nottingham and Nottinghamshire CCG's Strategic Objectives			Executive Lead (Risk Owner)	Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)
	Improving the health and well-being of our population	Improving the overall quality of care and life our service users, and carers, are able to have and receive	Improving the effective utilisation of our resources				
Risk 6: Prioritisation of Investment The CCG may not have a robust and consistent approach to prioritise investments and disinvestments to achieve maximum health benefit within available resources. *Organisational Priority 6: Delivering a financially balanced plan*	✓	✓	✓	Chief Commissioning Officer	*TBC*	*TBC*	*TBC*
Risk 7: Procurement The CCG's procurement arrangements may not be compliant with current legislative requirements and national guidance.			✓	Chief Commissioning Officer	*TBC*	*TBC*	*TBC*
Risk 8: Probity Arrangements The CCG's arrangements for ensuring openness, transparency and accountability in decision-making may not be suitably robust. *Organisational Priority 10: Corporate responsibilities (Agile decision making)*			✓	Chief Nurse	*TBC*	*TBC*	*TBC*
Risk 9: Contractual Arrangements The CCG's contractual arrangements may not be sufficiently developed to support outcome-based commissioning. For 2020/21, there is a specific risk relating to the CCG's ability to progressing new ways of working with the ICPs and PCNs. *Organisational Priority 3: Empower new parts of the ICS system architecture* *Organisational Priority 5: Commissioning for the future*	✓	✓	✓	Chief Commissioning Officer	*TBC*	*TBC*	*TBC*
Risk 10: Quality of Commissioned Services The CCG's arrangements for maintaining and improving the quality of commissioned services may not be effective. *Organisational Priority 8: Service and quality improvement*	✓	✓		Chief Nurse	*TBC*	*TBC*	*TBC*
Risk 11: Performance of Commissioned Services The CCG's arrangements for monitoring and improving the performance of commissioned services may not be effective. For 2020/21, there is specific risk relating to restoration and the performance of waiting lists (e.g. ensuring the 'back log' from Covid-19 is appropriately managed). *Organisational Priority 8: Service and quality improvement*	✓	✓		Chief Finance Officer	*TBC*	*TBC*	*TBC*

CCG's Strategic Risks (mapped against the strategic objectives and cross-referenced to the CCG's 10 Organisational Priorities for 2020/21[3])	NHS Nottingham and Nottinghamshire CCG's Strategic Objectives			Executive Lead (Risk Owner)	Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)
	Improving the health and well-being of our population	Improving the overall quality of care and life our service users, and carers, are able to have and receive	Improving the effective utilisation of our resources				
Risk 12: Personalised Care The CCG may not have a sufficiently developed and embedded approach to integrated personalised care. *(To develop further with Chief Nurse).*	✓	✓	✓	Chief Nurse	*TBC*	*TBC*	*TBC*
Risk 13: Equality, Diversity and Inclusion The CCG may not have suitable robust systems and processes for ensuring compliance with the general and specific Public Sector Equality Duties. *Organisational Priority 10: Corporate responsibilities (Equality objectives)*	✓	✓		Chief Nurse	*TBC*	*TBC*	*TBC*
Risk 14: Safeguarding The CCG's arrangements for safeguarding children and vulnerable adults may not be in accordance with legislative and statutory frameworks and guidance.		✓		Chief Nurse	*TBC*	*TBC*	*TBC*
Risk 15: Emergency Preparedness, Resilience and Response The CCG may not be adequately prepared to respond to business continuity and major incidents in line with legislative requirements and national guidance. For 2020/21, there are specific risks relating to COVID-19 and EU exit arrangements. *Organisational Priority 1: Leadership and co-ordination of the pandemic response*		✓	✓	Chief Commissioning Officer	*TBC*	*TBC*	*TBC*
Risk 16: Cyber Security The CCG's arrangements to protect its systems and information from potential cyber-attacks may not be suitably robust. *Organisational Priority 9: Developing digital resilience and transformation*			✓	Chief Finance Officer (SIRO)	*TBC*	*TBC*	*TBC*
Risk 17: Financial Management The CCG's financial management arrangements may not be sufficiently robust to ensure its' statutory financial duties are met. *Organisational Priority 6: Delivering a financially balanced plan*			✓	Chief Finance Officer	*TBC*	*TBC*	*TBC*

CCG's Strategic Risks (mapped against the strategic objectives and cross-referenced to the CCG's 10 Organisational Priorities for 2020/21[3])	NHS Nottingham and Nottinghamshire CCG's Strategic Objectives			Executive Lead (Risk Owner)	Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)
	Improving the health and well-being of our population	Improving the overall quality of care and life our service users, and carers, are able to have and receive	Improving the effective utilisation of our resources				
Risk 18: Workforce Management The CCG may not be effectively supporting the needs of its workforce in terms of ensuring that staff are engaged, developed and their well-being needs met. *Organisational Priority 10: Corporate responsibilities (Employer of Choice)*			✓	Chief Finance Officer	*TBC*	*TBC*	*TBC*



Risk ref:				
Strategic Risk Narrative and Risk Owner:	The CCG's operating model may not satisfy the requirements of a strategic commissioner within the local health and care system. **Risk Owner: Accountable Officer**	**Risk score (I x L)** Red (5 x 3)	**Target score (I x L)** Amber / Red (5 x 2)	**Movement in risk score** ⟺
Key Roles and Responsibilities:	– CCG's Joint Clinical Leaders. – GP Representatives appointed on the Governing Body; one for each of the three geographical Places defined within the CCG's Constitution (Mid-Nottinghamshire, South Nottinghamshire and Nottingham City). – Accountable Officer is a member of the ICS Board. – Non-Executive Chair of the CCG's Governing Body is a member (and Vice Chair) of the ICS Board. – ICP Clinical Directors appointed (Mid-Nottinghamshire, South Nottinghamshire and Nottingham City). – Locality Directors, and supporting structures, alignment with ICP 'footprints'. – Associate Director of Primary Care Networks (PCNs) with senior operational responsibility for development of PCNs.			

Controls

Categories of control	Control Description *(How are we going to stop the risk happening?)*	Gaps in Control	Action ref:
Policy / Framework	Nottingham/Nottinghamshire Five-year Long Term Plan (LTP) which describes the population needs, and case for change within Nottingham/shire, to deliver the commitments set out within the NHS LTP.		
	ICS Outcomes Framework which sets out the short, medium and long term outcomes the whole ICS will work together to achieve, and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes.	Further development of data capture and analytics to measure delivery of Outcomes Framework.	1.1

Assurances

Assurance Description *(How do we know the controls are working?)*	I[4]	E[5]	+[6]	-[7]	Gaps in Assurance	Action ref:
a) ICS updates reported to Governing Body via Accountable Officer (AO) Reports.	✓					
b) Strategic Commissioner Functions paper (presented to the June 2020 Governing Body)	✓				Further clarity required regarding future legislative changes.	1.2
c) NHSE/I 'System' Assurance meetings, focusing on collective finance and performance figures across the ICS.		✓			Further clarity required regarding the management of 'system by default'.	1.3
d) Updates in relation to delivery of the Finance and Commissioning Strategies to the relevant CCG	✓					

[4] Internal assurances,
[5] External assurances
[6] Positive assurance
[7] Negative assurance

Controls				Assurances						
Categories of control	**Control Description** *(How are we going to stop the risk happening?)*	**Gaps in Control**	**Action ref:**	**Assurance Description** *(How do we know the controls are working?)*	**I** 4	**E** 5	**+** 6	**-** 7	**Gaps in Assurance**	**Action ref:**
	Nottinghamshire ICS Memorandum of Understanding (MoU) which outlines the local priorities and deliverables. CCGs' 2019-2024 Financial Strategy which outlines strategic plans to achieve the best possible value for every pound of allocation we spend as a CCG and as a system. CCGs' 2020-2022 Commissioning Strategy which describes the approach to effect a change in the configuration of services, seeking to improve care delivery and meet the needs of our whole population.	Further refinement of roles and responsibilities between ICS and CCG.	1.4	Committees (PENDING)						
Operational / Steering Group(s)	Establishment of a CCG Transformation Group, focussing on internal CCG development to a strategic commissioner, which forms part of the wider system Recovery Cell. CCG representation on system meetings, including: – ICS Leadership Board; – ICS Planning Group; – ICS Finance Group; – ICS Clinical Reference Group; – ICS Performance Oversight Group; – Primary Care Programme Board. CCG representation on ICP meetings for Mid Nottinghamshire, Nottingham City and South Nottinghamshire.	To finalise the Terms of Reference for the internal group.	1.5	Assurance (a) listed above. e) ICP and PCN updates reported to the ICS Board (PENDING). f) Primary Care Network updates provided to the Primary Care Commissioning Committee (PENDING). g) Twice-weekly Executive Management Team meetings with ICP Clinical Leads.	✓ ✓ ✓				Need to establish routine reporting from the Transformation Group to the Finance and Resources Committee. Need to ensure systematic and routine reporting of ICP and PCN updates directly received by the CCG Governing Body.	1.6 1.7
Training	CCG's Organisational Development Strategy to up skill workforce to meet requirements of a strategic commissioner.	To ensure OD Strategy encompasses	1.8	h) Workforce transformation reporting to the Finance and Resources Committee (PENDING)	✓				None identified.	

Controls				Assurances						
Categories of control	**Control Description** *(How are we going to stop the risk happening?)*	**Gaps in Control**	**Action ref:**	**Assurance Description** *(How do we know the controls are working?)*	**I** 4	**E** 5	**+** 6	**-** 7	**Gaps in Assurance**	**Action ref:**
		organisational 'culture' as well as strategic commissioning priority.								
Other	N/A	N/A		N/A					N/A	

Action(s):	Responsible Officer	Implementation Date	Ref to Organisation Priority 'Tasks' *(if applicable)*
Action 1.1: To ensure robust data analytics are in place to measure delivery of the ICS Long-Term Plan (including the ICS Outcomes Framework and Levers of Change).	Accountable Officer	March 2021	2.2
Action 1.2: To take appropriate action depending on the legislation changes proposed.	Accountable Officer	To be determined when government legislation announced.	
Action 1.3: To seek clarity from the Regulator 'system by default' approach.	Accountable Officer	October 2020	
Action 1.4: To more clearly define roles and responsibilities between the CCG and ICS.	Accountable Officer	October 2020	2.1
Action 1.5: To approve the Terms of Reference for the internal group.	Chief Finance Officer	August 2020	
Action 1.6: To establish routine reporting from the Transformation Group to the Finance and Resources Committee.	Chief Finance Officer	October 2020	
Action 1.7: To ensure more routine reporting of ICP and PCN updates are received directly by the CCG Governing Body.	Accountable Officer	December 2020	3.1, 3.2
Action 1.8: To ensure the CCG's OD Strategy, and workforce transformation reporting, reflects organisational 'culture' development (e.g. hearts and minds), as well as strategic commissioning capability.	Chief Finance Officer	December 2020	10.6

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Meeting Title:	Governing Body (Open Session)	**Date:**	05 August 2020
Paper Title:	Corporate Risk Report	**Paper Reference:**	**GB 20 072**
Sponsor:	N/A	**Attachments/ Appendices:**	**Appendix A** - Extract from CCG's Corporate Risk Register
Presenter:	Lucy Branson, Associate Director of Governance		

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary			
The purpose of this paper is to present the Governing Body with the major (red) operational risks from the CCG's Corporate Risk Register. This paper is a standing agenda item, presented to each meeting to ensure that the Governing Body is kept informed of the key risks facing the CCG and assured that robust management actions are in place to manage and mitigate them.			
Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☒
Performance Management	☐	Procurement and/or Contract Management	☐
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not applicable to this report

Risk(s):

The paper details the current major (red) risks in the Corporate Risk Register.

Confidentiality:
☒No
Recommendation(s):
1. **NOTE** the major risks shown at Section 2.1 and comment on whether sufficient controls and actions are in place;
2. **APPROVE** the archiving of risk **RR 030;** and
3. **HIGHLIGHT** any risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

Corporate Risk Report

1. Introduction

The purpose of this paper is to present the Governing Body with the major (red) operational risks from the CCG's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

2. Major Operational Risks

The CCG currently has **six** major (red) operational risks in its Corporate Risk Register. This is a reduction in three major risks since the last Governing Body meeting.

The table to the right shows the profile of the current risk scores, along with a summary of the risk narratives and mitigating actions at Section 2.1 below.

Risk Matrix						
Impact	5 - Very High					
	4 – High				3	3
	3 – Medium					
	2 – Low					
	1- Very low					
		1 - Rare	2 - unlikely	3 - Possible	4 - Likely	5 - Almost Certain
		Likelihood				

2.1 Major/Red Operational Risks:

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
RR 032	Reducing workforce capacity within General Practice may impact the sustainability of some GP Practices. In responding to these challenges, Practices should consider adapting their workforce models to enable the sustained delivery of core services, whilst also ensuring sufficient capacity to deliver/contribute to system and transformation requirements. Lack of pace of change (e.g. adaption of workforce models) may present a risk that the CCG's population access needs are not met, adversely impacting patient experience and/or outcomes. ***Update:*** *Focus on GP workforce capacity continues to be centred around the COVID-19 emergency response and potential future local outbreaks. However, it is recognised that there continues to be a risk around the longer-term capacity within primary care.* *Work regarding the ICS Primary Care Workforce Strategy continues to take place; an update has been requested for the August meeting of the PCCC at which time a full 'risk review' of risk RR 032 will be undertaken.*	Overall Score 16: **Red** (I4 x L4)	Primary Care Commissioning Committee

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
RR 116	Lack of assurance regarding the culture and leadership at Nottinghamshire Healthcare NHS Foundation Trust, as identified by recent Care Quality Commission (CQC) reports, alongside non-achievement of required performance targets, raises concerns regarding the quality of services provided by the Trust. This, in turn, may present a risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for members of the CCG's population. ***Update:*** *A Board to Board meeting has been held, however, the Quality Assurance Group (QAG) which will oversight improvement actions from the joint action plan has yet to meet; with Community Services also not yet being back online, there has been limited assurance received by the CCG that would warrant a reduction in risk score. A formal review of this risk (and score) will be undertaken once evidence has been received against the mitigating actions.*	Overall Score 20: **Red** (I4 x L5)	Quality & Performance Committee
RR 121	Non-delivery of the CCG's financial duties for 2020/21 due to: • Brought forward deficit underlying positions of the six predecessor CCGs; • Impact of COVID-19 on the CCG's planned QIPP programme for 2020/21; • Potential delivery of recurrent savings schemes using non-recurrent monies; • Delays in system-wide transformation / materialisation of efficiencies; • Financial implications of COVID-19. This risk may be exacerbated given the lack of financial contingency planned. ***Update:*** *The risk to the CCG's financial position, as presented to the Governing Body and Regulators, has not changed. There continues to be a level of uncertainty as the CCG awaits national guidance; it is anticipated that this will now be received at the end of July 2020. Internal 'business as usual' meetings (e.g. Financial Recovery Group) are currently paused. As such, the risk score remains at 20.*	Overall Score 20: **Red** (I4 x L5)	Finance & Turnaround Committee

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
RR 130	COVID-19 may exacerbate health inequalities across the CCG's population. ***Update:*** *Mitigations to this risk largely link to the restoration and recovery work which is being undertaken by the Capacity and Recovery Cells.*	Overall Score 16: **Red** (I4 x L4)	Prioritisation & Investment Committee
RR 134	Block payments are currently being made to NHS providers in line with a nationally calculated methodology, based on providers' Month 9 financial reporting. Payments are overstated when compared with what they would have been if based on the CCG's forecast spend. The above presents a risk that current rate of spend may have a detrimental impact on the CCG's overall rate of expenditure, compared to revenue resources available. This may lead to a worsening exit position for 2020/21 compared to 2019/20. ***Update:*** *The CCG has not received any allocation adjustments; the Month 3 position has been submitted. However, with no adjustments having been received, alongside guidance not yet being issued, the risk score remains at 16.*	Overall Score 16: **Red** (I4 x L4)	Finance & Turnaround Committee
RR 135	Due to COVID-19, there is a risk that the CCG may not be spending its allocation in line with commissioning intentions/priorities. This may, in turn, result in the health needs of the CCG's population not being met. ***Update:*** *The CCG has had its allocation removed for the year and the first four months allocated to try and reflect COVID-19 expenditure. This demonstrates the current suspension of normal guidelines. The risk continues to exist for the CCG and is set at 20. Mitigations to be determined following national/regional guidance being published which is due at the end of July 2020.*	Overall Score 20: **Red** (I4 x L5)	Prioritisation & Investment Committee

2.2 The score for risk **RR 127** (Personal Protective Equipment (PPE)) has been reduced from 15 to 8 (I4 x L2) as processes are now in place to manage the supply chain and distribution of PPE.

The score for risk **RR 129** (excess deaths) has also been reduced from 15 to 12 (I4 x L3). Mitigating actions are taking place through the recovery and restoration work via the Capacity and Recovery Cells to reduce the indirect impact of COVID-19 (e.g. prioritisation of clinically urgent cases when managing waiting lists).

3. Archiving of Risks

3.1 Following discussions with the Chief Finance Officer and Head of Human Resources, it is proposed that risk **RR 030** is archived. This risk was originally identified following the alignment of the Greater Nottingham CCGs and continued to be included on the Corporate Risk Register during the merger of the six former Nottingham and Nottinghamshire CCGs.

The new CCG has established a clear workforce structure, which has enabled roles, responsibilities and reporting lines to be defined. Updates in relation to the structure have been communicated across all staff, as well as through each Directorate. In light of this, the risk score has been is below the threshold for inclusion in the Corporate Risk Register.

It is recognised that new potential risks regarding remote working and its potential impact of staff engagement would be discussed at a future meeting of the Finance and Resources Committee and, if appropriate, included within the Corporate Risk Register.

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
RR 030	Following a period of ongoing change, staff may become disengaged which could result in low morale and reduced productivity.	Overall Score 4: Amber (I4 x L1)	Executive Management Team

4. Recommendations

4.1 The Governing Body is requested to:

a) **NOTE** the major risks shown at Section 2.1 and comment on whether sufficient controls and actions are in place;

b) **APPROVE** the archiving of risk **RR 030;** and

c) **HIGHLIGHT** any risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

Siân Gascoigne

Head of Corporate Assurance

August 2020

NHS Nottingham and Nottinghamshire CCG Corporate Risk Register (July 2020)

Risk Ref	Oversight Committee	Directorate	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Trend
	(Relevant committee in the CCG's governance structure responsible for monitoring risks relating to their delegated duties)	(as per April 2020 CCG structure)	(Date risk originally identified)	(These are operational risks, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)				Impact	Likelihood	Score	(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).	Impact	Likelihood	Score	(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		(Movement in risk score since previous month)
RR032	Primary Care Commissioning Committee	Commissioning	Jul-19	Reducing workforce capacity within General Practice may impact the sustainability of some GP Practices. In responding to these challenges, Practices should consider adapting their workforce models to enable the sustained delivery of core services, whilst also ensuring sufficient capacity to deliver/contribute to system and transformation requirements. Lack of pace of change (e.g. adaption of workforce models) may present a risk that the CCG's population access needs are not met, adversely impacting patient experience and/or outcomes.	Commissioning	Lucy Dadge	Joe Lunn	4	4	16	• Role and remit of the Primary Care Commissioning Committee (and supporting governance structures - e.g. primary care quality / contracting teams) • PCCC assurance reporting requirements. • Establishment of Primary Care Cell, as part of CCG's Covid-19 incident response • ICS Primary Care Workforce Strategy; ICS Primary Care Board • Establishment of Primary Care Networks (PCNs) (and/or other collaboration/federation activities) • Ensuring the best use of funding via the GP Forward View, targeting resources to areas of need e.g. GP Resilience Funding, Practice Manager training and development funding. • CQC Inspection Rating(s) / Report(s).	Action: Implement and embed PCCC supporting governance and reporting requirements to ensure appropriate assurance is provided regarding primary care services (e.g. quality of services, delivery of contract requirements, patient experiences). Action: To continue to deliver requirements of Primary Care Workforce Strategy: to request further update regarding delivery of the Strategy to the CCG's PCCC.	4	4	16	**July 2020:** The ICS Primary Care Workforce Strategy continues to be in place; updates in relation to the delivery of this work have been requested from relevant CCG colleagues. The delivery of this Strategy is recognised as not being a short-term 'fix' for current workforce challenges. A further update in relation to the Strategy is to be requested for a future meeting of the PCCC. The CCG has contacted NHSEI to obtain the current/latest Primary Care workforce statistics (from the June 2020 quarterly data collection). It is recognised that there will be a shift in Primary Care workforce modelling as a result of the Covid pandemic.	06/07/2020	↔
RR116	Quality and Performance Committee	Quality and Governance	Oct-19	Lack of assurance regarding the culture and leadership at Nottinghamshire Healthcare NHS Trust, as identified by recent Care Quality Commission (CQC) reports, alongside non-achievement of required performance targets, raises concerns regarding the quality of services provided by the Trust. This, in turn, may present a risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for members of the CCG's population.	Quality	Rosa Waddingham	Danni Burnett / Maxine Bunn	4	4	16	• Establishment of Quality, Safety and Clinical Cell, as part of Covid-19 response; including establishment of weekly Quality and Safety Connect meetings, stakeholder teleconferences and CCG internal review meetings. • Quality reporting (including NHCT focussed reporting) to Quality & Performance Committee • Safe today quality assurance programme • Quality Surveillance Group	Action: To establish the Trust's final quality and governance structure (commence early Summer 2020). Action: To establish a Quality Assurance Group (QAG) to be chaired by the CCG as lead commissioner. The QAG to have oversight of the quality improvement plans across the Trust Action: CCG to liaise with NHSE Spec Comms regarding local agreement for SI reporting. Action: CCG to discuss with partners to review support offers to the Trust. Action: CCG to support internal discussions to address SI backlog.	4	5	20	**July 2020**: A Board to Board meeting has been held with the Trust since the last Q&P meeting, however, the first Quality Assurance Group (QAG) has not yet been held and with Community Services not yet being back online, there is limited assurance received by the CCG that would enable the risk score to be reduced at this time. A formal review of this risk (and score) will be undertaken once evidence has been received against the delivery of mitigating actions. Risk score to remain at 20 at present.	13/07/2020	↔
RR121	Finance and Turnaround Committee	Finance and Resourcing	Jan-20	Non-delivery of the CCG's financial duties for 2020/21 due to: • Brought forward deficit underlying positions of the six predecessor CCGs; • Impact of COVID-19 on the CCG's planned QIPP programme for 2020/21; • Potential delivery of recurrent savings schemes using non-recurrent monies; • Delays in system-wide transformation / materialisation of efficiencies; • Financial implications of COVID-19 (see risks RR 133 to RR 136). This risk may be exacerbated given the lack of financial contingency planned.	Finance	Stuart Poynor	Mick Cawley / Andrew Morton	4	5	20	• Established Finance and Turnaround Committee for the single CCG with clear membership and reporting structure • Financial Recovery governance structure, which reports to the Finance and Turnaround Committee (ON HOLD) • Appointment of a Chief Finance Officer including Turnaround Director for the single Nottingham and Nottinghamshire CCG • Provider Contract Monitoring Meetings and/or Contract Executive Boards (ON HOLD) • Finance Report provided to the Finance and Turnaround Committee (monthly) and to Governing Bodies (bi-monthly) • Financial Recovery Plan / QIPP Update Reports to the Finance and Turnaround Committee (monthly) (ON HOLD) • Financial Recovery Group minutes to the F&T Committees (ON HOLD)	To be developed once awaited national and regional guidance received.	4	5	20	**July 2020:** The CCG's financial risk, presented to the Governing Body and Regulators, has not changed. There continues to be a level of uncertainty as the CCG awaits national guidance; this is now anticipated to be received at the end of July 2020. NHSEI have advised that reimbursements will be assessed at Month 3; there is currently no additional guidance or allocation information post Month 4. Internal 'business as usual' meetings (e.g. FRG) and associated assurance reporting are still paused. As such, limited mitigations can be put in place and the risk score is to remain at 20.	13/07/2020	↔
RR130	Prioritisation and Investment Committee	Commissioning	May-20	Covid-19 may exacerbate health inequalities across the CCG's population.	Commissioning	Rosa Waddingham / Lucy Dadge	Danni Burnett	4	4	16	• Establishment of Quality, Safety and Clinical Cell within the CCG's Incident Response infrastructure. • Establishment of Health Economy TCG (health system partners). • Establishment of 'system' level Cells (Logistics Cell, Mental Health Cell, Discharge Cell); all of which have appropriate representation from the CCG. Daily CEO calls in place.	Action(s): • To work with system partners to strengthen the work around health inequalities, learning from COVID-19, aligning to the Outcomes Framework and future recovery and restoration plans; capture data to inform future planning and service provision. • To continue the EQIA process during COVID-19 with continued oversight of the impacts of service change ensuring that those people within protected characteristic groups, particularly disability, those within inclusion health, and other disadvantaged groups such as new emerging and traveling communities, the homeless, and people experiencing economic or social deprivation. • To ensure the oversight of health inequalities is integral to routine quality assurance processes and business continuity planning. • To ensure the CCG has the necessary expertise and capacity to respond to meeting the needs of our population	4	4	16	**July 2020**: Mitigations to this risk largely link to the restoration and recovery work which is being undertaken by the Capacity and Recovery Cells; it is proposed that this is considered as part of the Commissioning Directorate.	13/07/2020	↔
RR134	Finance and Turnaround Committee	Finance and Resourcing	May-20	Block payments are currently being made to NHS providers in line with a nationally calculated methodology, based on providers' M9 financial reporting. Payments are overstated when compared with what they would have been if based on the CCG's forecast spend. The above presents a risk that current rate of spend may have a detrimental impact on the CCG's overall rate of expenditure, compared to revenue resources available. This may lead to a worsening exit position for 2020/21 compared to 2019/20.	Finance	Stuart Poynor	Mick Cawley / Andrew Morton	5	5	25	• Role and remit of the Finance & Turnaround Committee; receipt and scrutiny of monthly Finance reports • Escalation and financial reporting processes to the Governing Body • Financial Resilience Group assurance reporting (PENDING)	To be developed once awaited national and regional guidance received.	4	4	16	**July 2020:** The CCG has not received any adjustments (as of 13 July); Month 3 has been submitted. With no adjustments received, alongside guidance not yet being issued, the risk score is to remain at a 16.	13/07/2020	↔
RR135	Prioritisation and Investment Committee	Commissioning	May-20	Due to COVID-19, there is a risk that the CCG may not be spending its allocation in line with commissioning intentions/priorities. This may, in turn, result in the health needs of the CCG's population not being met.	Finance	Stuart Poynor	Mick Cawley / Andrew Morton	5	5	25	• Role and remit of the Finance & Turnaround Committee; receipt and scrutiny of monthly Finance reports • Role and remit of the Recovery Cell; associated assurance reporting to the P&I Committee (PENDING) • Financial Resilience Group assurance reporting (PENDING)	To be developed once awaited national and regional guidance received.	4	5	20	**July 2020:** It was advised that the CCG has had its allocation removed for the year and the first four months' allocation to try and reflect Covid-19 expenditure. This demonstrates the current suspension of normal guidelines. This demonstrates that this risk continues to exist for the CCG and is to remain at the current risk score. Mitigations to be determined following national/regional guidance being published; as of 13 July, this had not yet been published and, as such, score is to remain at 20.	13/07/2020	↔

Risk Ref	Oversight Committee	Directorate	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Trend
	(Relevant committee in the CCG's governance structure responsible for monitoring risks relating to their delegated duties)	(as per April 2020 CCG structure)	(Date risk originally identified)	(These are operational risks, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)				Impact	Likelihood	Score	(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).	Impact	Likelihood	Score	(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		(Movement in risk score since previous month)

RISK MATRIX

Impact					
5 - Very High	A	A/R	R	R	R
4 - High	A	A	A/R	R	R
3 - Medium	A/G	A	A	A/R	A/R
2 - Low	G	A/G	A/G	A	A
1 - Very low	G	G	G	G	G
Likelihood	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain

Nottingham and Nottinghamshire
Clinical Commissioning Group

Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) held virtually on Tuesday 19 May 2020 at 2 pm

Attendees;
Sue Clague, Chair
Jasmin Howell, Vice-Chair
Chitra Acharya, Patient Leader/Carer
Gilly Hagen, Patient Leader, Sherwood Patient Participation Groups
Yesmean Khalil, Nottingham City
Daniel Robertson, Nottingham and Nottinghamshire Refugee Forum
Trevor Clower, Patient Leader/Carer
Colin Barnard, Diabetes/Patient Leader
Helen Miller, Healthwatch Nottingham and Nottinghamshire
Kerry Devine, Improving Lives
Teresa Burgoyne, Nottingham West
Paul Midgley, Rushcliffe

In attendance (NHS Nottingham & Nottinghamshire Clinical Commissioning Group's Staff):
Stuart Poynor, Chief Finance Officer and Deputy Accountable Officer
Lewis Etoria, Head of Insight & Engagement
Julie Andrews, Engagement Manager
Katie Swinburn, Engagement Officer
Tracy Lack, Engagement Officer
Sasha Bipin, Engagement Officer
Jane Hufton, Engagement Assistant

Apologies;
No apologies for absence were received

NN/01/05//20	**Welcome and Introductions**
	Sue Clague welcomed everyone to the inaugural meeting of the Nottingham and Nottinghamshire Patient and Public Engagement Committee and led a round of introductions. A special welcome was extended to Stuart Poynor, Chief Finance Officer and Deputy Accountable Officer. Stuart Poynor explained that his portfolio included financial control, probity and balance, service performance, management and improvement, information, IT/Senior Information Risk Owner, HR/Organisation Development, Estates and Technical Planning (activity and finance).
NN/02/05/20	**Declarations of Interest**
	Julie Andrews confirmed that all Declaration of Interest forms had been returned and would be included on the CCG's Register The Chair reminded PPEC members of their obligation to declare any interest they might have on any issues arising at the meeting which might conflict with the business of the CCG and any items on this agenda. No declarations were made.

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NN/03/05/20	**Minutes of the Last Meeting**
	The minutes of the last joint meeting of the Mid Nottinghamshire and Greater Nottinghamshire PPEC held on 9 April 2020 were agreed as an accurate record of the discussion that took place at that meeting.
NN/04/05/20	**Matters Arising including Action Log**
	An updated copy of the Action Log had been circulated to PPEC members prior to the meeting. Julie Andrews referred to actions outstanding in the Action Log and thanked those PPEC members who had contributed to the development of the PPEC Forward Programme. PPEC members were invited to continue to advise of any instances of vulnerable people being unable to register for help and support during the pandemic. An update on the PCN tooklkit featured on the agenda. Other notable updates related to: • Pain management service with particular reference to access to steroid injections. Lewis Etoria explained that national guidance stated that steroid injections should be suspended due to the risk of infection. In response to a question, it was confirmed that the service provider had provided assurance that letters had been issued to all patients affected and included advice for patients of where they could access further information and self-help resources. • Access to MSK physiotherapy services that had been raised some months ago. A full response had been provided by the Head of MSK Together. The response provided details of the plans put in place to address a shortfall in capacity versus demand through utilisation of telephone appointments, active management of the waiting list, use of group exercise and group follow and the introduction of an Early Education Group for low back pain. Due to the pandemic, these actions had been paused and the service has implemented changes to the MSK Pathway to ensure the service is delivered safely and in line with NHSE guidance for community services. Referrals are accepted into the service, assessed and available options explored, ie self-care, virtual appointments or being added to the waiting list for face to face or out- patient appointments where required. This will impact on the waiting times going forward, but recovery plans will be put in place as further guidance becomes available. Sue Clague referenced the CVS work plan and it was agreed this should be included on the agenda for the next meeting. **ACTION**: **Julie Andrews to include CVS work plan on agenda for the next PPEC meeting.** Kerry Devine reported that she had contacted the health and care system's joint Humanitarian Cell who had initiated discussions with BT to find a solution for those patients deemed to be at risk who have no telephone access. It was agreed that an update on this issue should be requested and shared with PPEC members.

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	ACTION: Julie Andrews to request an update on provision of telephone access for patients deemed to be at risk.
NN/05/05/20	**Membership Update** Sue Clague provided an update on recruitment of members to PPEC and explained that to date the membership had been drawn from the existing members of Greater Nottingham PPEC and Mid Nottinghamshire PPEC. Nominations had been requested from City and County Councils and Integrated Care Partnerships. However, it was noted that gaps in representation remain specifically representatives of maternity services, young people and the LGBTQ+ community. Further targeted recruitment was being progressed and PPEC members were asked to notify the Engagement Team of anyone who may be interested. **Action; PPEC members to forward any suggestions for PPEC membership to Julie Andrews of individuals or groups who would make PPEC more representative of the local population (maternity services, LGBTQ+ and young people).**
NN/06/05/20	**Engagement Work Priorities**
	Copies of a presentation providing details of the CCG Engagement Team's current priority programmes of work had been circulated to PPEC members prior to the meeting for information and noting. Lewis Etoria introduced the presentation and explained that the work had been categorised by types of projects as follows; - Infrastructure for Engagement - Projects for specific commissioning decisions, for example the NHS Rehabilitation Centre - Strategic review work, for example wider commissioning intentions - Strategic ICS/System Work, for example COVID recovery work and the ICS Clinical and Community Services Strategy Lewis Etoria explained that the initial focus on infrastructure development would shift to focus on delivery over the coming months and went on to highlight specific areas of work that fell into the above categories including; • PPEC merger • Development and management of CVS contracts • ICP engagement models • Patient Leadership Programme • Maternity Voices Partnership • NHS Rehabilitation Centre • Commissioning of planned care, mental health services and integrated urgent care services Sue Clague invited comments on the priority areas and requested that these be sent to Lewis Etoria by email. **Action; PPEC Members to email Lewis Etoria with any comments on the Engagement Team's work priorities**.

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NN/07/05/20	**Engagement to Support Recovery Cell Stage 1 Work - proposal**
	Copies of an engagement proposal to support the recovery cell work had been circulated to PPEC members prior to the meeting. Stuart Poynor, Chief Finance Officer/Deputy Accountable Officer introduced the Recovery Cell programme by explaining how the response to the pandemic had brought forward some of the service transformations included in the Long Term Plan, for example delivery of online and telephone consultations in primary and secondary care. The pandemic had also led to changes in patients' behaviours, there had been huge reductions in attendances at the Emergency Department and primary care. Stuart Poynor welcomed the opportunity to undertake early engagement. Lewis Etoria shared the detail relating to engagement proposal that would enable the CCG to understand the impact of the changes and the tolerance for keeping the changes made. The specific objectives are: • Understand people's views of the changes made, even if they are not directly affected • Understand the tolerance of the population for keeping the changes made • Understand the impact of changes on the people directly affected • Understand the impact of keeping changes on the people directly affected • Understand the impact of changes on groups who are vulnerable and face barriers to accessing services as a result of Covid-19. Engagement on emergent proposals and specific options for changes would include more detailed and specific objectives. The proposal aims to provide a baseline of population views that will underpin future recovery work, and potential formal consultation. The target audiences for the engagement would be: • A representative sample of the general public via a research agency • Specific patient cohorts affected by the changes the Recovery Cell wishes to review through the CCG's engagement team • Vulnerable groups and those who face barriers to accessing services as a result of Covid-19 using the CVS Patient and Public Engagement contract. Lewis Etoria referenced a report produced by Healthwatch Nottingham and Nottinghamshire entitled 'Information needs of vulnerable people during the COVID-19 pandemic'. The report provided details of a short survey carried out between 17th April and 4th May 2020. Copies of the report will be shared with PPEC members **Action; Julie Andrews to circulate copies of Healthwatch Nottingham and Nottinghamshire report to PPEC members**. PPEC Members were invited to provide feedback on the approach to

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	engagement, target groups and areas and themes to explore through the engagement. With regard to the adverse impact of Covid- 19 on BAME communities, Yesmean Khalil asked how this would be reflected in local strategic priorities from a workforce and communities perspective. Stuart Poynor referenced a national response to this issue but confirmed that CCGs have been asked to look at the impact on BAME communities and workforce as part of its incident response. With regard to the longer term strategy, the CCG has not yet has the opportunity to reflect on this but a commitment was given to ensure vulnerable groups are a priority given their different and multiple needs. Jasmin Howell referenced the Joint Strategic Needs Assessment that provides details of groups who are experiencing the greatest inequalities and suggested there is a real need to focus on how we listen to and deliver information to these groups. During discussion PPEC members raised a number of queries about the restoration of services and requested clarification regarding: • the support available for people who face barriers to accessing online/phone appointments due to interpretation issues or no access to phone particularly urgent dental care • the CCG's model for prioritising restoration of services including specific detail and timeline for the restoration of services • the CCG's response to Covid-19 and inequalities – how is the CCG responding to the impact on BAME communities and how will the CCG respond to the fact that Covid-19 has exacerbated other inequalities? Sue Clague acknowledged the concerns raised about the risk of Covid-19 changes accelerating inequalities and highlighted the recovery cell engagement as a really significant piece of work to understand the impact of changes and deliver better patient outcomes within the right financial package. Following discussion, it was agreed that responses to the issues raised regarding restoration of services would be obtained and circulated to PPEC members. **Action; Julie Andrews to request responses to the queries raised about the restoration of services.** **Post meeting note; Due to the number of queries raised the Restoration of Services has been prioritised as an agenda item for the next PPEC meeting on 23 June 2020.**
NN/08/05/20	**Primary Care Network Toolkit**
	Due to time constraints it was agreed to defer and prioritise this item to the next PPEC meeting. **Action: Julie Andrews to include Primary Care Network Toolkit on**

	next PPEC agenda.
NN/09/05/20	**Governing Body Feedback and Key Messages from PPEC**
	Sue Clague reported on the key highlights arising from the Governing Body meeting held on 6 May, 2020 as: • Focus on care homes and Covid 19 update • Work of the Recovery Cell PPEC members agreed that the key message to highlight to the Governing body should be: • To welcome the plans for early engagement to inform the Recovery Cell programme and acknowledge the importance of engaging different cohorts of patients including people directly affected, those not directly affected and those groups who are who are vulnerable and face barriers to accessing services. It was considered there should be a particular emphasis on effective engagement of the latter groups to avoid creating further barriers and exacerbating health inequalities. **Action; Julie Andrews to incorporate key message from PPEC to Governing Body in PPEC Highlight Report.**
NN/10/05/20	**Effectiveness and Impact of Engagement**
	Jasmin Howell suggested the development of a framework that would enable PPEC members to effectively review the quality and impact of engagement. Paul Midgley referred to a template used by the East Midlands Academic Health Science Network's PPI Senate that fulfilled a similar function and that this may be helpful to inform the framework. **Action; Julie Andrews to develop a framework to support PPEC members to effectively and consistently review the quality and impact of engagement.**
NN/11/05/20	**Any Other Business**
	Julie Andrews advised of an invitation for PPEC members to be involved in the development of a website for end of life/palliative care services to provide patients, carers and families with information. Anyone interested in participating in this development were asked to contact Sasha Bipin. **Action; PPEC members to contact Sasha Bipin to express an interest in being involved in website development for end of life/ palliative care services.** Paul Midgely highlighted a course being offered by the King's Fund - The NHS Explained – Get a detailed understanding of the NHS - its inner workings, current and future challenges, and how it all fits together, and suggested this may be helpful to PPEC members. Chitra Acharya referenced an offer from Connected Notts. to provide an

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	update on the NHS App to PPEC members. It was agreed that an information session should be arranged to take place prior to the next PPEC meeting. A brief update would be provided at the PPEC meeting on 23 June 2020 **Action; Sasha Bipin to liaise with Chitra Acharya to arrange an information session on the NHS App. Further details to be included in PPEC bulletin.**
NN/12/05/20	**Date of Next Virtual Meeting**
	The next meeting will be held virtually on Tuesday 23 June 2020 from 2 pm to 3 30 pm.

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Minutes of Meeting of NHS Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) held virtually on Tuesday 23 June 2020 at 2 pm

Attendees:
Sue Clague, Chair
Jasmin Howell, Vice Chair
Chitra Acharya, Patient Leader/Carer
Colin Barnard, Diabetes/Patient Leader
Teresa Burgoyne, Nottingham West/Breathe Easy
Trevor Clower, Patient Leader/Carer
Michael Conroy, My Sight Nottinghamshire
Mike Deakin, Nottinghamshire County Council
Kerry Devine, Improving Lives
Gilly Hagen, Patient Leader, Sherwood Patient Participation Groups
Amdani Juma, African Institute for Social Development
Yesmean Khalil, Nottingham City
Roland Malkin, Nottinghamshire Cardiac Support Group
Helen Miller, Healthwatch Nottingham and Nottinghamshire
Daniel Robertson, Nottingham and Nottinghamshire Refugee Forum

In attendance (representing NHS Nottingham and Nottinghamshire Clinical Commissioning Group):
Lucy Dadge, Chief Commissioning Officer
Kate Burley, Deputy Head of Mental Health Commissioning
Gary Eves, Head of Mental Health, Learning Disability & Children's Commissioning,
Lewis Etoria, Head of Engagement
Julie Andrews, Engagement Manager
Katie Swinburn, Engagement Officer
Tracy Lack, Engagement Officer
Sasha Bipin, Engagement Officer
Jane Hufton, Minute Taker, Engagement Assistant

NN/13/06/20	Welcome and Introductions
	Sue Clague welcomed everyone to the meeting of NHS Nottingham and Nottinghamshire Patient and Public Engagement Committee and led a round of introductions. Sue Clague also welcomed four new members who have joined the Patient and Public Engagement Committee recently:- • Mike Deakin, Nottingham County Council • Amdani Juma, African Institute for Social Development • Roland Malkin, Nottinghamshire Cardiac Support Group • Michael Conroy, My Sight Nottinghamshire A warm welcome was also extended to; • Lucy Dadge, Chief Commissioning Officer • Kate Burley, Deputy Head of Mental Health Commissioning • Gary Eves, Head of Mental Health, Learning Disability & Children's Commissioning.

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	All representing NHS Nottingham and Nottinghamshire Clinical Commissioning Group.
NN/14/06/20	**Apologies for Absence** Apologies for absence had been received from Paul Midgley.
NN/15/06/20	**Declarations of Interest**
	The Chair reminded PPEC members of their obligation to declare any interest they might have on any issues arising at the meeting which might conflict with the business of the CCG and any items on this agenda. No declarations of interest were made.
NN/16/06/20	**Minutes of the Last Meeting**
	The minutes of the last meeting of the NHS Nottingham and Nottinghamshire Patient and Public Engagement Committee held on 19 May 2020 were agreed as an accurate record of the discussion that took place at the meeting.
NN/17/06/20	**Matters Arising including Action Log**
	An updated copy of the Action Log had been circulated to all PPEC members prior to the meeting together with; • A comprehensive response from the CCG to the issues raised at the last meeting regarding the support available for people experiencing barriers to accessing services during the Covid-19 pandemic and the impact on BAME communities and health inequalities • PPEC Highlight Report presented to the Governing Body on 3 June 2020 Julie Andrews referred to a number of actions outstanding that would be included on the next PPEC agenda as follows; • Update on CVS Alliance implementation plan and Recovery Engagement • Framework to support PPEC members to review the quality and impact of engagement consistently and effectively • Primary Care Network toolkit It was noted that a public facing version of the Commissioning Intentions remained outstanding and would be followed up. **Action; Julie Andrews to include PCN Toolkit, CVS Alliance Update and framework for assessing impact of engagement on the forward programme for the next meeting.** **Action; Lewis Etoria to follow up the public facing version of the CCG's Commissioning Intentions 2020/21.** Sue Clague noted that there had been a comprehensive response from the CCG to a good quality set of questions raised at the previous PPEC Meeting. The quality of discussion had been commended by the Chief Finance Officer at the Governing Body meeting.
NN/18/06/20	**Restoration of healthcare services update – Lucy Dadge**
	Lucy Dadge, Chief Commissioning Officer introduced a presentation entitled Restoration and recovery of services following phase 1 of the COVID 19 incident. The presentation explained the various stages of the Covid-19 incident, provided

	detail on the incident response and associated service changes and the principles and priorities associated with the restoration of services. Lucy Dadge confirmed the CCG would be submitting a restoration plan to NHS England. Priorities for restoration in Nottingham and Nottinghamshire have been planned to ensure; • Patients have confidence that it is safe to access services when they need to • We maintain the positive changes we have seen in the way patients and clinicians have responded and behaved • We have sufficient capacity for the predicted increase in non-elective admissions (COVID and non COVID) • Patients have continued access to urgent services, using the Royal College of Surgeons framework for prioritising services as a guide • Routine services are resumed in a phased process safely • Staff continue to be alert to safeguarding issues for both adults and children, particularly as lockdown is lifted The focus will be on; • Ensuring cancer and urgent patients receive treatment, with a gradual increase of routine work • Non COVID activity is increasing; primary care consultations are nearing pre-COVID levels and non-elective admissions are increasing 1% per day since mid-April • Despite increased emergency admissions, there remain relatively low levels of occupancy in acute beds as the number of discharges is matching admissions – this is critical to maintaining capacity in acute care • Planning work for restoration of services is based on clinical prioritisation including use of the Royal College of Surgeons guidance and reflects current constraints (e.g. availability of PPE and anaesthetic drugs) • The biggest risk to restoring services in all care settings is the consistent availability of PPE • Plans remain in place for a potential second wave of COVID. During discussion, the following responses were provided to questions asked and comments made; • It was confirmed face-to-face consultations have continued to be available throughout the pandemic when clinically required. Furthermore, numbers of face-to-face consultations continue to increase. • It was noted there is finite testing capacity for Covid-19 and turnaround times vary with some test results being available within 48 hours. There are issues nationally with testing and some people are receiving multiple tests. It was agreed the testing resource needs to be more focused • Capacity plans must be realistic for the 'new normal' working environment taking into account requirements for social distancing, infection prevention and control practices, testing, etc. • Covid-19 has had a disproportionate impact on Black, Asian and Minority Ethnic Communities and Refugees (BAMER) and Lucy Dadge confirmed at a local level the CCG would welcome input from PPEC and Healthwatch to analyse and understand this more • Lucy Dadge anticipated that there would be a review of non-Covid related excess deaths in the future. **Action: Lucy Dadge agreed to share the CCG's plan for the restoration of services with PPEC Members.**

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	Action: Lewis Etoria will provide an update at the next meeting regarding the engagement activity being progressed as part of the recovery phase of Covid-19.
NN/19/06/20	**Mental Health services commissioning proposals and plans for engagement – Kate Burley/Gary Eves**
	Gary Eves and Kate Burley delivered a presentation on mental health services commissioning proposals and plans for engagement. Kate Burley, Deputy Head of Mental Health Commissioning, updated the group on NHS Long Term Plan priorities for mental health which include: • Specialist Community Perinatal Services – accessing evidence based therapies and signposting support where needed • Children and Young People Mental Health Services – early intervention, eating disorders, crisis services • Adult Common Mental Illnesses – increasing access to IAPT services • Adult Severe Mental Illnesses • Crisis Care and Liaison • Therapeutic Acute Mental Health Inpatient Care • Suicide Reduction and Bereavement Support. It was noted the priority areas referenced above may need to be refined in response to any Covid-19 guidance received from NHS England/Improvement. Mental Health Commissioning Team gave a commitment to return to PPEC as plans develop and more specifically to discuss plans for engagement. Gary Eves shared information about Children and Young People's Emotional Wellbeing and Mental Health Early Intervention and Prevention Pathway. He described the current service provision, proposed service changes and proposals for engagement that included co-production workshops delivered by MH:2K and discussions with GPs, parents and carers. The engagement would inform the service model and specification. In response to a question about Equality Impact Assessments (EQIAs) undertaken to assess the impact of a change to services or policy on people with protected characteristics and underserved communities, it was confirmed that EQIAs are undertaken as part of all programmes of work. In addition, population health management data is used to understand who is not accessing services, the barriers to services and appropriate interventions are put in place. Other insight is also available, for example, the CCG has commissioned the University of Leicester to look at inequalities experienced by LGBT+ communities and the CCG is working with the BAME Communities of Practice. Nottingham City ICP have identified as a priority action a need to improve communication with the BAME communities and this is being progressed through the Nottingham Together Board and Nottingham CVS. An update on this programme of work will be brought to a future meeting. **Action; Include an update on the work of the Nottingham Together Board on the PPEC Forward Programme**. **Action: Lewis Etoria will explore opportunities to align engagement and Equality Impact Assessments with the CCG's Equality Lead prior to the next**

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	PPEC meeting. Sasha Bipin confirmed that she had developed a Communication and Engagement Plan and would share this with PPEC members for review and comment. Jasmin Howell requested that engagement with children in care should be factored into the engagement plan. **Action: Sasha Bipin to circulate Communication and Engagement Plan to PPEC members for review and comment.** Gary Eves updated PPEC members on the programme of work relating to Improving Access to Psychological Therapies (IAPT). He provided an overview of current service provision and plans to develop the service to; • Provide increased access, including proportionate increase from target groups and localities with lowest uptake • Improved uptake of group and digital therapies • Expand long-term condition pathways. Initial scoping of engagement had identified the following target groups; • Current and previous service users through IAPT providers • Public engagement using online and virtual mediums • Targeted engagement with people aged over 65, BAME communities and Mansfield & Ashfield population • Utilising existing engagement opportunities. Gary Eves invited PPEC members to share any ideas to develop this scoping further. **Action: PPEC Members to share any ideas for engagement with Sasha Bipin.** Sue Clague thanked Gary Eves and Kate Burley for delivering an informative presentation.
NN/20/06/20	**Governing Body Feedback and Key Messages from PPEC**
	Sue Clague reported that the Governing Body at it its meeting on 3 June 2020 had acknowledged the good level of discussion that had taken place at PPEC regarding restoration and recovery of services across the health and social care system. The key messages to highlight to the Governing Body were confirmed as; 1. PPEC is encouraged by the early engagement that is taking place and the strong link that is emerging between commissioning and public engagement. The engagement team has good staffing levels and there are signs of a much stronger engagement process and an expectation regarding implementation of outcomes. 2. The reported lack of confidence amongst people shielding. The challenge to the CCG is to ensure this cohort of patients are not forgotten about and to emphasise the importance of good communication with shielded patients.

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NN/21/06/20	**Any Other Business**
	No further items for discussion were raised.
NN/22/06/20	**Date of Next Virtual Meeting via Zoom** The next meeting will be held on Tuesday 28 July 2020 from 2 pm to 3.30pm

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Quality and Performance Committee
Ratified minutes of the meeting held on
28/05/2020, 09:00 – 11:45
MS Teams

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Dr Manik Arora	GP Representative
Mindy Bassi	Chief Pharmacist
Danni Burnett	Deputy Chief Nurse
Sue Clague	Non-Executive Director
Andy Hall	Associate Director of Performance and Information
Dr Hilary Lovelock	GP Representative
Stuart Poynor	Chief Finance Officer
Dr Richard Stratton	GP Representative
Jon Towler	Non-Executive Director
Rosa Waddingham	Chief Nurse

In attendance:

Hazel Buchanan	Associate Director of Special Projects for agenda item QP/20/10
Maxine Bunn	Associate Director of Commissioning, Contracting and Performance – Mental Health and Community
Sarah Carter	Incident Executive Director – Covid-19 for agenda item QP/20/09
Fiona Daws	Corporate Governance Officer (minutes)
Vickie Elston	Corporate Governance Manager
Siân Gascoigne	Head of Corporate Assurance – for agenda item
Esther Gaskill	Head of Quality – Primary Care – for agenda item QP/20/11 and QP/20/15
Paula Hawkins	Specialist Safeguarding Practitioner (Adults) for agenda item QP/20/14

Apologies:

Nina Ennis	Associate Director of Joint Commissioning and Planned Care

Cumulative Record of Members Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Dr Manik Arora	1	1	Mindy Bassi	1	1
Danni Burnett	1	1	Sue Clague	1	1
Eleri de Gilbert	1	1	Andy Hall	1	1
Nina Ennis	1	0	Stuart Poynor	1	1

Cumulative Record of Members Attendance (2020/21)					
Dr Hilary Lovelock	1	1	Jon Towler	1	1
Dr Richard Stratton	1	1			
Rosa Waddingham	1	1			

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Introductory Items

QP/20/01 Welcome and Apologies for Absence

Eleri de Gilbert welcomed everyone to the Quality and Performance Committee of NHS Nottingham and Nottinghamshire CCG which was held virtually due to the Covid-19 situation.

Dr Manik Arora, Dr Richard Stratton, Dr Hilary Lovelock and Jon Towler were welcomed as new Committee members.

Apologies were noted as above.

QP/20/02 Agenda Format

Due to Covid-19, the agenda has incorporated system level assurance for which the Committee is responsible. Members were reminded how to use Microsoft Teams (MST) during meetings and the format for submitting questions.

QP/20/03 Confirmation of Quoracy

It was confirmed that the meeting was quorate.

QP/20/04 Declaration of interest for any item on the agenda

No interests were declared in relation to any other item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

QP/20/05 Management of any real or perceived conflicts of interest

No conflicts of interest had been identified to be managed at this meeting.

QP/20/06 Minutes of the meeting held on 26 February 2020

It was agreed that the minutes were an accurate record of the meeting.

QP/20/07 Action log and matters arising from the meeting held on 26 February 2020

The following actions were discussed:

QSP 19 132 Safeguarding Toolkit - this will be added to the next Committee agenda for discussion. Safeguarding Board accountabilities and the impact of Covid-19 will be

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incorporated within future quality reports.

SC 20 026 Memory Assessment Service – members noted that waits for this service require improvement which is being discussed with Nottinghamshire Healthcare NHS Foundation Trust (NHT) with a paper due to be presented to Prioritisation and Investment Committee (PIC) in June 2020. Performance for this service will be detailed in future Performance Reports.

All other actions were noted as ongoing or completed (and can be closed). There were no further matters arising.

Assurance – Response to Covid- 19

QP/20/08 **CCG response to Care Homes and Home Care**

Rosa Waddingham presented this item, highlighting the following key points:

(a) The report highlights the impact of Covid-19 on commissioned services and in relation to care homes and the home care sector.
(b) The CCG has additional responsibility as part of the incident response for both residential and nursing homes as well as a system partner and leader to work with Local Authorities, providing assurance to NHS England/NHS Improvement (NHSE/I)
(c) The offer of support to the care home and home care sector is greater than usual and is incredibly complex with a more operational, hands on approach, for example, fit testing of Personal Protective Equipment (PPE).
(d) The impact of Covid-19 within the care homes setting is far greater than envisaged; however, it is now on a downward trend.
(e) The result of the roll out of swabbing and testing is likely to result in an initial increase in confirmed cases as those with no symptoms are identified as positive. The surveillance will provide data and highlight those areas of most need and prioritisation.
(f) Death rates in care homes are declining; however, it is currently not clear whether this trend is due to the natural progress of the disease or the management of it.
(g) Following a large piece of work, a single data set around care homes and home care for the Infection, Prevention and Control (IPC) footprint has been established providing the CCG with the data to be able to respond to actual, not perceived, need.
(h) A care home and home care multi-agency cell was established from the outset of the response to the pandemic and a strategic group meets at least weekly. The action response is fast paced and links in with the Health and Social Care Tactical Coordination Group.
(i) A Toolkit is available via the Integrated Care System (ICS) website and is utilised by the care homes, home care and end of life forums. Behind the Toolkit sits the work of the enhanced care response team providing support for nine areas, although it has been challenging to devise an offer to suit all. The Toolkit assists tailoring training requirements most appropriately and 100 sets of training have

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currently been delivered, some of which has been mandated by NHSE/I.

(j) In primary care, letters have been sent to clinical leads providing assurance regarding care homes along with named support, weekly checks, clinical assessment and medication support complementing the offer.

(k) The completion of Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) have increased and an agreement to roll out online pharmacy training to care homes, coupled with an on line resource to help manage medication, has been escalated to start earlier.

(l) Directed Enhanced Services (DES) and Ageing Well work has been accelerated to support the system response.

(m) A new discharge process has been signed off which includes a strong focus on training and support.

(n) Asymptomatic testing could have a huge impact on the availability of staff in care homes which is a concern. However, an emergency/contingency staffing plan has been developed which will utilise support from Sherwood Forest Hospital NHS Foundation Trust (SFH) bank staff facility together with discussions with the military around nursing capacity.

(o) Further work is underway regarding the impact of discharges, incorporating stakeholder engagement as well as the sustainability of the care home long term market. It is envisaged that the new NHS responsibility in care homes is likely to continue.

(p) Next month’s focus will be on workforce and wellbeing

The following points were made in discussion:

(q) Members sought clarity on the decision to accelerate discharge from hospital to care homes at the outset of the pandemic. It was confirmed that in accordance with national guidance and policy at that time, residents were not routinely tested on discharge. Some patients were asymptomatic and developed visible symptoms later. The CCG worked with providers to ensure that isolation measures were put in place. Members were assured that homes receiving discharges are limited to those with an Infection Prevention and Control (IPC) assessment confirming the ability to manage Covid-19 patients and safety requirements.

(r) Members queried the conflicting reports in the media regarding a lack of support to care homes and those reports provided by the CCG evidencing resource. Members were assured that despite one home raising concern they had been visited and further support offered. A substantial amount of financial support has been invested in care homes and claims from the Local Authority have been put in place, mitigating potential closures due to financial pressures.

(s) The model of support from the CCG was confirmed as sustainable. Some routine work has been suspended, allowing the CCG to move to a more supportive work model and cellular working.

(t) Members acknowledged the amount of work undertaken and that the care home response has been proactive and positive. Staff are risk managed via the nationally driven processes, however private business and those working in personal homes may not be risk assessed in the same way. A piece of work detailing how inequalities are being addressed would be received at the next Committee meeting.

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(u) Support to care homes is currently on a case by case basis, noting that some care homes are declining the support offer. Members were assured that care homes are offered support from primary care, pharmacists and the care home team.
(v) Members sought assurance that care homes were supported with the appropriate calibre of GP and were assured that care home support is provided in each Primary Care Network (PCN). It was confirmed that there have been no concerns raised by care homes in relation to GP access.
(w) Although members acknowledged the fast pace of this complex piece of commissioning and the work involved, concern was expressed regarding care homes declining the support offer, particularly if a second wave occurs. Members were assured that those declining support were often accessing their own services but the CCGs continued to maintain contact.
(x) Members queried if care home residents who develop Covid-19 symptoms are required to move to those homes registered to receive infected patients. Members were assured that this is not the case and the homes manage on a case by case basis, which is particularly important as the winter season starts to approach.
(y) It was acknowledged that the quality of the ReSPECT forms will need revisiting for proper assessment as the majority are Covid-19 specific.
(z) Members acknowledged the move towards more strategically managing the care homes sector and closer working with the Local Authorities.
(aa) It was noted that the Toolkit was a significant project which has received national recognition as best practice and is being shared at every opportunity. The committee thanked to the team, recognizing the workload and pace involved in often challenging unchartered territory.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance.

ACTION:
Danni Burnett will bring a report on how inequalities are being addressed to the next meeting of the Committee.

QP/20/09 **Swabbing and Testing**

Sarah Carter was welcomed to the meeting to present this item which was tabled. The following key points were highlighted:

(a) The Local Resilience Forum (LRF) had identified the need for a single cell to harness the physical assets, skills and expertise available across the Nottingham and Nottinghamshire footprint to ensure a transparent, well-planned and co-ordinated response to the national swabbing and testing requirement, across the system.
(b) This will ensure all operational, scientific and clinical issues are addressed, focussing on four areas: workforce, care homes and home care, community and planning, through a model of 5 pillars of testing.

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(c) Key priorities are:
- To improve the number of tests eligible staff have access to.
- Discharge testing for care home and home care patients.
- Whole Care Home testing.

(d) Access to whole home testing is limited to those on a priority list and a summary was provided regarding current care home testing activity.

(e) A Testing Coordination Centre has been established by the CCG on behalf of the LRF and has been in operation for a number of weeks using a combination of a regional testing site, military mobile testing units, home drop tests and limited capacity through testing in local acute hospitals.

(f) Swabbing activity is currently declining.

(g) Various challenges have been faced relating to rapidly changing government policy; capacity; logistics; expectations; targets; communications; leadership and delays in operational guidance.

(h) The second phase of the testing programme focusses on access; improving access to results; channeling where we test against national priorities; more local determination in response and responsibility for local testing; governance review and phase three – Winter Ready.

The following points were made in discussion:

(i) Members questioned if there is no test confirming immunity, moving to pillar four will be on the assumption that immunity is present. It was noted that a track and trace (T&T) element of the workforce guidance had just been received and will be circulated or widely.

(j) Members were keen to know the latest developments regarding the NHSX App. It was noted that no further information is available other than it is based on people self-reporting their symptoms. Antibody testing will provide surveillance of those professionals that have had the virus, although, it is unknown what a positive result would mean. Whole home testing and data will also provide an insight into this area.

(k) Members enquired as to the progress regarding whole nursing homes testing. Results from both Nottingham City and Nottinghamshire County homes are providing good intelligence, although conclusions are unable to be drawn as yet as data is being compiled. Of those tests undertaken the results show low positive results. Where this is not the case actions are being taken to reduce further spread. Testing will be completed over the next few weeks, although not by the requirement date of 6 June 2020 due to a delay regarding the portal, prioritising homes and swab delivery issues.

The Committee:

- **RECEIVED** and **NOTED** the presentation/report for information and assurance

QP/20/10 Personal Protective Equipment (PPE)

Hazel Buchanan was welcomed to the meeting and presented this item in the form of a presentation. The following key points were highlighted:

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(a) A shortage of PPE was recognised early on in the Covid-19 response, impacted by a complicated NHS supply chain causing PPE to be sourced by a variety of measures, sometimes desperate, within a context of continually changing guidance.
(b) A description was provided as to what constitutes PPE, from Fit Test Kits to hand sanitiser and scrubs. There has been a shortages of all items, with particular challenges regarding failure/pass rates and respirator masks; hand sanitiser availability ranging from none to some being currently available and wipes and scrubs needed for different settings.
(c) Provision of PPE is being prioritised to those who undertake home visits with Continuing Healthcare and Personal Health Budgets influencing this area. Provision also extends to general practices, the Clinical Management Centres and out of hours centres. The CCG is also assisting Primary Integrated Care Services (PICS) and Nottingham CityCare Partnership.
(d) Six dental hubs have been set up and informed to access PPE via the CCG for support with transport services should they be unable to source their own.
(e) Provision is on a just-in-time basis and the CCG now has a stock room and distribution system at Standard Court.
(f) Within the local sourcing market, opportunities for profiteering are becoming evident and affecting prices.
(g) Mutual aid has been administered and considerable donations received from the education sector initially. The University of Nottingham has been successful in developing a reusable visor which has been awarded the CE Mark of conformity
(h) Since the start of the crisis, £490,000 has been spent on PPE.
(i) Volunteer and military support regarding supply and distribution has been excellent, however not sustainable as workers in this sector are returning to work.
(j) Moving forwards, a twelve month strategy, considering market factors, will focus on continuing to supply and distribute PPE across the system; establishing a contingency stockpile and moving to reusables where practically possible. This will be presented at a future Committee meeting.
(k) Work with the Local Authorities and Trusts will continue and is similar to national practice.
(l) The National Portal is due to go live in July following Nottinghamshire tests and will provide more confidence of PPE availability.
(m) The response to the Covid-19 situation will need to be dynamic as the situation continues to develop.

The following points were made in discussion:
(n) Committee members recognised the extent of local support and that the National Portal (for GPs and Care Homes initially) should assist with alleviating pressure on the CCG. Dentists are keen to be included and this is being pursued. From a pharmacy perspective, large chains had already stockpiled PPE supplies, however, smaller independent businesses have struggled. Portal access needs to be addressed for these key businesses as they are in the front line.

The Committee:

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- **RECEIVED** and **NOTED** the presentation/report for information and assurance

ACTION:
Hazel Buchanan will present a twelve month PPE strategy at the July meeting of the Committee.

QP/20/11 Equality Quality Impact Assessments (EQIA)

Esther Gaskill was welcomed to the meeting and presented this item. The following key points were highlighted:

(a) The paper provided an overview of the emergency processes in place to ensure EQIAs are quickly expedited.
(b) Of all the EQIAs received, the majority are around the establishment of Clinical Management Centres (CMCs).
(c) Common themes concerning the majority of adverse impacts identified are regarding services moving away from face to face contact to video alternative, in particular the effect on patients whose first language is not English, or those who use sign language.
(d) CMC patients may have to travel further to access GP services.
(e) Some of the services have changed and may want to keep changes in place. Where this is the case, the EQIAs will need to be revisited.

The following points were made in discussion:
(f) The EQIAs are in response to the impacts of Covid-19 and the CCG response for those who have protected characteristics. This is the mechanism used to monitor, mitigate and respond and is a process that works widely. However, the CCG will need to mitigate through the recovery phase where there is an impact.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance

Quality and Performance of Commissioned Services

QP/20/12 Quality Report

Rosa Waddingham presented this item. The following key points were highlighted:

(a) On this occasion, the Quality Report is separate to the Integrated Performance Report (IPR) as the latter is currently still being developed
(b) The report provides assurance of active oversight across the system, covering intelligence and information received and updates around statutory functions and transformation.
(c) Urgent care and mental health have presented in a different way, work is underway

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to respond to this and to learn for the future.

(d) Nottinghamshire Healthcare NHS Foundation Trust (NHT) continues to work to address the issues of concern arising from the recent Care Quality Commission (CQC) reports and other concerns identified by Commissioners. Meetings relating to Rampton Hospital and the Lucy Wade unit have taken place, the discussions of which will be presented at a future Committee meeting.

(e) The CQC have published the report regarding SFH, who have achieved an overall trust quality rating of good with outstanding in the caring domain and for Kings Mill Hospital. End of Life care at Newark Hospital is in development and was rated as requires improvement overall.

(f) Primary Care and enhanced surveillance conversations have continued in a virtual format.

(g) Oversight of Methicillin-resistant staphylococcus aureus (MRSA) is being maintained and detailed in the report.

(h) Work with the Safeguarding Boards is taking place as part of the recovery and restoration phase.

The following points were made in discussion:

(i) Members were concerned that whilst safeguarding services remained business as usual, referrals were down and the usual routes of referral were not working as normal, for example schools; sports clubs etc.

(j) It was noted that there has been an increase in members of the public accessing helplines around abuse and domestic violence. It was explained, that Safeguarding Boards have addressed how to actively reach out to communities, alongside awareness raising initiatives such as Every Contact Counts. Multi-agency Safeguarding Hub (MASH) referrals are reverting back to Pre-Covid-19 levels and Domestic Violence will be an area of increasing focus in the coming months, especially as there may well be a surge of referrals once schools were back

(k) The Safeguarding team has been involved in national work regarding Covid-19 and feeding in to the Safeguarding Boards.

(l) Members were informed that no quality concerns regarding safeguarding have been received.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance

ACTION:
Danni Burnett will provide an update regarding the NHT Improvement Plan plus a review on the progress of the actions agreed following the Risk Scoping Exercise during February/March 2020**.** This will be added to the meeting forward plan.

QP/20/13 **Performance Report**

Andy Hall presented this item consisting of an exception report and 2019/20 Integrated

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Quality and Performance Report for Quarter Four. The following key points were highlighted:

(a) The Committee received the outturn report of 2019-20, up to the end of the financial year.
(b) The key indicators that NHSE/I use to assess the CCG's performance were summarised for the benefit of new Committee members.
(c) In a letter of 28 March 2020, NHSE/I set out the approach to the performance and quality standards that are most directly impacted by the Covid-19. The letter provided clarity on the range of indicators that will continue to be monitored and managed during the Covid-19 pandemic and those that will be suspended for a three month period. The following indicators will continue to be monitored and actively managed:
   - A&E and Ambulance performance – monitoring and management against the four–hour standard and ambulance performance (Ambulance Quality Indicators: System Indicators)
   - Referral to Treatment (RTT) – monitoring and management of RTT ambitions will continue. Therefore, recording of clock starts and stops will continue in line with current practice. However, financial sanctions relating to beaches of the 52+ week waiting will be suspended.
   - Cancer – monitoring and management of cancer treatment will continue. In addition, data to support the 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1 April) will still be collected, but will not be reported until the 2020-21 reporting year.
(d) Since the Covid-19 issue, Accident and Emergency (A&E) attendances are down, a 55% reduction in typical attendees. Regarding case mix and severity, minors are down by 85%. However, in line with the reported national position a reduction of cardio-vascular disease events has also been recorded, triggering national media coverage to encourage patients to call 111 or their GP. Due to the reduction in emergency admissions, A&E performance has improved with SFH at 96.5% along with increased bed capacity.
(e) Electives have seen a 60% reduction in GP referrals going into secondary care.
(f) Of concern is a reduction of two-week wait cancer referrals by around a third compared to the level seen in the previous year. Nottingham University Hospitals NHS Trust (NUH) have been actively engaging with the private sector and sub-contracting activity increasing the volume of cancer patients being treated overall. The type of cancers being operated on in the private sector is limited in some cases, due to the critical care capabilities available. As a result this limits the more complex cases, increasing the length of wait for some patients. Improvement has been seen in the 31-day decision to treat since the poor January position. The new faster diagnosis cancer standard is included within the IPR for April 2020 onwards.
(g) The treatment of patients waiting for routine elective treatment has largely been suspended from mid-March at both NUH and SFH. This has had a relatively small impact on the RTT performance due to the reduction in elective referrals into the Trusts.
(h) Although there is an overall reduction in waiting list volumes, the shape of the list

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has shifted. Demand is expected to increase when patients start to present in primary care. The CCG is working with providers to plan the recovery and restoration phase whilst addressing clinical priorities and waiting lists.

(i) Diagnostic services during quarter four, has seen a reduction in activity with an April position of 54% waiting more than six weeks, against a standard of 1%. Clinical priorities are being actioned by both acute Trusts.

(j) Magnetic Resonance Imaging (MRI) has the largest percentage breaching the standard. The use of the private sector, in particular, the Woodthorpe Ramsey Hospital will support the recovery of performance.

(k) Improving Access to Psychological Therapies (IAPT) challenges exist around patients entering the service. An Integrated Care System (ICS) deep dive is taking place and will feature in the Covid-19 recovery plan.

(l) Children and younger people eating disorder services have improved, however, the former Mansfield and Ashfield CCG failed the March standard.

The following points were made in discussion:

(m) It was noted that a large amount of work has been identified for the restoration and recovery cell to address. The high demand for recovery planning requires further information to form a better picture of the underlying demand for services. Work continues with primary care to track uptake. The restoration work, led by Nina Ennis, has received national recognition and intends to cover initial restart followed by reviewing the rest of the year and beyond (reset process).

(n) Members commented on the good working response at SFH A&E department with improved patient flow prompt decision making and a reduction in minors, noting that public behavior has been a key factor.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance, and:
- **NOTED** the remedial actions being taken to recover performance standards laid out in section three of the report.
- **NOTED** the work being undertaken to Restore services and Recover performance following the outbreak of Covid-19

Reports / Policies

QP/20/14 Learning Disabilities Mortality Review (LeDeR)

Paula Hawkins was welcomed to the meeting and presented this item. The following key points were highlighted:

(a) The report provides an update on the implementation, progress and learning from the LeDeR reviews that have been carried out following the deaths of Nottingham City citizens with learning disabilities and/or autism. The report reflects the excellent performance that has been achieved since the February 2019, where completed reviews have increased from 2% to 92%. The input of private

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consultancy in Care and Treatment reviews has been fundamental in the quality of the reports.

(b) The recommendations within the report are for the Safeguarding Boards.

(c) Paula is the local area contact leader, chairing the steering group, quality review meetings and provides quality assurance of the reviews and analysis. The steering group has wide representation from all sectors.

(d) Consideration will be given to the representation of the steering group given that data has highlighted prevalence rates relating to pneumonia/aspiration pneumonia and cancer.

(e) Work will continue to progress, taking into account valuable learning, highlighted themes and pattern and evidence collated.

The following points were made in discussion:

(f) Members were encouraged by the tremendous progress that has been made in completion of reviews in a timely manner and were interested to receive an update on further developments.

(g) Members noted the need now to focus on the themes arising from the reviews – higher numbers of learning disability patients die in hospital; lack of end of life planning; pneumonia care in the city; sepsis and uptake of annual health checks in general practice

(h) A positive increase in referrals from primary care is being seen, with a good response from the community. Black, Asian and Minority Ethnic (BAME) referrals along with private providers/residential care homes or supported living need to be improved.

(i) Easy read documents will be a continuing feature of reports. The Committee agreed the publication of the easy read report.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance
- **AGREED** to the publishing of the easy read report.
- **ENDORSED** the CCG's approach.

Paula Hawkins left the meeting.

QP/20/15 Patient Experience Policy

Esther Gaskill presented this item. The following key points were highlighted:

(a) The policy is updated to reflect the single CCG ensuring the fulfillment of its statutory requirements.

(b) Building on lessons learned, changes have been incorporated regarding the unreasonable contact process which includes a communications management plan in the event of the process being enacted.

The following points were made in discussion:

(c) Members enquired if there are some complaints for which the CCG is not an

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access point. The process will be clarified and added as an appendix to the policy.
(d) The complaints log cannot be shared as it contains patient identifiable data.

ACTION:
Esther Gaskill will append the policy with the process for receipt of complaints where the CCG is not an access point.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance.
- **APPROVED** the CCG's Patient Experience, Complaints and Enquiries Policy 2020-2023 subject to the incorporation of the process for the receipt of complaints where the CCG is not an access point.

Risk Management

QP/20/16 **Risk Report**

Sian Gascoigne was welcomed to the meeting and presented this item. The following key points were highlighted:

(a) The format of the report continues to be the same as presented to the Quality, Safeguarding and Performance Committees of the predecessor CCGs.
(b) There are nine risks pertaining to the Committee's responsibilities, an increase of three since the last meeting. The new risks have portioned one Covid-19 risk (RR 122) into components parts following a review and Governing Body approval.
(c) Comments from the Committee are sought regarding the new risks.
(d) The Committee is asked to approval archiving of risk RR122.

The following points were made in discussion:
(e) Members felt that reducing the risk score from 20 to 16 for RR116 (NHT) is premature and that further evidence of continuing improvement should be received before this is amended. As a report will be provided at the Committee's next meeting, the risk will remain recorded as 20 and be reviewed then.
(f) Risk RR129 will be amended to read "but not directly as a result of" in relation to the impact of Covid-19 and related deaths.

ACTION:
Siân Gascoigne will amend the wording of risk RR129 in relation to the indirect impact of Covid-19 on excess deaths.

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- **APPROVED** the archiving of risk **RR 122;**
- **COMMENTED** on the risks shown within this paper (including the high/**red** risks) and those at **Appendix A**.

Closing Items

QP/20/17 **Any other business**

There was no other business discussed.

QP/20/18 **Key Messages to escalate to the Governing Body**

The following key messages for the Governing Body were highlighted:

- Assurance around the Covid-19 response relating to Care Homes and Home Care; Swabbing and Testing; PPE; EQIAs and Safeguarding.
- Concerns around the Covid-19 impact on long waiters; cancer backlog and the future demand for services as public confidence increases.
- The reduction in the number of patients referred to IAPT and the forthcoming deep dive by the ICS.
- Progress and achievement of LeDeR and the challenges going forwards.

QP/20/19 **Date of next meeting**

Thursday 25 June 2020 virtually, via MS Teams

Nottingham and Nottinghamshire
Clinical Commissioning Group

Quality and Performance Committee
Ratified minutes of the meeting held on 25/06/2020, 09:00 – 12:25
MS Teams

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Dr Manik Arora	GP Representative
Mindy Bassi	Chief Pharmacist
Danni Burnett	Deputy Chief Nurse
Sue Clague	Non-Executive Director
Andy Hall	Associate Director of Performance and Information
Dr Hilary Lovelock	GP Representative
Stuart Poynor	Chief Finance Officer
Dr Richard Stratton	GP Representative
Jon Towler	Non-Executive Director
Rosa Waddingham	Chief Nurse

In attendance:

Maxine Bunn	Associate Director of Commissioning, Contracting and Performance – Mental Health and Community
Rhonda Christian	Head of Adult Safeguarding for agenda item QP/20/028
Fiona Daws	Corporate Governance Officer (minutes)
Lisa Durant	Director of Commissioning (Mid-Notts)
Siân Gascoigne	Head of Corporate Assurance
Robana Hussain-Mills	Head of Professional Standards and Leadership, Deputy Clinical Director, PCN Nottingham City East for agenda items QP/20/026 and QP/20/027
Dr Laura James	GP attending in an observation capacity
Sandy Smith	Assistant Director for Quality Assurance for agenda item QP/20/029
Gemma Waring	Head of Human Resources, for agenda item QP/20/026

Apologies:

Nina Ennis	Associate Director of Joint Commissioning and Planned Care

Cumulative Record of Members Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Dr Manik Arora	2	2	Mindy Bassi	2	2
Danni Burnett	2	2	Sue Clague	2	2
Eleri de Gilbert	2	2	Andy Hall	2	2
Nina Ennis	2	0	Stuart Poynor	2	2

Cumulative Record of Members Attendance (2020/21)					
Dr Hilary Lovelock	2	2	Jon Towler	2	2
Dr Richard Stratton	2	2			
Rosa Waddingham	2	2			

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Introductory Items

QP/20/020 **Welcome and Apologies for Absence**

Eleri de Gilbert welcomed everyone to the Quality and Performance Committee of NHS Nottingham and Nottinghamshire CCG, which was being held virtually due to the Covid-19 pandemic.

Apologies were noted as above.

QP/20/021 **Confirmation of Quoracy**

It was confirmed that the meeting was quorate.

QP/20/022 **Declaration of interest for any item on the agenda**

No interests were declared in relation to any other item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

QP/20/023 **Management of any real or perceived conflicts of interest**

As no conflicts of interest had been identified, this item was not necessary for the meeting.

QP/20/024 **Minutes of the meeting held on 28 May 2020**

It was agreed that the minutes were an accurate record of the meeting.

QP/20/025 **Action log and matters arising from the meeting held on 28 May 2020**

All actions were noted as completed (and can be closed). There were no further matters arising.

Eleri de Gilbert provided feedback from the Governing Body meeting held on 3 June 2020 where it was requested that changes to the Integrated Performance Report (IPR), at this Committee and the Governing Body, be aligned to that which is also reported to the Integrated Care System (ICS). The importance of "one version of the truth" was emphasised and also for the IPR to evidence how the ICS outcomes framework is being progressed. The Governing Body had supported that the IPR should be clear around providing assurance and identifying risks to delivery for the CCG. Also

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requested was that the Committee is to seek more qualitative data around safeguarding and to receive assurance around capacity to respond to any surge in referrals post lockdown.

It was agreed these issues raised at Governing Body would be reflected later in the meeting when considering the IPR and Safeguarding assurance.

Assurance in the Context of Response to Covid- 19

QP/20/026 **Workforce and Wellbeing**

Gemma Waring presented this item, highlighting the following key points:

Wellbeing Survey

(a) The presentation provides an update and insight into the actions taken across the CCG in relation to Workforce and Wellbeing; how health partners have responded during the Covid-19 pandemic and illustrates the response to the incident including challenges, good practice and shared learning.
(b) Within Nottingham and Nottinghamshire CCG a recent staff wellbeing survey was conducted to gauge feelings of the new working arrangements at a point in time.
(c) Respondents were asked five questions with the opportunity to add comments. A total of 196 anonymous responses were received.
(d) The results showed that the majority of staff (almost 60%) were feeling good at the time of responding. 80% responded that they felt supported by their line manager. Challenges identified have been categorised in to themes of: mental wellbeing; childcare responsibilities; equipment; agile working; line manager support and objectives/direction.
(e) Where areas of concern or challenge have been raised, mitigating and supportive interventions have been put in place as outlined within the presentation.

System Workforce Response

(f) The impact of Covid-19 on the frontline workforce has been well documented by the national media.
(g) Concerns exist around redeploying staff into areas managing the Covid-19 response and bringing non-practicing clinicians back to frontline work.
(h) System redeployment has primarily been kept to moving staff within their existing Trust, although processes were established to move staff around the system if it were required.
(i) Bringing non-practicing clinicians back has been managed successfully within Nottingham University Hospitals NHS Trust (NUH), Sherwood Forest Hospitals NHS Foundation Trust (SFH) and Nottinghamshire Healthcare NHS Foundation Trust (NHT). The Trusts are now looking at ways to retain these staff on a more permanent basis.
(j) As a local system, the CCG has implemented wellbeing initiatives for staff on the front line, further supported by the development of a Black and Minority Ethnic (BAME) nursing, midwifery and allied health professionals' network.

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(k) NUH have established a staff Covid-19 BAME group to feedback any concerns or worries they may have. A BAME lead exists in each Trust and also in CityCare Partnership.

(l) In partnership with NHS England/Improvement (NHSEI) and Nottinghamshire Alliance of Training Hubs, funding has been secured for the Shiny Mind Wellbeing App and is being introduced to al community, care home and home care staff.

(m) In acute care initiatives are in place to provide psychological support to Intensive Care Unit (ICU) and Emergency Department (ED) staff.

(n) The Local Medical Committee (LMC) has a free mentoring service open to all GPs and Primary Care nurses.

(o) The People and Culture Board will have a staff wellbeing group sitting under Human Resource and Organisational Development Committee (HRODC) to feedback concern.

Vulnerable Staff Risk Assessment

(p) NHS England/Improvement (NHSEI) initially requested that all NHS staff that declared their ethnicity as Black or Minority Ethnic undertake a risk assessment due to the disproportionate effect that Covid-19 was having on the BAME community.

(q) The CCG took the decision to risk assess all staff that were considered clinically vulnerable under NHSEI's definition.

(r) Risk assessment highlighted concerns relating to caring responsibilities, returning to the office, public transport, isolation and childcare/home schooling.

(s) Actions have been taken as appropriate to mitigate the level of risk to this vulnerable staff group.

The following points were raised in discussion:

(t) Regarding the wellbeing survey, members were encouraged by the CCG response as an employer, which is hoped will continue, and acknowledged the support mechanisms that have been put in place.

(u) Members pointed out that the survey is at a point in time and agile working as it develops further will support the easement of anxiety and uncertainty. It is planned that further work in this area is expected to produce a blended/mixed approach of both office and home working options, towards September/October.

(v) It was highlighted that an enhanced set of leadership skills and corresponding development programme would support middle management to better manage the challenges that have been identified.

(w) The ICS People and Culture Board have an overarching responsibility for system response from the Integrated Care System (ICS) and, along with the HRODC, have wide representation including Local Authorities and local universities. It was noted that there is an absence of Primary Care representation but this is under review.

(x) Members were keen to know sickness levels across the system and resultant impact on services/pandemic response. It was noted that NUH and SFH have not been reporting high levels of sickness absence and that psychological support services had been put in place for staff.

(y) It was noted that the primary care staffing picture is not straight forward and data was unavailable for the Committee. Operational Priority Escalation Level (OPEL)

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reporting did, however, consider staffing as part of the consideration in terms viability and sustainability of practices and was being monitored by the Primary Care Cell and Primary Care Commissioning Committee

(z) Members queried whether accrued annual leave could affect recovery and restoration capacity. It was confirmed that this was being addressed by organisations in a flexible manner to avoid impact on capacity especially over winter.

(aa) Members expressed interest in plans regarding retaining returning staff and the cost and usage. In the past, providers have relied heavily on bank and agency staff.

(bb) Regarding the vulnerable staff risk assessment, members highlighted that obesity should be noted as within the long term condition category due to its associated risk factor. It was noted, however, that this is a sensitive area and staff would need to self-identify.

(cc) It was clarified that the report focusses on HR type metrics for providers; however, it was felt that the CCG does not routinely hold itself accountable in the same way via internal quality and performance measures.

(dd) Members queried whether the Quality and Performance Committee was the correct forum to receive assurance regarding internal CCG workforce. It was highlighted that consideration was being given to expanding the role of the Finance and Turnaround Committee to consider internal CCG performance and transformation. It was agreed that an action would be taken to confirm which Committee assurance regarding internal CCG HR and workforce matters would be considered, recognising the benefit of the Quality and Performance Committee having comparative data around CCG performance, given that it monitored workforce metrics for commissioned services.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance.

QP/20/027 Health Inequalities

Robana Hussain-Mills presented this item, highlighting the following key points:

(a) The discussion paper summarises actions taken during the pandemic to date to address health inequalities and includes risk assessment, mitigation and next steps in relation to the CCG response.

(b) A summary of the Equality, Quality Impact Assessment presented at the May Committee meeting highlighted local themes of the impact of service changes on disadvantaged groups and those groups in most need.

(c) In response to concerns highlighted around the impact on those people not seeking health advice, prompted by the significant reduction in two week wait cancer referrals, a series of local, regional and national campaigns were adopted to encourage people to go to their GP.

(d) Advice given to those whose treatment or diagnostic tests have been postponed has been helped by proactive signposting and direct patient contact from specialist

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teams regarding care planning during this time.

(e) Various initiatives have been supported to improve access and communication, including increased support from interpretation and translations services; a free taxi service for patients needing to attend a clinical management centre; Primary Care extended and virtual appointments; support from NEMS with Clinical Assessment Service during peaks in calls to 111. Work is underway to better understand the implications around vulnerable and shielding patients' needs.

(f) On-going work across the system has identified high risk populations and helped to identify those individuals within receipt of community and mental health care along with an understanding of the distribution of risk across deprivation and ethnic groups.

(g) A review is being undertaken of the demographics of those with increased support needs, for example, domestic violence victims and the traveller community, and work with both Public Health and Local Authorities is taking place to ensure services are adapting.

(h) The Designated Clinical Officer (DCO) and partners are reviewing the impact on services and developing recovery plans for those with Special Educational Needs and Disabilities (SEND).

(i) The Local Authorities have provided hotel accommodation for the homeless population with support from outreach services and GPs have adjusted the provision of commissioning via the Local Enhanced Services to provide on-call support.

(j) Meeting the needs of local asylum seekers has been via accelerated assessment of health and care needs during their hotel residence, facilitating access to appropriate care, remotely, wherever possible.

(k) Various actions have been undertaken to improve discharge and support, for example, two community hubs have been developed by the Local Authorities; collaborative working is taking place within the voluntary sector, councils and Primary Care Network link workers; launch of a free grief support helpline and mobilised discharge to assess pathways across the system.

(l) Health risk factors such as pregnancy, have been supported with the implementation of Florence Simple Telehealth (FLO) for women in order to continue surveillance whilst social distancing. Community services areas of respiratory and end of life have been deemed clinical priorities following national guidance and have been enacted. Medium and lower priority work has been suspended, however, monitoring of rising risk will continue throughout the disruption.

(m) Regarding care home residents, an Enhanced Care Home and Home Care Support offer is available which includes the use of a toolkit to support to manage the Covid-19 response including admission avoidance, discharge from hospital, medicines management, use of Personal Protective Equipment (PPE) and testing.

(n) BAME primary care and care sector workers have been supported with practice risk assessments and PPE. More broadly the CCG is working with the Local Medical Committee (LMC) to ensure joint communications to this vulnerable sector are efficiently articulated.

(o) Virtual Protected Learning Time events are starting to emerge and will capture learning from the pandemic

(p) The CCG continues to respond to concerns raised through its complaints process and patient experience team. In response to initial dental services concerns, the

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CCG checked directly with NHSE/I as to the correct information to be given to patients.

(q) Internally, equality and diversity resources have also been utilised to support the Service Change Cell. Vulnerable staff groups' risk assessments have been launched and mitigations implemented where appropriate.

(r) As recovery and restoration comes into focus, plans are being developed which include responding to the impact on health inequalities.

The following points were made in discussion:

(s) Members enquired whether the CCG is similar to the national picture regarding health inequalities and whether any proxy measures are available as no real data was being presented to support the local position. The CCG needs further data and an outline of what systematic action is needed to tackle the underlying causes of health inequalities.

(t) Members requested that communications and engagement effectiveness be measured and linked in with the Patient Participation and Engagement Committee (PPEC) and that the guidance be written in simple English.

(u) Further information from the data cell, Public Health, and the Health Scrutiny Committee will inform the ongoing work in this area along with the incorporation of PPEC input. Engagement work is being undertaken across the system and will feed into a more comprehensive update report to be presented to the Committee at its August meeting.

(v) Members enquired as to the next steps for those who are shielding. It was confirmed that letters from individual practices are due to be circulated to patients. A consistent approach was being coordinated by the CCG due to public confusion caused by the national inconsistent messages.

The Committee:

- **RECEIVED** and **NOTED** the CCG response and involvement to addressing health inequalities during COVID-19.
- **DISCUSSED** and **AGREED** the draft risk assessment.

ACTION:

Robana Hussain-Mills will present an updated and comprehensive report regarding health inequalities, linking in to system health management work, to the Committee at its August meeting.

QP/20/028 **Safeguarding**

Rhonda Christian was welcomed to the meeting to present this item and highlighted the following key points:

(a) The presentation provides an insight into the themes and actions taken across the CCG in relation to the safeguarding agenda during the Covid-19 pandemic.

(b) The impact of Covid-19 has brought faster escalation of concerns and accelerated

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solutions, however, common language and consistent messaging has been highlighted as a challenge to address.

(c) The Safeguarding Commissioning Assurance Toolkit links directly to the NHS Safeguarding Accountability and Assurance Framework. The CCG is part of a pilot for the new tool, completing the "commissioner" toolkit. The launch has been delayed until 1 October 2020 to confirm whether this will be the continuation of the pilot or the full launch. It is planned that the toolkit will be submitted to the CCG's Governing Body and shared with this Committee. Discussions will be initiated by NHSE/I with Chief Nurses from which actions plans will be formulated. NHSE/I will then follow up with checks against the action plan.

(d) The repercussions of the Covid-19 lockdown has caused people to be "hidden from view".

(e) Increased call volume has been reported by Domestic Abuse helplines and Childline and a reduction in referrals experienced by non-accidental injury and Child Sexual Exploitation (CSE) medical examinations and the Multi-Agency Safeguarding Hub (MASH).

(f) All statutory functions have been maintained with modified responses in areas.

(g) As a team, mobilisation has taken place alongside an increase in partnership meetings to ensure an "at time" response. The development of a Risk and Recovery Incident Log has helped support the identification of risks to be encompassed within the recovery plan.

(h) Regular information sharing has taken place via the TeamNet platform as a single point of call as well as the utilisation of System Connect regarding daily safeguarding calls.

(i) Safeguarding colleagues have been deployed into the Clinical Safety & Quality Cell to provide wider support.

(j) NHSE/I have been provided with a weekly assurance report.

(k) The CCG has responded to the safeguarding challenges with support to: Asylum Seekers; those seeking emergency accommodation; reviewing queries regarding unsafe/delayed transfers of care; deprivation of liberty and consent advice; maternity services and the Care Home and Home Care sector.

(l) Data regarding the challenges and experiences will need to be captured and learned from.

(m) Multi-agency Risk Assessment Conference (MARACs) are experiencing high numbers of cases within each meeting, however, virtual meeting arrangements are proving to be positive.

(n) No domestic homicides have been reported, although calls have increased to helplines. Where a refuge is required, the option of a hotel has been utilised.

(o) Focus is needed on children and young people, especially the unheard and the untold, which is a recognised challenge, along with focus on care home and domiciliary care of residents and families.

The following points were made in discussion:

(p) Members felt assured by the good work that has been carried out and noted that GPs are appreciative of the information and guidance received.

(q) Noting that referral levels have decreased, in particular from schools and Accident and Emergency (A&E) departments, members felt that the public should be more

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responsible in reporting any concerns regarding safeguarding. Conversations are taking place within the local safeguarding partnership and these include inequalities, however, it is acknowledged that there is an element of unknown safeguarding concerns. The CCG has sought assurances that everything is being done that can be done. Additionally, the Safeguarding Boards have altered their priorities to include understanding on the impact of Covid-19 on those who are vulnerable.

(r) It was noted that capacity was under review across the partnership to address any future surges in referrals.

The Committee:

- **RECEIVED** and **NOTED** the presentation and actions in relation to Regional Insights.

Quality and Performance of Commissioned Services

QP/20/029 Nottinghamshire Healthcare NHS Foundation Trust Quality Assurance Update

Sandy Smith was welcomed to the meeting and presented this item regarding Nottinghamshire Healthcare NHS Foundation Trust (including Trust Improvement Plan and Risk Scoping Exercise Progress)

The following key points were highlighted:

(a) The presentation outlines the extensive work that has been undertaken by the Trust to review, restructure and re-align governance and reporting mechanisms to improve oversight and consistency with an increased focus on quality.
(b) A Board to Board meeting has been arranged for Tuesday 30 June.
(c) A summary of chronological key events that the Trust has experienced was provided and included executive leadership changes, significant events and Care Quality Commission inspections and reports.
(d) Of particular note was the Channel 4 documentary “losing it; our mental health emergency” where NHT opened its door to cameras to reveal what it means to be in crisis, depicting an unprecedented rise in demand for services as well as the challenges that this has posed to staff.
(e) The Trust has been an Award finalist for Reducing Out of Area Placements, an area where significant improvements have been made.
(f) Regarding Care Quality Commission (CQC) updates, the Lucy Wade Unit at Millbrook Hospital has had admission restrictions lifted due to the Trust providing significant assurance. Rampton Hospital’s risk review has received a positive response and actions fed into the improvement plan.
(g) Examples of evidence of improvement have been seen in the areas of workforce, culture and values, physical healthcare, clinical leadership, patient and staff experience and safety.
(h) An improved trend in staff absence levels is evident despite the Covid-19 situation and the Trust has continued to undertake staff appraisals.
(i) A regional service is in place should there be a Covid-19 second wave.

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(j) In specific response to Covid-19 the Trust has taken various actions including a focus on patient and staff experience; working virtually; dedicated teams for PPE, uniforms and staff support; Covid-19 structure and governance; specific discharge cells and enhanced support to care homes; staff training and support for essential and new skills including returners and bank staff; involvement in NHS Confederation/Good Governance Institute Chairs' meeting and informing Trust Restoration Plans with Covid-19 learning.
(k) A Quality Assurance Group has been established with the first meeting planned for 30 July 2020, led by the CCG with invitations to Associate Commissioners.
(l) A review is taking place regarding Serious Incident reports to mitigate the backlog.
(m) It was summarised that extensive work has been undertaken by the Trust to review, restructure and re-align governance and reporting mechanisms. Recent risk review meetings and monitoring of associated action plans provide a good level of assurance and improvement which regulators are encouraged by. The Trust has responded well to the pandemic in areas of resourcing, training, staff wellbeing, equality and diversity, engagement and communication.

The following points were made in discussion:
(n) Further work on improving how mental health and physical health services work together is required. Members felt that community services strands were seen as less of a priority and queried the clinical leadership in this area. It was acknowledged that the Trust is aware that this area is a pressure point and is due for discussion at their next meeting. There is some commonality between the services across the Trust footprint, however, the CCG no longer work to that footprint.
(o) The risk score relating to NHT will remain the same for now but will be updated following the Board to Board meeting. It was, however, recognised that the Trust is working positively with the CCG and proactively working across the system in terms of response to the Covid 19 pandemic – including community services

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance.

ACTION:
Danni Burnett will provide an update at a future Committee meeting and the risk score will be reviewed following the Board to Board meeting.

QP/20/030 **Integrated Performance Report**

Andy Hall presented this item which included a review of Covid-19 elements and report accessibility. The following key points were highlighted:

(a) The report has been modified with a highlighted executive summary, risks and gaps in assurance. Performance is illustrated as one CCG; however, in some cases information is available at a more granular level for providers which is helpful in identifying issues as they arise.

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(b) The narrative around root cause, assurance and gaps is still being developed.
(c) The general theme around performance is focusing on Covid-19 response.
(d) Elective care has further deteriorated due to acute provider capacity.
(e) Urgent care services are performing well due to reduced demand.
(f) The measured performance against mental health service standards remains good overall with low waiting times for patients accessing services.
(g) Referral to Treatment (RTT) performance figures reflect Trust totals and cover all specialties. A further reduction has been seen in waiting list volume with a corresponding drop off in referrals, which is stabilising. An increase in 52-week waiters is evident, due to a change in the shape of the waiting list but is similar to the national position. Recovery cells are reviewing this whilst maintaining social distancing and ensuring capacity for a potential second wave.
(h) RTT diagnostics have worsened slightly at the end of May with 59% of patients waiting against the 1% target, which has received media attention and affects all modalities. Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and Non-obstetric ultrasound diagnostics are experiencing a high volume of patients waiting longer than six weeks, which is being mitigated through use of the private sector.
(i) Referrals to cancer services remain low with 70% of referrals being seen. The use of the independent sector on cancer performance has been positive (other than in the faster diagnosis standard). The backlog of waiting times against the 62 day wait cancer standard has increased. A need exists to target long waiting patients across both Trusts and performance has plateaued during the early weeks of June. Work within the recovery cells and developing plans is providing assurance. Increased demand from primary care will factor in developing models which include a recovery profile with providers whilst maintaining a 70% bed occupancy.
(j) Urgent care has experienced a reduction in activity, with performance improvement being see in both A&E and ambulance services, again, largely due to the limited level of activity but also due to elective care and the cancellation of services to maximise bed availability. The recovery cell is aiming to maintain flexible bed occupancy levels.
(k) Mental health services have seen a reduction in demand which is concerning as people are not attending. Improving Access to Psychological Therapies (IAPT) is performing well, however, ensuring patient access is challenging.
(l) Access to some diagnostic services is seen to be affecting confirmation of dementia diagnosis.
(m) Children and young people eating disorders, whilst performance is fair, concern is around parents not coming forward due to Covid-19. This is recognised across all mental health services. Members highlighted that Committee members could be better sighted on mental health performance by the inclusion of five other national standards not currently reported in the Integrated Performance Report (IPR). Members agreed that going forward these standards will be incorporated.

The following points were made in discussion:

(n) Members enquired as to the proportion of outpatients being seen virtually. Figures suggest between 16% and 30% of activity taking place via this route, however, providers are stating a level nearer to 70%, the difference existing due to possible

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variations around how this is being recorded across specialties.

(o) Regarding RTT diagnostics members felt that letters to patients informing them of a delay in being seen is an interim measure rather than a change in process. Pieces of work within the recovery cell links in with the Clinical Design Authority around this.

(p) Members were keen to know who owns the commentary regarding regional and national cancer diagnostics. Simon Castle works across the CCG on cancer services and is engaged with the East Midlands Cancer Alliance.

(q) The ICS atlas framework, in relation to mental health, has been extensively considered, however issues exist where relevant data isn't collected. A CCG approach to developing the process to capture baseline data to improve indicators would be necessary.

(r) Members suggested a report on the system transformation priorities, incorporating proxy measures such as life expectancy, which is part of the health inequalities work. A new ICS performance report executive draft exists, however, reporting needs to be consistent and within one report across the system. Further work is required to gain more information and will be reported at the next Committee meeting.

(s) It is intended that the recovery cell will develop a series of metrics mapped over time including statutory themes that are required to be reported.

(t) A move to population health is expected to evolve from provider performance. It was noted that 90% of mental health is dealt with within primary care, although not currently reported for community services within the IPR.

(u) Members noted that the Committee is not sighted on Primary Care performance, it is discussed within the remit of the Primary Care Commissioning Committee.

The Committee:

- **RECEIVED** and **NOTED** the report and its content for information and assurance.
- **NOTED** and welcomed the new narrative throughout the report which seeks to identify:
    - The root cause of performance issues being reported?
    - What mitigating actions are in place to recover performance?
    - What assurance can be given to its sustainability?
    - Are there any gaps in assurances?
- **NOTED** the work being undertaken to Restore services and Recover performance following the outbreak of COVID-19.

Actions:
The five national standards regarding mental health (currently not included) are to be incorporated within future Integrated Performance Reports. A report will be provided to the Committee at its next meeting in July regarding the Outcomes Framework and ICS management performance reporting to further refine and improve the IPR.

ITEM
QP/20/031 **Quality Report**

Danni Burnett presented this item. The following key points were highlighted and discussed

(a) The report provides continued oversight and understanding of the current quality and safety concerns during Covid-19 based on information and intelligence throughout the response to the pandemic. The current climate challenges are highlighted whilst detailing progress on specific programmes of work.
(b) Since the last report there has been no escalation or request for support from the Acute, Independent Sector, Community, or Mental Health.
(c) Activity and demand is manageable, although increasing, and there has been significant focus on redeployment and staff well-being.
(d) PPE has continued to be flagged and the supply chain or mutual aid is now able to respond to the current demand, however, this is monitored daily.
(e) The Urgent Care sector has been stable with an apparent emerging theme of increased Mental Health attendances, currently being investigated; however, early data does not show a significant increase.
(f) The system is in the second phase of the response with providers working through recovery and restoration plans whilst keeping monitoring capacity across all sectors.
(g) Enhanced Surveillance and support continues for Nottinghamshire Healthcare NHS Foundation Trust plus a close monitoring of twelve-hour breaches once Emergency Department attendances start to increase.
(h) Partners are coming together to respond to and work in partnership with the Care Home and Home Care Sector with the Cell leading on ensuring a strategic and operational response.
(i) Four GP Primary Care Practices across the County remain subject to enhanced surveillance. Operational Priority Escalation Levels continue to indicate a generally good position across all localities with the occasional request for additional PPE. Practices have been asked to complete an Infection Prevention and Control assessment and preparedness checklist to enable progress with the recovery phase and re-introduction of routine work and the additional face to face appointments that will be required.

The Committee:

- **RECEIVED** and **NOTED** the report for information and assurance of the approach outlined.

At this point Manik Arora, Andy Hall and Stuart Poynor left the meeting. As such the meeting was not quorate.

Risk Management

QP/20/032 **Risk Report**

Sian Gascoigne presented this item. The following key points were highlighted:

ITEM

(a) There are currently ten risks pertaining to the Committee's responsibilities within the CCG's Corporate Risk Register, which is an increase of one risk since the last meeting.
(b) There are three major (red) risks within the Committee's remit, relating to key agenda items discussed at the meeting (NHT, excess deaths and exacerbation of health inequalities). It was highlighted that the risk relating to NHT (RR 116) would remain at a score of 20. This would be reconsidered following the Board to Board meeting and further assurance being received at the July 2020 meeting.
(c) As the meeting is not quorate for this agenda item, the approval of the recommended archiving of risks RR 033 and RR 047 will be deferred to the next meeting.

There were no other discussion points raised.

The Committee:

- **DEFERRED** the archiving of risks **RR 033** and **RR 047** until the next meeting.

Information Items

QP/20/033 Patient Experience Policy

The Committee received and noted the final version of the Patient Experience Policy for information and assurance.

QP/20/034 Summary of Equality and Quality Impact Assessments (EQIA) Q1-4 2019-2020

The Committee received and noted the summary of EQIA for 2019-20 for information and assurance.

Closing Items

QP/20/035 Any other business

There was no other business discussed.

QP/20/036 Key Messages to escalate to the Governing Body

The following key messages for the Governing Body were highlighted:

The Covid-19 impact, actions and mitigations on the areas of Workforce and Wellbeing, Health Inequalities and Safeguarding.

Areas of performance concerns relating to a further deterioration of elective care standards; RTT diagnostics worsening position which has received media attention and affects all modalities; referral into cancer services remains low; performance improvement is being see in both A&E and ambulance services, largely due to the limited level of activity and the reduction in demand for mental health services.

ITEM	
QP/20/037	**Date of next meeting**
	Thursday 23 July 2020 virtually, via MS Teams

Nottingham and Nottinghamshire Clinical Commissioning Group

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Finance and Turnaround Committee
Ratified minutes of the meeting held on
27/05/2020, 9.00-10.10
MS Teams Meeting

Members present:

Shaun Beebe	Non-Executive Director (Chair)
Maxine Bunn	Associate Director of Commissioning, Contracting and Performance - Mental Health and Community
Michael Cawley	Operational Director of Finance
Lisa Durant	Director of Commissioning
Nina Ennis	Associate Director of Joint Commissioning and Planned Care
Andy Hall	Associate Director of Performance and Information
Dr James Hopkinson	Joint Clinical Leader
Andrew Morton	Operational Director of Finance
Stuart Poynor	Chief Finance Officer
Mark Sheppard	Associate Director of Commissioning, Acute Contracts
Dr Stephen Shortt	Joint Clinical Leader
Amanda Sullivan	Accountable Officer
Sue Sunderland	Non-Executive Director
Jon Towler	Non-Executive Director

In attendance:

Helen Brocklebank-Clark	Corporate Governance Officer (minutes)
Siân Gascoigne	Head of Corporate Assurance
Jack Rodber	Associate Director of Financial Recovery

Apologies:

Gary Thompson	Director of Special Projects

Cumulative Record of Members' Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Shaun Beebe	1	1	Stuart Poynor	1	1
Maxine Bunn	1	1	Mark Sheppard	1	1
Michael Cawley	1	1	Stephen Shortt	1	1
Lisa Durant	1	1	Amanda Sullivan	1	1
Nina Ennis	1	1	Sue Sunderland	1	1
Andy Hall	1	1	Gary Thompson	1	0
James Hopkinson	1	1	Jon Towler	1	1
Andrew Morton	1	1			

Introductory Items

FT 20 001 **Welcome and Apologies**
Shaun Beebe welcomed everyone to the Finance and Turnaround Committee.

Apologies were noted as above.

FT 20 002 **Confirmation of Quoracy**
The meeting was confirmed as quorate.

FT 20 003 **Declaration of interest for any item on the shared agenda**
No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

FT 20 004 **Management of any real or perceived conflicts of interest**
As no conflicts of interest had been identified, this item was not necessary for the meeting.

FT 20 005 **Ratified minutes from the predecessor CCGs' meetings in common held on 27 February 2020**
These minutes were received for information only as they had been ratified virtually on 15 April 2020.

FT 20 006 **Consolidated action log from the predecessor CCGs' Finance and Turnaround Committee meetings**
Two actions had been carried forward from the predecessor CCGs' Finance and Turnaround Committee meetings:

- Action FT 20 012: Archive risk RR 090.

  This risk was agreed for archiving under item FT 20 010 Risk Report as its impact and/or likelihood scores have reduced in line with the 2019/20 year-end financial positions for the former six Nottingham and Nottinghamshire CCGs. This action was agreed as complete.
- Action FT 20 024: Andy Hall to confirm why there is a variance between the planned and actual contractual position of the community contracts.

  Andy had confirmed with finance colleagues that the variance related to additional services which fell outside the block contract. This action was agreed as complete.

There were no matters arising.

Contracting

FT 20 007 **Cross Provider Report**

Andy Hall introduced the item and highlighted the following points:

a) This report provides an overview of financial and activity performance for the predecessor CCGs' as at month twelve, with a focus on the major acute contracts.

b) The cumulative position at month twelve deteriorated from £39.5 million to £41.8 milllion over plan. The key drivers were prescribing, and the contracts at Sherwood Forest Hospitals NHS Foundation Trust and Ramsay Woodthorpe Hospital.
c) There have been significant shifts in activity in response to Covid-19, with the closing down of elective services, and a corresponding reduction in first and follow up outpatient appointments.
d) There has been a similar reduction in non-elective activity, down to 55%, mirrored by a reduction in Emergency Department attendances which are down to 60%. This is challenging for 2020/21 activity modelling, with work taking place alongside provider colleagues to achieve a realistic understanding of the recurrent demand baseline and what it means for patient contact moving forward.
e) Alongside restoration, waiting list standards will need to be recovered and built into contracts. This will include non-recurrent activity to reduce waiting lists, the provision of which may be delivered through 2020/21 and 2021/22 onwards.

The following points were made in discussion:
f) It was explained that there are currently national block contracts in place, with an indication that these will be extended. However, as no formal notice of extension has been received work is taking place to explore what the contracts will look like moving forward.
g) It was noted that the healthcare community has utilised the Independent Sector hospitals to deliver NHS services to patients during this period, which has resulted in an improvement in cancer performance at Nottingham University Hospitals NHS Trust (NUH).
h) Restoring patient choice was discussed and it was noted that for the foreseeable future patient choice will be limited as Independent Sector hospitals are used to manage clinical risk by safely cohorting patients.

The Finance and Turnaround Committee:
- **NOTED** the report.

Financial Management

FT 20 008 **Month One Finance Report**

Michael Cawley introduced the item, highlighting the following points:

a) The report highlights an overall adverse variance position of £1.2 million (full year £25.9 million adverse) at month one, when compared to an amended balanced/ Financial Improvement Trajectory (FIT) delivery plan. This reflects that at month one, no additional resources have been received as part of the month one allocation.
b) The assessment of forecast spend is based on the CCG’s interpretation of the latest intelligence received from NHS England and NHS Improvement (NHSE/I) in relation to Covid-19, and other assumptions (including those relating to the deliverability of Quality, Innovation, Productivity and Prevention schemes).
c) Since the report was written, guidance has been provided through verbal briefings, which indicates that at month two there will be a resource adjustment. This is expected to be a monthly top up or a top slice depending on the CCG’s reporting

position; thereby allowing the CCG to report a break-even position to NHS England and its Governing Body.

d) The CCG has a Quality, Innovation, Productivity and Prevention (QIPP) target of £89.2 million, of which £57.9 million is unallocated at month one. Currently the CCG's transformation and QIPP schemes are effectively on hold, leading to a risk that identified schemes may not deliver.

The following points were made in discussion:

e) Thanks were expressed to Ian Livsey, Deputy Director of Finance as the author of the paper, for clearly explaining a complex financial position.
f) It was noted that the resource adjustments that the CCG is expecting to receive in month two will also be received by NHS Trusts, which means any variance to their top up position was also being addressed.
g) It was confirmed that the reported position did not include the CCG's contingency. However, it was anticipated that national guidance would provide further clarity on whether the CCG's contingency could continue to be held in reserve.
h) It was emphasised that although the current financial position will change and shape over the coming month, the financial position prior to the Covid-19 pandemic was challenging, and remains so.
i) Confirmation was received that a further £16 million of QIPP schemes have been identified, however these are yet to be worked up and risk rated. The role of the Recovery Cell in supporting the identification and allocation of QIPP schemes was queried. It was explained that this responsibility would reside with the Financial Sustainability Group which had been refreshed to enable broader conversations to take place regarding the financial sustainability of the Integrated Care System (ICS) as a whole. However, this did not preclude the possibility of establishing a forum, internally to the CCG, with oversight for QIPP scheme identification and delivery.
j) Assurance was received that the terms of reference for the Recovery Cell and the Financial Sustainability Group were being progressed and the membership was such that each fora would understand its role and remit in relation to the other.
k) Further discussion regarding QIPP and the realisation of some of the system wide opportunities that have emerged in response to the Covid-19 pandemic would be further explored in coming months.
l) Confidence was expressed that the costs submitted for Covid-19 at month one would be reimbursed in full as they have been robustly scrutinised via the CCG's governance processes.
m) Discussion took place as to whether any work was taking place to gauge patient perception in relation to how they are currently accessing services with a view to understanding how to improve patient flow moving forward. It was noted that this was being progressed by the CCG's Engagement Team, as embedding online triage and the minor conditions pathways that have emerged in response to Covid-19 is a priority for diverting patients away from unnecessary attendance at the Emergency Department.

The Finance and Turnaround Committee:

- **NOTED** the financial position of the CCG for the reporting period, based on the interpretation of the latest intelligence received from NHSEI.
- **REVIEWED** and **APPROVED** the month one Finance Report for submission to the

Governing Body

FT 20 009 **Covid-19 Related Expenditure Update**

Michael Cawley introduced the item, highlighting the following points:

a) The update outlines the costs associated with Covid-19 to April 2020/21 and the recording and control arrangements in place for seeking reimbursement from NHS England/Improvement.
b) To April the costs relating to Covid-19 total £2.5 million. Following appropriate checks by NHSEI, the funding for this expenditure will be confirmed and released to the CCG.
c) The monthly request for reimbursement of costs now forms part of the normal monthly finance reporting cycle to NHSE/I. The process has matured to ensure that submitted costs have been challenged and scrutinised internally prior to submission.

The following points were made in discussion:
d) Clarification was received that the running cost associated with the Incident Coordination Centre (ICC) were contractual in nature, as staff on Agenda for Change (AfC) are entitled to claim for unsocial hours payments.
e) It was noted that the CCGs submission aligns with other CCG's in the region. NHSE/I are reviewing how they expect expenditure to change over the next few months which will inform the categories the CCG can claim against.

The Finance and Turnaround Committee:
- **NOTED** the contents of the paper

Risk Management

FT 20 010 **Risk Report**

Siân Gascoigne was in attendance to present this item. The following key points were highlighted:

a) There are currently ten risks pertaining to the Committee's responsibilities. Four of these are related to Covid-19 and will be discussed under item FT/20/011, Summary of Financial Risk due to Covid-19.
b) It is proposed that risks RR 090, RR 091 and RR 092 are archived as their impact and/or likelihood scores have been reduced in line with the 2019/20 year-end financial positions for the former six Nottingham and Nottinghamshire CCGs.
c) The narrative of new risk, RR 121, has been amended to reflect the factors that would contribute to the non-achievement of the CCG's financial duties for 2020/21.

The following points were made in discussion:
d) Discussion took place regarding whether risk RR 121 remained confidential; it was agreed that as the risk had been fully articulated it could now be made public.
e) Members agreed that risks RR 090, 091 and 092 could be archived.

The Finance and Turnaround Committee:

- **APPROVED** the proposed archiving of risks **RR 090 and RR 091 and RR 092;**
- **COMMENTED** on the risks shown within the paper (including the high/red risk) and those at Appendix A; and
- **HIGHLIGHTED** any risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

FT 20 011 **Summary of Financial Risk due to Covid-19**

Michael Cawley introduced the item, highlighting the following points:

a) As a consequence of Covid-19, four risks have been identified as pertaining to the responsibility of the Committee.
b) Discussion took place regarding the narrative and likelihood/impact scores for these risks and whether any were regarded as significant enough to be rated as red and reported to the Governing Body.
c) The likelihood of risk RR 133 was felt to be low due to the internal controls in place to secure reimbursement for Covid-19 related costs.
d) Risk RR 134, RR 135 and RR 136 were felt to have a moderate to high impact and likelihood. Risk RR 136 was discussed at length and it was agreed that there were future costs associated with continued infection prevention and control, workforce related factors, continued minimisation of bed capacity within the acute sector and increased waiting lists due to the suspension of elective activity. As such, this risk was likely to impact in both 2020/21 and 2021/22.
e) Siân Gascoigne stated that she would progress the suggested changes in relation to RR 133, RR 134, RR 135 and RR 136 outside of the meeting.
f) No new risks were highlighted during the course of the meeting.

The Finance and Turnaround Committee:

- **COMMENTED** on the four additional risks have been identified due to Covid-19;
- **DISCUSSED** the risk narrative and scores for inclusion future risk reports.

Closing Items

FT 20 012 **Any other business**

a) Members discussed the role of the Finance and Turnaround Committee in the assurance and oversight arrangements for the Financial Sustainability Group.

FT 20 013 **Key messages to escalate to the Governing Body**

a) At month one, the overall adverse variance position is £1.2 million (full year £25.9m adverse) when compared to an amended balanced/ Financial Improvement Trajectory delivery plan.
b) The archiving of risks RR 090 and RR 091 and RR 092.

FT 20 014 **Date of next meeting**:

24/06/2020

MS Teams meeting

Nottingham and Nottinghamshire Clinical Commissioning Group

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Finance and Turnaround Committee
Ratified minutes of the meeting held on
24/06/2020, 09:00 – 10:10
MS Teams Meting

Members present:

Shaun Beebe	Non-Executive Director (Chair)
Maxine Bunn	Associate Director of Commissioning, Contracting and Performance - Mental Health and Community
Michael Cawley	Operational Director of Finance
Lisa Durant	Director of Commissioning
Andy Hall	Associate Director of Performance and Information
Dr James Hopkinson	Joint Clinical Leader
Andrew Morton	Operational Director of Finance
Stuart Poynor	Chief Finance Officer
Mark Sheppard	Associate Director of Commissioning, Acute Contracts
Amanda Sullivan	Accountable Officer
Sue Sunderland	Non-Executive Director
Jon Towler	Non-Executive Director

In attendance:

Fiona Daws	Corporate Governance Officer (minutes)
Siân Gascoigne	Head of Corporate Assurance
Jack Rodber	Associate Director of Financial Recovery
Lindsay Sutherland	Head of Project Management Office (PMO)

Apologies:

Nina Ennis	Associate Director of Joint Commissioning and Planned Care
Dr Stephen Shortt	Joint Clinical Leader
Gary Thompson	Director of Special Projects

Cumulative Record of Members' Attendance (2020/21)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Shaun Beebe	2	2	Stuart Poynor	2	2
Maxine Bunn	2	2	Mark Sheppard	2	2
Michael Cawley	2	2	Stephen Shortt	2	1
Lisa Durant	2	2	Amanda Sullivan	2	2
Nina Ennis	2	1	Sue Sunderland	2	2
Andy Hall	2	2	Gary Thompson	2	0
James Hopkinson	2	2	Jon Towler	2	2
Andrew Morton	2	2			

Introductory Items

FT 20 015 **Welcome and Apologies**

Shaun Beebe welcomed everyone to the Finance and Turnaround Committee.

Apologies were noted as above.

FT 20 016 **Confirmation of Quoracy**

The meeting was confirmed as quorate.

FT 20 017 **Declaration of interest for any item on the shared agenda**

No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

FT 20 018 **Management of any real or perceived conflicts of interest**

As no conflicts of interest had been identified, this item was not necessary for the meeting.

FT 20 019 **Minutes from the meeting held on 27 May 2020**

It was agreed that the minutes were an accurate record of the meeting.

FT 20 020 **Action log and matters arising from the meeting held on 27 May 2020**

There were no actions outstanding; all other actions were noted as complete and there were no matters arising.

Contracting

FT 20 021 **Cross Provider Report**

Andy Hall introduced the item and highlighted the following points:

a) The report provides an overview of financial and activity performance for the Nottingham and Nottinghamshire CCGs with a focus on the major acute contracts.
b) The format of the report has been revised with greater emphasis and focus on local providers. Low level aggregated data is presented; however, reports at a practice level can still be accessed.
c) At month one the Nottingham and Nottinghamshire CCG is paying a block payment to NHS providers and the usual contracting processes have been suspended. It is important to note that the areas of spend reported in this report are only a selection of the overall financial position reported by the CCGs.
d) Independent sector providers receive less focus in this report due to the national contracts struck with the IS for the national COVID response. However, inclusion will be reviewed as the Covid-19 situation evolves. Quality, patient services and activity data continue to be received and analysed.
e) SLAM data is currently used for local providers in section one Financial Summary, will continue to be populated as the financial year progresses. An approximation of the national tariffs will also be included where SUS data is used.
f) The decrease in elective, urgent and two week wait referrals is reflected in a

significant reduction in demand being seen through the front door. A reduction in activity is also evident in the acute services and outpatients.

g) Both Nottingham University NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFH) have seen an increase in non-face to face outpatient appointments, utilising telephone or video conferencing, to provide the service since lockdown.

h) A significant reduction in referrals for SFH and the Treatment Centre reflects a continuing trend, also identified in April activity. The Integrated Care System (ICS) work being undertaken by Nina Ennis will allow the mapping of data as values become confirmed and the recovery of services are more accurately reflected.

i) Contractual financial challenges are not taking place due to the link to block payments. Where data quality is identified, this is raised with the provider for further information and scrutiny and continues to take place.

The following points were made in discussion:

j) It was explained that non-face to face outpatient attendance lends more appropriately to some specialities than others. This method is adopted more frequently for follow up appointments. Further analysis of this change in service delivery (and others) is encompassed in a review which includes consideration of continuing or not continuing with the changes resulting from the Covid-19 situation. Further details will be provided within next month's report regarding first and reduced follow up appointments. Consideration is to be given to the tariff based on activity for face to face and non-face to face appointments and a reconciliation exercise to highlight benefits will be undertaken.

k) NHS England/Improvement (NHSEI) is responsible for the Independent Sector, Nottingham University Hospitals NHS Trust (NUH), Nottinghamshire Healthcare NHS Foundation Trust (NHT) and Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) contracts.

l) Recovery and transformation work is being carried forward. The recovery cell is mapping the identified 25 priorities, one of which is the planned care pathway. A stocktake exercise will ensure each priority is appropriately reviewed. The financial situation is on catch up and is hugely complex – fixed and staffing costs and productivity issues around social distancing will all be considered and will influence changes, including a reset of NHS funding over the next couple of years. Members were informed that the allocation may not meet previous levels and it was reiterated that there are many issues to unravel in this complex issue.

The Finance and Turnaround Committee:

- **NOTED** the report and the actions taken to manage the key acute contracts.

Action:
Andy Hall will provide further analysis and details within next month's report regarding first and reduced follow up appointments.

Financial Management

FT 20 022 **Month Two Finance Report**

Andrew Morton introduced the item, highlighting the following main aspects of the

report:

a) The CCG is reporting an initial £11.2 million adverse variance against this budget for the period ending 31 May 2020. The key variances to this are Covid-19 costs £4.8 million, 2019/20 accrual fall out £1.5 million, deferred commitments from 2019/20 non-NHS organisations £2.1 million, commitment to the ICS £0.9 million and £1.9 million of on-going budget pressures.
b) NHSEI have issued reporting guidance only for months one to four of 2020/21; with the allocation for these months being non-recurrent. When compared with the CCG budget for the four-month period a £7.8 million shortfall translates to £3.9 million at month two and is an impact of the £11.2 million variance.
c) The variance can be attributed in the main, to Prescribing and Continuing Health Care both being lower than expected.
d) A top up for the first four months is anticipated whilst the financial framework for the remainder of the year is reviewed and has yet to be confirmed to the CCG.
e) The rest of the £11.2 million is made up of the impact of 2019/20:
    i. £1.5 million. Fall-out from 2019/20 accruals relating to prescribing (£1.5m higher than what was accrued at year-end).
    ii. £2.1million. Cost of re-providing on commitments associated with investment slippage from 2019/20. (This includes the making good of slippage on Primary Care Network Investments and ICS Transformation Funds).
    iii. £0.9m commitment to the ICS in respect of ICS costs.
f) £4.8 million is expected to be reimbursed. The top up process is subject to approval and scrutiny with NHSEI. The rest of the year's framework is being worked through and will highlight budgetary gaps to be filled which is an area of concern. The CCG's case regarding budgetary shortfall has been presented to NHSEI.

The following points were made in discussion:
g) Members sought clarification regarding ICS running costs. In the previous year, higher funding was received by the ICS as non-running costs, however, these are now allocated. In terms of the impact from 2019/20, this will be provided in the form of a summary table and shared with Committee members.
h) Members reaffirmed that pressure should continue to be applied to underlying financial pressures.
i) Members sought clarification as to where the costs sit for Nicole Atkinson. It was confirmed that due to her dual role, the cost would be apportioned accordingly between the two routes. Previously, ICS team costs have been shared between partners, with the six CCGs paying £80,000 to cover costs, however, since the CCG merger, the contribution is being discussed. It is proposed that the CCG picks up certain elements of core strategic commissioning and communications and engagement. All costs and agreed processes are to be set out regarding the cost base and will include assumptions, who is included etc. and presented at a future meeting.
j) Members stated that the CCG is to focus on those costs that are within the CCG's control in the short term, including those that feature within the internal efficiency programme. Recognition of the Covid-19 situation and transition to business as usual is required.

k) It was acknowledged by members that future provider discussion may be challenging but transparency regarding trade-offs is needed.

The Finance and Turnaround Committee:

- **RECEIVED/NOTED** and **APPROVED** the Finance Report for the reporting period on behalf of the Governing Body

Actions: A summary table of 2019/20 ICS running costs to be provided to a future meeting of the FTC.

FT 20 023 **Covid-19 Related Expenditure Update**

Stuart Poynor introduced the item, highlighting the following points:

a) The report illustrates the 2020/21 year to date (month two) financial position regarding the Covid-19 costs and arrangements for the reimbursement by NHSEI of expenditure resulting from Covid-19.
b) The end of May costs relating to Covid-19 total £4,805 million.
c) The majority of spend relates to Continuing Health Care and hospital discharges.
d) The CCG may have been selected, along with five other CCGs across the country, as part of a national audit that is reviewing the reasonableness of claims for Covid-19 costs by CCGs. A similar approach is being applied to NHS providers as well. The process commences 6 July 2020.
e) The initial set of audit requirements were received yesterday, with focus on information needs and decision making processes.

There were no further points arising in discussion.

The Finance and Turnaround Committee:

- **RECEIVED** and **NOTED** the content of the paper for information and assurance

Risk Management

FT 20 024 **Risk Report**

Siân Gascoigne was in attendance to present this item. The following key points were highlighted:

a) There are currently seven risks pertaining to the Committee's responsibilities, which is a reduction of three risks since the last meeting. It was highlighted that there are three high risks within the Committee's remit.

The following points were made in discussion:

b) Members queried the score for risk RR 121 (overall risk score 20) and whether this could be reduced given the block contract payments being made to providers. It was highlighted that, although verbal discussions have happened, the CCG has yet to receive any formal guidance regarding its allocation for 2020/21. As such, members agreed that due to this continued uncertainty, it would be appropriate to for the risk score to remain at 20.

The Finance and Turnaround Committee:

- **COMMENTED** on the risks shown within the paper (including the high/red risk) and those at Appendix A.

Closing Items

FT 20 025 **Any other business**

a) The performance management objective that was recently presented to the Governing Body is underway with a description of sub-deliverables being discussed at the Directors' meeting this afternoon. Over the next three weeks, this initiative will be worked through into a template for governance around performance, delivery plans and milestones with a paper coming to next month's Committee for further refinement.

FT 20 026 **Key messages to escalate to the Governing Body**

a) At month two, the overall adverse variance position is £11.2 million.
b) The CCG is in a position of uncertainty, with challenges ahead based on month nine in the last financial year plus the underlying position from last year and Quality, Innovation, Productivity and Prevention (QIPP).
c) Focus relating to those areas that the CCG has influence and control are to be captured in a paper to the Governing Body to illustrate our activity.
d) Announcement on allocations for the remainder of the year is expected mid-July in the form of the Phase Three letter.

FT 20 027 **Date of next meeting**:

22/07/2020

MS Teams meeting

Nottingham and Nottinghamshire
Clinical Commissioning Group

Audit and Governance Committee
Ratified minutes of the meeting held on
12/05/2020, 1.00pm-4.00pm
Teleconference

Members present:

Sue Sunderland	Non-Executive Director (Chair)
Eleri de Gilbert	Non-Executive Director
Jon Towler	Non-Executive Director

In attendance:

Lucy Branson	Associate Director of Governance
Michael Cawley	Operational Director of Finance
Ian Livsey	Deputy Director of Finance *(item AG 20 053)*
Audrey McDonald	Deputy Director of Finance *(item AG 20 053)*
Claire Page	Client Manager, 360 Assurance
Stuart Poynor	Chief Finance Officer
Richard Walton	Senior Manager, KPMG
Sue Wass	Corporate Governance Officer (minutes)

Cumulative Record of Members' Attendance (2020/21)					
Name	***Possible***	***Actual***	***Name***	***Possible***	***Actual***
Eleri de Gilbert	*1*	*1*	*Jon Towler*	*1*	*1*
Sue Sunderland	*1*	*1*			

Introductory Items

AG 20 001 Welcome and Apologies

Sue Sunderland welcomed everyone to the meeting of the Audit and Governance Committee.

Apologies were noted as above.

AG 20 002 Confirmation of Quoracy

The meeting was declared quorate

AG 20 003 Declaration of interest for any item on the shared agenda

No interests were noted on any item on the agenda. Ian Livsey and Audrey McDonald gave a verbal assurance that they had no interests on any of the items on the agenda, as they weren't included in the extract register presented to the meeting.

Sue Sunderland reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

AG 20 004 Management of any real or perceived conflicts of interest

This item was not required as no interests were declared.

AG 20 005 Shared minutes from the predecessor CCGs' meeting held on 27 March 2020

The minutes of the predecessor CCGs' meeting held on 27 March 2020 were agreed as an accurate record of the discussions held, subject to the following changes:

AG 20 026: Action Log

- AG 19 054: Regarding a further report to be brought to the Committees on the Mental Health Investment Standard. ~~A report had been scheduled to be discussed at this meeting; however it had been deferred due to the emergency response to the Covid-19 outbreak.~~ Andrew Morton noted that NHS England/Improvement had recently announced revised methodology and all six CCGs were expected to meet the target for 2019/20. *Consequently the action to produce a further report was longer necessary. Consequently, Action AG 19 054 dated 29.11.19 should be closed.*

AG 20 006 **Action log and matters arising from the predecessor CCGs' meeting held on 27 March 2020**

Action AG 20 054 was noted as closed, with reference to the amendment to the minute as above.

Action AG 20 034 was noted as closed. The Chair had approved the parameters for the use of procurement cards; however an update report on their usage was requested for the June meeting.

All other actions were noted as completed.

ACTION:

- **Stuart Poynor to present a report to the June meeting of the Committee on the use of the CCG's procurement cards.**

AG 20 007 **Action log from Governing Body**

Action GB 20 033: An assurance report on payroll system issues to be brought to the Audit and Governance Committee. It was noted that conversations had been undertaken to understand a number of issues and a report would be brought to the June meeting. Action ongoing.

Corporate Assurance and Risk Management

AG 20 008 **Risk Management Arrangements – Year End Update**

Lucy Branson introduced the report, highlighting the following points:

a) The report provided the Committee with a year-end update on the work undertaken during 2019/20 to embed the predecessor CCGs' strategic and operational risk management arrangements, as well as to introduce the risk management arrangements being established for the single CCG. It also provided an update as to how risk was being managed during the CCG's incident response to Covid-19.
b) The mechanisms that had been implemented for the routine assurance of the CCG's strategic and operational risks were detailed.
c) Risk management processes during the response to the Covid-19 pandemic were detailed. A Covid-19 Risk/Issues Log, which reflected potential risks and issues, was currently being managed. Other risks deemed as 'business as usual' had been classed as inactive during this period, but continued to be reviewed and it was noted that risk management processes would return to normal as soon as practicable.
d) This Committee had oversight of two operational risks, and it was proposed that risk RR 025 should be archived as the IT issue had been addressed.

The following points were made in discussion:

e) Members supported the proposal to receive a risk report from the Quality Directorate as the first of the cycle of targeted risk reports for 2020/21.
f) Members discussed the need for the opening Governing Body Assurance Framework for 2020/21 to reflect the CCG's focus on recovery actions arising from the Covid-19 pandemic. It was noted that the CCG's key deliverables for 2020/21 would be brought to the Governing Body for discussion in June, which would support the development of the Assurance Framework.
g) Members sought assurance that the CCG's risks were fully owned by the Executive. Lucy Branson confirmed that they were, noting that the CCG's Head of Corporate Assurance held regular update meetings with individual directors and had good engagement from the senior leadership team.
h) Members queried whether a number of the risks currently marked as 'inactive' would need adjusting to change their focus in light of the pandemic; and it was noted that work was currently being undertaken on this.
i) Members queried whether risk RR087, relating to the contract management framework should remain inactive and it was noted that there was a report scheduled to be discussed at the Prioritisation and Investment Committee on the process for the treatment of smaller contracts.
j) Members agreed to the archiving of risk RR 025.

The Committee:
- **NOTED** the full Corporate Risk Register at Appendix B.
- **APPROVED** the archiving of risk RR 025.
- **NOTED** the risk management processes being followed during the Covid-19 emergency response period.

AG 20 009 **Fraud Risk Assessment**

Lucy Branson introduced the report, highlighting the following points:
a) The report provided the Committee with the output of the CCG's local fraud risk assessment and outlined the process by which fraud risks would be managed moving forward, which was in line with the NHS Counter Fraud Authority's revised Standards for NHS Commissioners 2020/21 Fraud, Bribery and Corruption.
b) The CCG's risk assessment had identified that fraud risks continued to be in the areas identified in previous years; specifically in relation to the use of personal health budgets; and fraud risks resulting from cybercrime.
c) A fraud risk assessment had been held with representatives from various CCG functions and as a result a fraud risk register had been populated.

The following points were made in discussion:
d) Members queried whether there were any risks that had been identified associated with primary care, such as the payment verification process or prescribing. It was agreed that Lucy Branson would look into this and report back to a future meeting.
e) Members sought to understand the associated actions for risks FRR 004 and FRR 005. For FRR 004, it was noted that the CCG was working with 360 Assurance to strengthen assurance mechanisms around jointly funded health and care packages; and for FRR 005, it was noted that the controls in place via the CCG's Expenses Policy mitigated the risk, pending the implementation of the single electronic payment system.
f) It was noted that recent approval for individuals within the CCG to have use of procurement cards during the emergency response period would be added to the fraud risk register.

The Committee:
- **NOTED** the output from the annual fraud risk assessment.

ACTION:
- **Lucy Branson to confirm whether any specific fraud risks associated with primary care and the use of procurement cards should be added to the fraud risk register.**

Financial Stewardship

AG 20 010 **Off Payroll Arrangements**

Stuart Poynor introduced the report, highlighting the following points:

a) Appendix one of the report provided a summary of all off-payroll arrangements that had been in place during the final quarter of 2019/20. During the period, there had been 12 off-payroll engagements across the six CCGs, of which six remained current at the time of reporting.

The following points were made in discussion:

b) Members acknowledged the reduced number of off-payroll workers since the more proactive monitoring and reporting had begun.
c) Members noted the need for the CCG to be cognisant of the start dates of individuals who had worked for the CCG for over a year, which was acknowledged.

The Committee:
- **NOTED** the off-payroll arrangements in place during Quarter 4 2019/20.

AG 20 011 **Tender Waiver Register**

In Neil Moore's absence, Michael Cawley introduced the report, highlighting the following points:

a) The report provided assurance that all decisions to direct award contracts had been made in line with the CCG's Procurement Policy and Standing Financial Instructions.
b) A notable theme of the register had been the use of single tender waivers to enable alignment of contracting end dates as a consequence of the CCG's commissioning intentions.

The following points were made in discussion:

c) Members noted that the justification for a number of tender waivers was not explained in enough depth for the Committee to take assurance. Information was also missing on some items with regard to approval dates and the approval routes. An updated register was requested to be brought to the next meeting.

The Committee:
- **NOTED** the closing position of the 2019/20 Tender Waiver Register for the predecessor CCGs.
- **NOTED** the 2020/21 Tender Waiver Register for NHS Nottingham and Nottinghamshire CCG.

ACTION:
- **Neil Moore to present an updated Tender Waiver Register to the June meeting of the Committee.**

AG 20 012 **2019/20 Accounting Policies**

Michael Cawley introduced the report, highlighting the following points:

a) The report presented the Accounting Policies, which formed part of the Statutory Accounts.
b) There had been no major changes to the policies for the 2018/19 accounts, with the

exception of the discount rates for provisions. There had also been some minor amendments to align the policies across the six Nottinghamshire CCGs.

The Committee:
- **RECEIVED** the 2019/20 Accounting Policies.

AG 20 013 **Covid-19 Emergency Delegated Financial Limits**

Michael Cawley introduced the report, highlighting the following points:

a) At its 8 April 2020 meeting, the CCG's Governing Body had approved the governance arrangements during the emergency response period, which had included changes to the CCG's delegated financial limits. These delegated financial limits had since been reviewed and tightened.
b) The proposed changes were noted as detailed at Appendix one of the report, which also noted the rationale for the changes.

The Committee:
- **ENDORSED** the changes to the delegated financial limits during the emergency response period, for approval by the Governing Body at its June 2020 meeting.

Internal Audit

AG 20 014 **Internal Audit Progress Report**

Claire Page introduced the report, highlighting the following points:

a) The report provided an update for Committee members on progress made regarding the provision by Internal Audit of planned assurances for 2019/20 and 2020/21.
b) Two assignments from 2019/20 plan remained in progress: Data Quality Framework and Workforce and Organisational Development. These would be brought to the June 2020 committee meeting.
c) To date, no reviews from the 2020/21 Internal Audit Plan had commenced.
d) The implementation of 360 Assurance's electronic recommendations tracking system had been put on hold due to the Covid-19 pandemic. Liaison with the Governance Team would take place regarding the appropriate timing for the implementation of the new system.
e) Given the significance of the current pandemic, Appendix B to the report had listed initial proposals of potential areas for review. This was at an early stage of development and was likely to change, but had been provided for consideration by the Committee.

The following points were made in discussion:

f) Members noted the need to examine the CCG's response to the pandemic as a whole, and suggested it would be helpful to link some of the areas described to areas already in the 2020/21 internal audit plan.
g) It was noted that Claire Page would scope potential areas for initial discussion with Sue Sunderland and Michael Cawley.

The Committee:
- **RECEIVED** the progress report and **NOTED** the key messages and progress being made with the delivery of planned assurances for 2019/20 and 2020/21.

AG 20 015 **Internal Audit Assignment Reports**
- **Head of Internal Audit Opinion**
- **Financial Management Arrangements**
- **Data Security Standards and Protection Toolkit**
- **Delegated Primary Medical Care Functions**

- **Cyber Security Phase 2**

Claire Page introduced the report, highlighting the following points:

a) The draft 2019/20 Head of Internal Audit Opinion had been updated to comment on the impact of Covid-19 and to reflect the latest financial position of the CCGs. There had been no change to the opinion level, with significant assurance still being provided.
b) The financial management arrangements review assessed whether efficient and effective processes; and robust financial monitoring and reporting arrangements were in place. Two medium risk actions and one low risk action had been agreed.
c) The Data Security and Protection Toolkit review provided an opinion on the framework established by the CCGs to develop, deliver, maintain and monitor their data security and protection arrangements. Four low risk actions had been agreed.
d) All of the above reports had received 'Significant Assurance'.
e) The delegated primary medical care functions review was to determine whether a robust, efficient and effective control environment was in place in relation to commissioning and procurement of primary medical care. Three low risk actions had been agreed. The 'Substantial Assurance' opinion provided was as specified by NHS England and it was noted that this was considered to be equivalent to the significant assurance opinion issued by 360 Assurance.
f) The cyber security report was a non-assurance report that assessed the susceptibility of the CCGs' workforce to phishing emails. One medium risk action regarding training and communication requirements had been agreed.

The following points were made in discussion:

g) Regarding the cyber security report, members asked for assurance that management had responded to the wider issue of training for all staff. Lucy Branson noted that plans were in place for a programme of communication and training for all staff.
h) It was noted that the CCG would work closely with the internal auditors to agree implementation dates for these actions and on-going actions from previous reports, taking into account the pressures of responding to the Covid-19 pandemic.
i) The Committee thanked Claire Page and her team for their support.

The Committee:

- **NOTED** the internal audit reports.

Annual Report and Accounts

AG 20 016 **Draft 2019/20 Annual Reports**

Lucy Branson introduced the report, highlighting the following points:

a) The draft Annual Report for each predecessor CCG had been submitted to NHS England by the deadline of 27 April 2020.
b) The six draft annual reports had been brought to the Committee for retrospective review and comment prior to finalising and submitting the reports to the Committee for final approval in June 2020.
c) A number of areas required further work prior to final approval, which included the completion of the performance analysis section. It was noted that updated national guidance in view of the Covid-19 situation had given organisations the choice to omit this section. However, given the extended timeline for submitting the final reports, the CCG had opted to submit this section in full for each report.
d) As the six CCGs had been working towards a merged organisation for the majority of the year, the reports had been structured in the same way and the narrative was consistent with the exception of areas relating to specific CCGs, for example Governing Body members, GP member practices, and figures relating specifically to individual CCGs.

The following points were made in discussion:

e) Members queried whether reference would be made to the Covid-19 pandemic and it was noted that the Accountable Officer's introduction would need to be updated to reflect the CCGs' performance and reference would also be made to Covid-19.
f) Members queried whether the CCGs would need to report on their gender pay gap. It was noted that the six CCGs had been exempt from this requirement due to their individual sizes, but would report in the 2020/21 annual report.
g) Members requested that the section of Equality and Diversity be revisited to ensure clarity of message, which was agreed.
h) Members requested that the tables in the Remuneration Report by revisited to ensure accuracy, which was agreed.
i) Members made a number of observations on small typographical errors.
j) The Committee thanked the Governance Team for the work completed to produce the six annual reports by the stated deadline, given the current circumstances.

The Committee

- **NOTED** the predecessor CCGs' draft annual reports 2019/20 and provided feedback on areas for further development.

AG 20 017 **Unaudited 2019/20 Annual Accounts**

Michael Cawley introduced the report, highlighting the following points:

a) During a year of significant financial challenge and a year of organisational change, the predecessor CCGs had delivered all financial targets for the year.
b) The accounts templates had been submitted to NHS England in line with the year-end timetable and were currently under review by the external auditors.

Ian Livsey and Audrey McDonald provided further detail:

c) The provisional year-end financial position for 2019/20 was referenced, with all financial duties and metrics having been met, subject to confirmation by the external auditors.
d) Key financial pressures during the year related to acute care, community care and prescribing costs. This had been offset by use of reserves and other programme underspend, the majority of which was non-recurrent in nature, adding significant financial challenge for 2020/21.
e) There had been a number of recharges, particularly between the six CCGs and staffing costs had been shared between the six CCGs.
f) There had been a reduction in the purchase of healthcare from non-NHS bodies, which was primarily due to the ending of the contract with Circle for the Nottingham Treatment Centre.
g) A large increase in receivables was due to two General Practices moving from Nottingham West CCG to Nottingham North and East CCG.
h) Under Note 4.4 the reference to Elaine Moss as a redundancy was noted as a mistake that would be corrected.

The following points were made in discussion:

i) The Committee thanked the Finance Team for the briefing note, which had addressed a number of issues that had been raised by members prior to the meeting.
j) The Committee thanked the Finance Team for the work completed to produce the six sets of accounts by the stated deadline, given the current circumstances.

The Committee:

- **RECEIVED** the 2019/20 Accounts Narrative.

External Audit

AG 20 018 **External Audit Progress Update**

Richard Walton gave a verbal update, highlighting the following points:

a) The audit of the predecessor CCGs' accounts was well underway and no major issues had been highlighted to date.
b) The audit was on track to be completed by the end of May 2020.

The Committee:

- **NOTED** the verbal update.

Information Governance

AG 20 019 **Record Management Policy**

Lucy Branson introduced the report, highlighting the following points:

a) The purpose of this paper was to present the CCG's Records Management Policy to the Audit and Governance Committee for approval.
b) The Records Management Policy set out the approach taken within the CCG to provide a robust records management system for the management of corporate information. It included all aspects of record keeping, in any format or media type, from their creation, all the way through their lifecycle and to their eventual destruction.
c) This was the last of the suite of Information Governance policies to be updated for the new CCG.

The Committee:

- **APPROVED** the Records Management Policy.

Closing Items

AG 20 020 **Any other business**

There was no other business.

AG 20 021 **Risks identified during the course of the meeting**

No new risks were identified.

AG 20 022 **Key messages to escalate to the Governing Body**

- The production of six draft annual reports and accounts during a very difficult time by the stated deadlines.
- Significant assurance from a number of internal audit reports.

AG 20 023 Date of the next meeting:

22/06/2020

Venue to be confirmed