

Chair: Jon Towler

Enquiries to: ncccg.notts-committees@nhs.net

Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Agenda (Open Session)

Governing Body
Wednesday 06 April 2022 (09:00 – 11:00)
Virtual meeting via Zoom

Time	Item	Presenter	Reference
09:00	Introductory Items		
	1. Welcome, introductions and apologies	Jon Towler	GB/22/001 – Verbal
	2. Confirmation of quoracy	Jon Towler	GB/22/002 – Verbal
	3. Declarations of interest for any item on the agenda	Jon Towler	GB/22/003
	4. Management of any real or perceived conflicts of interest	Jon Towler	GB/22/004
	5. Questions from the public	Jon Towler	GB/22/005 – Verbal
	6. Minutes from the meeting held on 2 February 2022	Jon Towler	GB/22/006
	7. Action log from the meeting held on 2 February 2022	Jon Towler	GB/22/007
09:10	Strategy and Leadership		
	8. Accountable Officer Report	Stuart Poynor	GB/22/008
	9. Joint Clinical Leaders' Report	Stephen Shortt /James Hopkinson	GB/22/009 – Verbal
09:30	Commissioning Developments		
	10. Primary Care Commissioning Committee Highlight Report – 16 February 2022 and 16 March 2022	Eleri de Gilbert	GB/22/010
	11. Patient and Public Engagement Committee Highlight Report – 22 February and 29 March 2022	Sue Clague	GB/22/011
09:45	Financial Stewardship and Resources		
	12. Finance and Resources Committee Highlight Report – 23 February 2022 and 23 March 2022	Shaun Beebe	GB/22/012
	13. 2021/22 Financial Report Month Eleven	Stuart Poynor	GB/22/013
	14. 2022/23 Draft Financial Plans and Budget Setting	Stuart Poynor	GB/22/014
10:15	Quality and Performance		
	15. Quality and Performance Committee Highlight Report – 24 February 2022 and 24 March 2022	Eleri de Gilbert	GB/22/015

Time	Item	Presenter	Reference
	16. Nursing and Quality Report	Rosa Waddingham	GB/22/016
	17. Integrated Performance Report	Stuart Poynor	GB/22/017
10:45	Corporate Assurance		
	18. Audit and Governance Committee Highlight Report – 3 March 2022	Sue Sunderland	GB/22/018
	19. Governing Body Assurance Framework Year End Report	Lucy Branson	GB/22/019
	20. Corporate Risk Report	Lucy Branson	GB/22/020
10:55	Information Items		
	<i>The following items are for information and will not be individually presented. Questions will be taken by exception.</i>		
	21. Ratified Minutes of CCG committee meetings:	N/A	GB/22/021
	a) Patient and Public Engagement Committee – 25 January 2022 and 22 February 2022		
	b) Quality and Performance Committee – 27 January 2022 and 24 February 2022		
	c) Finance and Resources Committee – 26 January 2022 and 23 February 2022		
	d) Primary Care Commissioning Committee – 17 January 2022 and 16 February 2022		
	e) Audit and Governance Committee – 13 January 2021		
11:00	Closing Items		
	22. Any other business	Jon Towler	GB/22/022 – Verbal
	23. Date of the next meeting: 01/06/2022 To be held virtually	Jon Towler	GB/22/023 – 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 140 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 publicly available on the CCG's website).
This document was extracted on 29 March 2022 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 CCG	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest			Indirect Interest	Date From:	Date To:	Action taken to mitigate risk
				Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests				
ARORA, Dr Manik	Governing Body GP Representative	Nottingham City GP Alliance Limited a federation of GP practices to work together to develop and deliver solutions for member practices to deliver services to the local community	Rivergreen Medical Centre (of which Dr Arora is a GP Partner) is a member of the NCGPA. As a shareholder the practice is entitled to receive a dividend payment (albeit no dividend is currently paid to members).	✓				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 Nottingham 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.
BALL, Alex	Director of Communications and Engagement	Keyworth Medical Practice	Registered Patient			✓		01/12/2019	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	University of Nottingham	Senior manager with the University of Nottingham	✓				-	Present	This interest will be kept under review and specific actions determined as required.

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.
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.
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	First for Wellbeing Community Interest Company (Health and Wellbeing Company)	Director	✓				01/12/2016	01/10/2021	Interest expired no action required.
DADGE, Lucy	Chief Commissioning Officer	Valley Road Surgery	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.
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.
DADGE, Lucy	Chief Commissioning Officer	Care Workers Union	Director (not remunerated)			✓		01/09/2021	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Cleaners Union	Director (not remunerated)			✓		01/09/2021	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, Daughter in law are registered patients			✓		18/10/2019	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.
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	Major Oak Medical Practice, Edwinstowe	Son, daughter in law and grandchildren are registered patients			✓		-	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.
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.
HOPKINSON, Dr James	Joint Clinical Leader	NEMS Healthcare Ltd - owns several properties of which NEMS Community Benefit Services (a not for profit provider of out of hours GP services) is a tenant	Shareholder and entitled to receive a dividend payment	✓				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 CBS and Services where it is believed that the organisations could be interested bidders
HOPKINSON, Dr James	Joint Clinical Leader	Primary Integrated Community Service (PICS) - provider of local health services and non-core member of numerous PCNs in the Nottinghamshire area	Practice partner is a shareholder of PICS and is entitled to receive a dividend payment				✓	-	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	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.
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.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	OBIC Ltd - facilitates improvement in education attainment and the quality of teaching and learning for ethnic minority children in the UK and Nigeria.	Director			✓		04/10/2020	Present	This interest will be kept under review and specific actions determined as required.
OKUBADEJO, Dr Adedeji	Independent Secondary Care Doctor	Burcot Hall Hospital, Bromsgrove	Independent private clinical anaesthetic practice	✓				01/11/2020	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Chief Finance Officer	Denstone College Uttoxeter.	School Governor			✓		-	Present	This interest will be kept under review and specific actions determined as required.
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 arrangements) relating to services that are currently, or could be, provided by this group.
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	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 this group.

SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group as a subcontractor for Nottingham University Hospitals NHS Trust to deliver surgical dermatological services	Spouse is a GP Partner				✓	10/06/2021	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 this group.
SHORTT, Dr Stephen	Joint Clinical Leader	Partners Health LLP - a membership organisation of general practices in Rushcliffe. Provider of extended access service and non-core provider for Rushcliffe PCN and employer for additional roles staff with the PCN	GP member and is entitled to receive profit shares (although profit shares are not currently paid out to members). Acts in an advisory capacity to Partners Health Board which is not remunerated. Also provides weekend shift cover once a month.	✓				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	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 this group.
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group (formerly Keyworth Medical Practice)	Spouse is 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 this group.
SHORTT, Dr Stephen	Joint Clinical Leader	Partners Health LLP - a membership organisation of general practices in Rushcliffe. Provider of extended access service and non-core provider for Rushcliffe PCN and employer for additional roles staff	Wife is a GP member and also provides weekend shift cover once a month.				✓	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
SHORTT, Dr Stephen	Joint Clinical Leader	Village Health Group (formerly Keyworth Medical Practice)	Registered Patient				✓	-	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 this group.
SHORTT, Dr Stephen	Joint Clinical Leader	Rushcliffe Primary Care Network (funded by NHS England and NHS Improvement via the CCG and the Integrated Care System)	Voting Member		✓			01/10/2019	Present	This interest will be kept under review and specific actions determined as required.
SHORTT, Dr Stephen	Joint Clinical Leader	Rushcliffe Primary Care Network (funded by NHS England and NHS Improvement via the CCG and the Integrated Care System)	Spouse is a Voting Member				✓	10/06/2021	Present	This interest will be kept under review and specific actions determined as required.
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.
SUNDERLAND, Sue	Non-Executive Director	Nottinghamshire Healthcare NHS Foundation Trust	Non-Executive Director (not yet commenced in post)		✓			08/02/2022	Present	Management action to be agreed with Accountable Officer.
SUNDERLAND, Sue	Non-Executive Director	Derbyshire Integrated Care Board	Non-Executive Director		✓			08/02/2022	Present	Management action to be agreed with Accountable Officer.
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.
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 - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	YPO - a publicly owned central purchasing body based in Wakefield, Yorkshire. It is owned and governed by a consortium of county, metropolitan and borough councils in Yorkshire and the North West England. It provides a wide range of resources and services to schools, councils, charities, emergency services, and other public sector organisations.	Independent Director (remunerated)	✓				01/10/2020	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

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.

Governing Body (Open Session)
UNRATIFIED minutes of the meeting held on
 02/02/2022, 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
Lucy Dadge	Chief Commissioning Officer
Eleri de Gilbert	Non-Executive Director
Dr Hilary Lovelock	GP Representative, Mid-Nottinghamshire
Amanda Sullivan	Accountable Officer
Sue Sunderland	Non-Executive Director
Rosa Waddingham	Chief Nurse
Dr James Hopkinson	Joint Clinical Leader
Dr Adedeji Okubadejo	Secondary Care Specialist
Stuart Poynor	Chief Finance Officer
Dr Stephen Shortt	Joint Clinical Leader

In attendance:

Lucy Branson	Associate Director of Governance
Kathy McLean	Chair Designate, NHS Nottingham and Nottinghamshire Integrated Care Board
Sue Wass	Corporate Governance Officer (minutes)
Alex Ball	Director of Communication and Engagement

Apologies:

None

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Dr Manik Arora	6	5	Stuart Poynor	6	5
Shaun Beebe	6	6	Dr Stephen Shortt	6	6
Sue Clague	6	6	Dr Richard Stratton*	3	3
Lucy Dadge	6	5	Amanda Sullivan	6	6
Eleri de Gilbert	6	6	Sue Sunderland	6	6
Dr James Hopkinson	6	5	Jon Towler	6	6
Dr Hilary Lovelock	6	4	Rosa Waddingham	6	6
Dr Adedeji Okubadejo	6	5			

* Dr Richard Stratton left 24/09/2021

Introductory Items

GB 21 114 Welcome and Apologies

Jon Towler welcomed everyone to the open session of NHS Nottingham and Nottinghamshire CCG's Governing Body meeting. 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 21 115 Confirmation of Quoracy

The meeting was declared quorate.

GB 21 116 Declaration of interest for any item on the shared agenda

There were no identified conflicts of interest.

Jon Towler reminded members of their responsibility to highlight any interests should they transpire because of discussions during the meeting.

GB 21 117 Management of any real or perceived conflicts of interest

No management action was required.

GB 21 118 Questions from the Public

There were no questions.

GB 21 119 Minutes from the meeting held on 01 December 2021

The minutes were agreed as an accurate record of the discussions held.

GB 21 120 Action log from the meeting held on 01 December 2021

Discussing action GB 21 083, regarding the development of the System Analytics and Intelligence Unit (SAIU), members queried oversight arrangements. It was noted that a development plan for Integrated Care Board (ICB) Board members was being drafted and this would form part of the plan.

Discussing action GB 21 100, regarding the development of primary care networks (PCNs), members expressed concern that there was no visibility of developments at Governing Body level. It was noted that a report on the role of PCNs would be brought to the March meeting of the ICS Transition and Risk Committee. It was also noted that the Clinical Design Authority and PCN Clinical Directors were due to meet shortly, and an invitation was extended to any members of the Governing Body or the Patient and Public Engagement Committee who wished to join.

Discussing issues relating to the development of PCNs, members queried whether a systematic programme management approach was being taken, and it was confirmed it was. It was noted that there needed to be a clear public message regarding the role of PCNs, namely were they General Practice at scale or units of delivery for population health management. It was noted that the vision for PCNs was the latter; however, PCNs were at different stages of maturity. It was agreed that it would be important to be clear on the governance route for the oversight of PCN development going forward.

All other actions were noted as completed and there were no other matters arising.

Strategy and Leadership

GB 21 121 Accountable Officer Report

Amanda Sullivan presented the item and highlighted the following key points:

- a) Covid infection rates were decreasing slowly, but significant pressure remained within both health and social care settings, with a high rate of community transmission. The focus was on hospital discharge to maintain flow. GP consultation rates continued to rise, which was a significant support to the urgent care system.
- b) 84% of over 18s in the CCG's area had received two doses of vaccination. To protect as many people as possible from the Omicron strain, three additional walk-in vaccination sites had been opened to meet demand. These had now closed, and

focus had switched to a targeted response in areas of low take up. This was proving successful, and learning would be taken into future work programmes to address wider health inequality issues.

- c) The CCG continued to operate under emergency governance arrangements following the move back into a Level 4 National Incident during December.
- d) Work on the recovery of services continued and planning guidance for 2022/23 had been received. It set out ten ambitious priorities, which included investment in workforce, clearing the elective care backlog, access to primary care and investment in mental health and learning disabilities services.
- e) Following the delay to the establishment of ICBs, approval was sought to extend the review dates until March 2023 for several key corporate policies. The Integrated Care System (ICS) Partnership Board had also been re-instated to provide a framework for the ongoing oversight of the ICS Transition Plan.
- f) Nottingham University Hospitals Trust (NUH) had recently appointed a new Chair.
- g) Thanks were extended to Dr Hilary Lovelock, who was stepping down from the Governing Body at the end of March. Hilary had worked with CCGs since their inception and had played an invaluable role in the development of integrated care pathways, and more recently on the vaccination programme.

Kathy McLean joined the meeting at this point

The following points were raised in discussion:

- h) Members queried how the development of the operational plan was being taken forward. It was noted that there was a whole system focus, with working groups developing detailed plans for each priority. Oversight of the draft plans would be via both the ICS Partnership Board and the CCG Governing Body. Members queried whether a similar monitoring process that had been used previously would be used in order for the Governing Body to be assured of progress. It was noted that it would, and performance reporting would be linked to strategic objectives. It was also agreed to develop a 'plan on a page' to monitor progress.

The Governing Body:

- **RECEIVED** the Accountable Officer's Report for information.
- **APPROVED** 12-month extensions to the review dates for the CCG's policies outlined within Appendix A.

GB 21 122 Joint Clinical Leaders' Report

Dr Stephen Shortt and Dr James Hopkinson gave a verbal update and highlighted the following key points:

- a) Although General Practice staff sickness rates were falling, focus remained on supporting staff.
- b) Work was on-going on the development of clinical support structures for the ICB.

The following points were raised in discussion:

- c) Members noted that activity in primary care had risen above pre-pandemic levels and queried whether this would be sustainable. It was noted that there had been a corresponding drop in activity in 111 and the clinical advice service. There was no action to take at this time and the trend would be monitored by the A&E Delivery Board.
- d) Members discussed the need to have visibility of metrics relating to access and it was noted there was work in progress to put in place metrics to monitor this as part of the development of the Primary Care Strategy.

The Governing Body:

- **NOTED** the verbal update.

GB 21 123 Arrangements for ICS Boundary Change and ICB Establishment

Amanda Sullivan presented the item and highlighted the following key points:

- a) To allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised target date of 1 July 2022 had been agreed for the new statutory arrangements to take effect and for ICBs to be legally and operationally established. The report detailed the local arrangements being put in place to ensure continued safe and effective operation of the CCG in the interim period.
- b) The date for the transfer of the area of Bassetlaw from the South Yorkshire and Bassetlaw ICS into the Nottingham and Nottinghamshire ICS would remain as 1 April 2022. The two CCGs would remain as separate legal entities and would continue to work collaboratively, with increasing operational alignment and formal meetings would be held 'in common' between the two CCGs as appropriate.
- c) The accounting period for 2022/23 would be split, with a 3-month period for CCGs and a 9-month period for ICBs.
- d) In light of the revised target date for the new statutory arrangements, an exercise had been completed to ensure the CCG remained able to operate effectively, as detailed in the report. As such a change to the Finance and Resources Committee's terms of reference was proposed to allow urgent decisions to be made.
- e) It was anticipated that shadow operating arrangements would be implemented incrementally during quarter one and governance arrangements were currently being finalised.
- f) ICS Partnership Board meetings had been re-instated to provide a governance framework for oversight of the ICS Transition Plan.

The following points were raised in discussion:

- g) Members queried arrangements for the Patient and Public Engagement Committee (PPEC) and plans for citizen engagement in the ICB. It was noted that PPEC would continue to meet until June in line with proposals for other CCG committees. Plans for patient and public engagement featured in the governance arrangements for the ICB, which were currently being finalised.

The Governing Body is asked to:

- **NOTED** the contents of the report.
- **APPROVED** the proposed amendment to the Finance and Resources Committee's Terms of Reference.

Commissioning Developments

GB 21 124 Primary Care Commissioning Committee Highlight Report – 15 December 2021 and 19 January 2022

Eleri de Gilbert presented the item and highlighted the following key points:

- a) The Committee had received an update on the Springfield Medical Centre merger in December 2021. This issue had been subject to four questions from members of the public and the Committee had been able to give assurance that the engagement undertaken had been thorough and there were no quality concerns.
- b) The Committee continued its focus on the sustainability and wellbeing of GP practices.
- c) The outcome of the PCN NHS England/Improvement (NHSE/I) Maturity Matrix review had been received, which had demonstrated good progress in PCN development.

The Governing Body:

- **RECEIVED** and **NOTED** the Primary Care Commissioning Committee Highlight Report.

GB 21 125 Patient and Public Engagement Committee (PPEC) Highlight Report – 30

November 2021 and 25 January 2022

Sue Clague presented the item and highlighted the following key points:

- a) PPEC members received a comprehensive report detailing the outcome of engagement undertaken to inform the development of a new service for children and young people, noting that the engagement had been undertaken at a stage that it could be used to inform the service specification. It would now be aligned to the development of a new service for adults to support transition arrangements between children and young people and adult services.
- b) Regarding the ICS Transition, there was some concern about the maturity of place and neighbourhood infrastructure to deliver effective citizen engagement. There was strong support for Patient Participation Group (PPG) involvement, but a recognition that not all areas had strong PPGs.
- c) An update was provided regarding Interpretation and Translation Service in relation to the planned engagement.
- d) The Primary Care IT Strategy for Nottingham and Nottinghamshire had generated specific interest in relation to tackling digital exclusion to enable all citizens to equitably access care and information. PPEC members requested that they be actively involved in its development.

The following points were raised in discussion:

- e) Noting that digital inclusion was an important factor in the reduction of health inequalities, Jon Towler requested that this issue be escalated to the Governing Body if PPEC members did not feel assured of the robustness of measures to address digital exclusion.

The Governing Body:

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

Financial Stewardship and Resources

GB 21 126 Finance and Resources Committee Highlight Report – 26 January 2022

Shaun Beebe presented the item and highlighted the following key points:

- a) An extra ordinary meeting scheduled for December had been cancelled due to the move into emergency governance arrangements; however scheduled reports had been circulated for assurance purposes.
- b) The Committee had received the finance report for month nine, which showed a forecast breakeven position for the remainder of the year. This was noted as being consistent with previous months. Mitigations for overspending areas had been scrutinised.
- c) The underlying deficit continued to pose a challenge for the CCG, with concern over the reliance on non-recurrent measures to ensure a break-even position.

The Governing Body:

- **RECEIVED** and **NOTED** the Finance and Resources Committee Highlight Report.

GB 21 127 2021/22 Financial Report Month Nine

Stuart Poynor presented the item and highlighted the following key points:

- a) The CCG remained under a temporary financial regime due to the continuing response to the pandemic, which had split the financial year into two planning periods H1, April to September and H2, October to March. The financial year was now to be reported on the entire twelve-month period and the forecast outturn for the year was a breakeven position.
- b) The year-to-date month nine reported position was on plan. Continuing healthcare costs continued to be the main cost pressure for the CCG; and the continued response to the pandemic had impacted on the level of income generated from the

Elective Recovery Fund. A financial savings group met weekly to ensure efficiency targets were on track.

- c) A surplus in the CCG's capital plan now seemed likely, as a result of delays in primary care estates schemes and the Finance and Resources Committee had asked the CCG to initiate discussions with NHSE/I on how best to manage this.
- d) A system-wide deficit continued to be forecast for 2021/22, due to the impact of the Omicron variant on the system's capacity to deliver the Elective Recovery Plan, which was an issue not unique to the Nottingham and Nottinghamshire system, and discussions with regulators were currently on-going.

The following points were raised in discussion:

- e) Looking ahead to the return of business-as-usual financial management, members discussed the need for both primary care and secondary care clinicians to take more ownership for the effective management of resources. It was noted this could be an area of focus for ICB clinical forums.
- f) Members queried how the system-wide deficit was being addressed. It was noted that system finance leads were developing a financial framework, which included mutual risk sharing. Members stressed the need for a continued focus on the issue.

The Governing Body:

- **NOTED** the 2021/22 Financial Report Month Nine.

Kathy McLean left the meeting at this point.

Quality and Performance

GB 21 128

Quality and Performance Committee Highlight Report – 27 January 2022

Eleri de Gilbert presented the item and highlighted the following key points:

- a) The Committee had received a deep dive report into Care Homes and the Home Care sector, which had provided a good level of assurance regarding governance arrangements. The report also detailed the continuing pressure in the sector relating to workforce pressures and looking ahead there would be a focus on developing an approach to market management.
- b) An update on quality assurance and oversight of services provided by NUH had been discussed. Although some progress was evident, particularly around leadership and culture, significant concern remained given continued operational and workforce pressures. The Committee had agreed to maintain the risk score at 25 at this time, given that, despite progress, the required level of assurance was not yet available.
- c) The Committee had received an external report on existing quality assurance processes, commissioned to assess if the CCG's current quality assurance model was fit for purpose now and for the future operating environment. The report's conclusions were positive but included twelve recommendations for improvement that would be taken forward.
- d) Thanks were given to Rosa Waddingham and her team for their continued hard work in this area.

The following points were raised in discussion:

- e) Members noted the importance of care homes and the home care sector being integral to the ICB's responsibilities for strategic workforce development, which was acknowledged.

The Governing Body:

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

GB 21 129

Integrated Performance Report

Stuart Poynor presented the item and highlighted the following key points:

- a) The report detailed the performance against key standards and targets for the CCG.
- b) As the H2 plan was predicated on significantly lower rates of covid infection than had been experienced during November and December, elective care performance was lower than trajectory. There was a focus on hospital discharge, which had been challenging over the past months, to improve elective care rates.

The following points were raised in discussion:

- c) Members noted the national drive to reduce waiting list times and queried whether the CCG had clear plans in place. It was noted that there was good system working on challenge areas, such as discharge, to help accelerate elective care. There was also work to re-profile elective care trajectories to give realistic timeframes for the recovery of services.
- d) Members queried off-target cancer rates. It was noted that cancer surgery had been impacted by hospital discharge issues and recovery plans were in place. It was also noted that diagnostic performance had continued to be strong, and this may have had a knock-on impact on cancer waiting times.
- e) Members noted the need for there to be visibility in forecast projections for the recovery of services and how the CCG was performing against the projections. It was agreed that the Quality and Performance Committee would allocate time to examine how this could be incorporated into the Performance Report.
- f) It was agreed that the Quality and Performance Committee would also examine the performance of cancer services. It was noted that a deep dive report had recently been drafted for the ICS and it was agreed that this would be circulated to the Committee for them to decide on the areas of focus ahead of any discussion.

The Governing Body:

- **NOTED** the Integrated Performance Report.

ACTIONS:

- **Development of the Performance Report in relation to the recovery of elective services to be added to the work programme for the Quality and Performance Committee.**
- **Performance of cancer services to be added to the work programme for the Quality and Performance Committee.**

Corporate Assurance

GB 21 130 Audit and Governance Committee Highlight Report – 13 January 2022

Sue Sunderland presented the item and highlighted the following key points:

- a) The Committee had reviewed several assurance reports on key areas of CCG business, including the annual fraud risk assessment, and a full review of all strategic risks on the Governing Body's Assurance Framework; and the Committee had met in common with the Audit Committee of Bassetlaw CCG to review the progress of the CCGs' joint Due Diligence Plan.

The Governing Body:

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

GB 21 131 Corporate Risk Report

Lucy Branson presented the item and highlighted the following key points:

- a) The CCG currently had ten major operational risks on its Corporate Risk Register, all of which had been discussed by the relevant Committees prior to being presented to the Governing Body.
- b) Following the request at the December 2021 Governing Body meeting, an

assessment had been undertaken on the workforce related risks currently held within the CCG's Corporate Risk Register and was detailed within the report.

The following points were raised in discussion:

- c) Regarding risk RR 130, relating to health inequalities, members queried whether work to develop the action plan that sat underneath the strategy was on track. It was noted that the plan was scheduled to be discussed at the ICS Development Session in February and be presented to the ICS Board in March 2022.

The Governing Body:

- **NOTED** the Corporate Risk Register.

For Information

- GB 21 132** **Ratified minutes of Governing Body committee meetings**
The minutes were **NOTED**.

Closing Items

- GB 21 133** **Any other business**
There was no other business.
- GB 21 134** **Date of the next meeting:**
06 April 2022 to be held virtually.

Governing Body
ACTION LOG for the meeting held on 02/02/2022

Meeting date	Agenda reference	Agenda item	Action	Lead	Date to be completed	Comment
ACTIONS OUTSTANDING						
-	-	-	<i>No actions outstanding</i>	-	-	-
ACTIONS ONGOING / NOT YET DUE						
-	-	-	<i>No actions ongoing</i>	-	-	-
ACTIONS COMPLETE						
02/02/2022	GB 21 129	Integrated Performance Report	Development of the Performance Report in relation to the recovery of elective services to be added to the work programme for the Quality and Performance Committee	Sue Wass	-	Discussed at the February meeting of the Quality and Performance Committee and included in the Committee's highlight report at GB 22 015
02/02/2022	GB 21 129	Integrated Performance Report	Performance of cancer services to be added to the work programme for the Quality and Performance Committee	Sue Wass	-	Discussed at the February meeting of the Quality and Performance Committee and included in the Committee's highlight report at GB 22 015



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
-----------------------	-------------------------------	--------------	---------------

Paper Title:	Accountable Officer's Report	Paper Reference:	GB 22 008
---------------------	------------------------------	-------------------------	------------------

Sponsor:	Amanda Sullivan, Accountable Officer	Attachments/ Appendices:	N/A
Presenter:	Stuart Poynor, Chief Finance Officer		

Summary Purpose:	Approve	<input checked="" type="checkbox"/>	Endorse	<input type="checkbox"/>	Review	<input type="checkbox"/>	Receive/Note for:	<input checked="" type="checkbox"/>
							<ul style="list-style-type: none"> Assurance Information 	

Executive Summary

The purpose of the Accountable Officer's Report is to summarise recent local and national developments and areas of interest for Clinical Commissioning Groups (CCGs) 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	<input checked="" type="checkbox"/>	Establishment of a Strategic Commissioner	<input checked="" type="checkbox"/>
Financial Management	<input type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input checked="" type="checkbox"/>
Performance Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input type="checkbox"/>
Strategic Planning	<input checked="" type="checkbox"/>	Procurement and/or Contract Management	<input type="checkbox"/>

Conflicts of Interest:

No conflict identified

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not required for this item.

Risk(s):

No risks are identified within this report.

Confidentiality:

No

Recommendation(s):

The Governing Body is requested to:

- **RECEIVE** the Accountable Officer's Report for information.
- **RATIFY** the contract award to Fittleworth Medical Ltd for the provision of a Stoma Appliance Prescription Service for three years, with an option to extend by a further two years.
- **RATIFY** the appointment of KPMG as the CCG's provider of external audit services from 1 April 2022 until disestablishment (subject to legislation).
- **RATIFY:** the contract awards/extensions to the current providers of the Discharge to Assess Pathway One to the value of £6.24 million for a period of six months from 1 April 2022.

Accountable Officer's Report

COVID-19 update

1. Local prevalence and response

As of 20 March, 350 beds in Nottinghamshire's hospitals were occupied by patients with Covid-19 (which compares to 485 beds at the peak during early January). Although hospitalisation rates are falling slowly, infection rates remain high and may rise again with the easing of social distancing restrictions.

GP practices continue to see high volumes of patients; however 61% of patients have been able to secure an appointment on the same day or the next.

Information on the latest Covid-19 related data is published on a weekly basis on the CCG's website at <https://nottsccg.nhs.uk/news>.

2. Covid-19 Vaccination Programme

Latest figures show in Nottingham and Nottinghamshire that 2,101,300 vaccinations (first, second, third and boosters) have been administered since the start of the programme. This means that 85.1% per cent of over 18s have now received two doses and 67.8% of over 18s have had a booster dose.

The Spring booster campaign commenced on 21 March. All adults aged 75 and over, residents in care homes for older people and those age 12 and over with a severely weakened immune system are eligible for a vaccine. Vaccines can be obtained from over 50 sites across Nottinghamshire, including pharmacies, vaccination centres and GP practices. These sites also remain open for those individuals who have not yet come forward for their first, second or booster dose.

CCG updates and developments

3. Notification to the Governing Body of the use of urgent decision-making powers

Since the last meeting of the Governing Body, there have been three occasions where the Governing Body's urgent decision-making powers have been used. In all instances, the use of these powers was either pre-agreed with the Governing Body or in line with emergency governance arrangements.

- (i) In February 2022, emergency powers were utilised to approve a contract award to Fittleworth Medical Ltd for the provision of a Stoma Appliance Prescription Service for three years, with an option to extend by a further two years. The contract award has enabled the existing service to continue, albeit with an adapted service specification pending further improvements to the pathway to achieve a fully integrated service. This decision was taken following a recommendation from the Prioritisation and Investment Committee as a result of its 9 February 2022 meeting.

Members of the Governing Body are requested to:

- **RATIFY** the contract award to Fittleworth Medical Ltd for the provision of a Stoma Appliance Prescription Service for three years, with an option to extend by a further two years.
- (ii) In March 2022, emergency powers were utilised to appoint the CCG's external auditor from 1 April 2022 based on a recommendation from the CCG's Auditor Panel, which met on 9 March 2022. In line with recent national guidance, the appointment covers the CCG's Annual Report and Accounts Process for 2021/22 and will stand until 1 July 2022, when (subject to legislation) the new Integrated Care Board will need to appoint its own external auditor.

Members of the Governing Body is requested to:

- **RATIFY** the appointment of KPMG as the CCG's provider of external audit services from 1 April 2022 until disestablishment (subject to legislation).
- (iii) In March 2022, emergency powers were utilised to approve a number of contract awards/extensions for a period of six months to the current providers of the Discharge to Assess Pathway One. The contract awards allow plans to implement longer term discharge support services to be progressed. This decision was taken following a recommendation from the Prioritisation and Investment Committee as a result of its extra ordinary meeting on 23 March 2022.

Members of the Governing Body are requested to:

- **RATIFY:** the contract awards/extensions to the current providers of the Discharge to Assess Pathway One to the value of £6.24 million for a period of six months from 1 April 2022.

4. Tomorrow's NUH: Shaping the future of health facilities at Queen's Medical Centre, City Hospital and Ropewalk House

The period of public engagement for people in Nottingham and Nottinghamshire to give their views on a once-in-a generation opportunity to shape the way its health and care services are delivered came to an end on 1 April 2022. The CCG launched a four-week engagement programme, which included a survey and public events, to help shape the future of health facilities at Queen's Medical Centre, City Hospital and Ropewalk House. The facilities at these sites, run by Nottingham University Hospitals NHS Trust (NUH), are set to benefit from the Government's New Hospital Programme, which is offering an opportunity to secure significant investment to redevelop them, as well as constructing some new buildings and carrying out major refurbishment work – these plans are known as Tomorrow's NUH. In November and December 2020, the public were able to share their thoughts on the possible changes to the way services could be delivered, to improve the experiences of all who use the QMC and City Hospitals. Since then, a lot of work has been undertaken to develop the plans further and to identify what can be done to make the best use of the funding available. Feedback will be incorporated into the next stage of the project, which is the development of a business plan, which will be subject to formal public consultation.

Partner updates

5. Integrated Care System (ICS) Board update

When the Nottingham and Nottinghamshire Integrated Care System (ICS) Board last met on 3 March 2022 and received reports on the development of the Citizen Intelligence Strategy; the progress of operational planning for 2022/23; the ICS Green Plan; and reports on preparations for the establishment of the Integrated Care Board and Integrated Care Partnership.

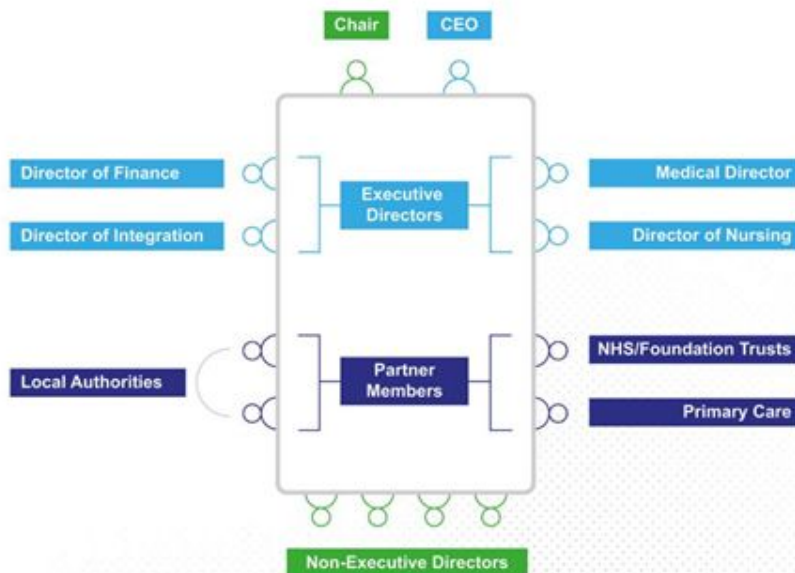
The Board will meet again on 5 May 2022.

All meeting papers will continue to be published on the ICS website at <https://healthandcarenotts.co.uk/>.

6. Integrated Care Board designate appointments

The Health and Care Bill intends to put Integrated Care Systems (ICSs) on a statutory footing, which will see Integrated Care Boards (ICBs) being legally and operationally established from a target date of 1 July 2022.

The membership of our local ICB Board (as illustrated below) was agreed by ICS partners in November 2021, which was subsequently approved by NHS England, subject to the legislative process.



As previously reported, Dr Kathy McLean OBE is appointed as designate Chair of the ICB, and Amanda Sullivan as designate ICB Chief Executive.

More recently, Jon Towler, Professor Marios Adamou OBE and Stephen Jackson have been appointed as designate Non-Executive Directors of the ICB. Designate appointments to

three of the ICB Executive Director positions have also been made: Stuart Poynor as Director of Finance, Rosa Waddingham as Director of Nursing and Lucy Dadge as Director of Integration.

Recruitment processes have recently concluded to make designate appointments to the fourth and final Non-Executive Director role and to the Medical Director role.

Appointments to the Partner Members of the ICB Board will be subject to secondary legislation, which is anticipated in a timeframe that will enable local appointments to be made during May 2022.

7. Appointment of new Lead for Nottingham City Place Based Partnership

Mel Barrett, Chief Executive of Nottingham City Council, has been appointed as Lead for the Nottingham City Place Based Partnership (PBP). He will take over from Dr Hugh Porter as Interim Lead on 1 April 2022. The Nottingham City PBP, formerly known as the Integrated Care Partnership, was established in 2019 to bring together health and care services including GPs, local authority services, community services and hospitals, as well as wider services provided by the community, voluntary and social enterprise sector. The Nottingham City PBP is one of four 'place-based' partnerships in the Nottingham and Nottinghamshire Integrated Care System.

8. Appointment of new Chief Executive for Sherwood Forest Hospitals NHS Foundation Trust

Paul Robinson has been appointed as Chief Executive of Sherwood Forest Hospitals. Paul, who has been interim Chief Executive since September last year, takes up the position permanently following an open and competitive recruitment process.

Paul joined the Trust in May 2015 and has worked in the NHS for more than 30 years. Paul has wide experience across all sectors of healthcare and has a strong track record of financial performance and delivery. He was part of the team that delivered NHS trust status for Lincolnshire Community Healthcare Services and has also held senior positions in foundation trusts and primary care trusts. Paul is a Chartered Management Accountant.

9. Health and Wellbeing Board updates

Nottinghamshire County Health and Wellbeing Board

The Nottinghamshire County Health and Wellbeing Board last met on 23 March 2022. The meeting received a report on the Nottinghamshire Joint Health and Wellbeing Strategy 2022-2026.

The papers and minutes from the meeting are published on Nottinghamshire County Council's website here: <https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board>.

Nottingham City Health and Wellbeing Board

The Nottingham City Health and Wellbeing Board met on 30 March 2022. The meeting received updates on the green social prescribing programme, the Integrated Care System and the Nottingham City Place-Based Partnership; and the Joint Health and Wellbeing Strategy for Nottingham City.

The papers and minutes from the meeting are published on Nottingham City Council's website here:

<https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0>.

National updates

10. Secretary of State for Health and Social Care's vision for healthcare reform

On 8 March, Sajid Javid gave a speech giving his long-term vision for the NHS. Whilst confirming the principle of ensure healthcare remained free at the point of use, he listed the long-term challenges of futureproofing the NHS as “changing demographics and disease; how to meet rising patient expectations and address the injustices of widespread disparities; and how to deal with an unsustainable financial trajectory while backing the brilliant people who work in health and care”.

And the three reform areas were described as:

- Prevention – how we build, not just a ‘national hospital service’ but a true ‘National Health Service’.
- Personalisation – how we deliver more personalised care, empower patients and fulfil the promise of the technological leaps we’ve seen throughout the pandemic.
- Performance – how we make sure the NHS can deliver the British people the very best healthcare in the world.

Several new commitments and initiatives were showcased in the speech, including:

- A new ‘Health Promotion Taskforce’ to join up work with every part of government and the launch of a Health Disparities White Paper later this year to help prevent disease and reduce deep-seated inequalities.
- Putting Community Diagnostic Centres at the heart of communities.
- Putting the prevention agenda at the heart of every part of the NHS, with particular emphasis on cardio-vascular disease and the use of the NHS app.
- The expansion of Personal Health Budgets.
- Working with local authorities to expand the ‘shared lives model’, where people in need of care go to live with carers and become like any other member of the family.
- Improving the roles of the patient voice.
- The ‘Right to Choose’, a move to a model where long-waiters will be offered the ‘right to choose’, proactively contacted to discuss an offer of alternative provisions.

- The publication of a comprehensive Digital Health and Care Plan, which will include social care.
- The ambition for electronic records to be rolled out to 90 percent of trusts by December 2023, and 80 percent of social care providers by March 2024.
- Taking forward recommendations from the General Sir Gordon Messenger and Dame Linda Pollard review of leadership in Health and Social Care.

The full speech can be found at <https://www.gov.uk/government/speeches/health-and-social-care-secretary-speech-on-health-reform>

11. Government White Papers

On 2 February 2022, the government published *Levelling up the United Kingdom* ([Levelling Up the United Kingdom - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/white-papers/levelling-up-the-united-kingdom)), which sets out a moral, social and economic programme for the whole of government across four objectives to:

- Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging.
- Spread opportunities and improve public services, especially in those places where they are weakest.
- Restore a sense of community, local pride and belonging, especially in those places where they have been lost.
- Empower local leaders and communities, especially in those places lacking local agency.

On 9 February 2022, the government published *Health and social care integration: joining up care for people, places and populations* ([Health and social care integration: joining up care for people, places and populations - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/white-papers/health-and-social-care-integration-joining-up-care-for-people-places-and-populations)). The White Paper focuses on integration arrangements at place level and aims to accelerate better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. It covers governance and leadership requirements, budget pooling, oversight arrangements, and digital and workforce planning.

The integration White Paper invites views on several questions to support progress on the effective implementation of proposals. A system response is being discussed. Work is also being completed to produce a local roadmap for place development in the context of the White Paper.

NHS Confederation have published helpful overviews of both White Papers and what they mean for the health and care sector, which are available here:

- <https://www.nhsconfed.org/publications/levelling-uk-what-you-need-know>
- <https://www.nhsconfed.org/publications/integration-white-paper-what-you-need-know>

12. Proposals for the NHS Provider Selection Regime

On 21 February 2022, the Department of Health and Social Care published details of proposed regulations for the Provider Selection Regime ([Preview of proposals for the Provider Selection Regime - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/white-papers/provider-selection-regime)). Subject to the passage of the Health

and Care Bill through Parliament, the Provider Selection Regime will be a new set of rules for arranging healthcare services, which is intended to give decision makers a flexible, proportionate decision-making process for selecting providers to deliver healthcare services to the public. The Provider Selection Regime would replace the existing procurement rules for healthcare services, with the aim of making it easier to integrate services and enhance collaboration and ensure that decisions are:

- Made in the best interest of patients, taxpayers, and the population
- Robust and defensible, with conflicts of interests appropriately managed
- Made transparently

Due to timing constraints, the Provider Selection Regime will not be established at the same time as ICBs, but will be established as soon as possible thereafter, subject to Parliamentary approvals and scheduling. A consultation on proposals closed on 28 March 2022.

13. CCGs: Transferring the Legacy into Learning

The NHS Confederation has recently released a publication seeking to highlight key aspects of the CCG legacy. The report's findings highlight that CCG leaders acknowledge ICSs as the logical next step towards full integration, using collective resources to do more to address health inequalities and advance a population health management approach. The report examines the factors that have influenced CCG successes, what is at risk in the new arrangements and what are the opportunities to build on the successes. It makes 11 recommendations to help ICSs learn from this legacy:

Empowering clinical leadership and engagement

- Nurture and differentiate clinical, professional and operational leadership and encourage individuals from underrepresented professional disciplines to take broader leaderships roles.
- Invest in comprehensive engagement of primary care clinicians, enabling their direct influence of decision-making. Consider protecting a portion of primary care practitioners' time for continued input to strategic planning.
- Support a primary care leadership pipeline from 'place' through to system and national roles, to encourage a strong voice from grass-roots practitioners.

Driving quality and improvement

- Embrace peer learning, mutual support and system learning as key drivers of improving quality across wider areas of service delivery.
- Prioritise and 'systematise' medicines optimisation efforts, building on CCGs' legacy, to improve health outcomes and deliver financial efficiencies.
- Develop clinically-led models of care at place level to promote safety, efficacy and quality.
- Embed multidisciplinary commissioning skillsets within ICS operations and safeguard institutional memory.

Facilitating place-based integration

- Delegate resources and decision-making powers as near to the patient as possible at a neighbourhood and place level where the deeper understanding of the population sits.
- Support primary care leaders to collaborate with directors of public health at place to reprioritise investment which best reduces health inequalities, drawing on their day-to-day experience of treating patients whose health is shaped by wider determinants.
- Learn from the most effective health and wellbeing boards and best practice to support shared understanding and integrated working.
- Continue integrated local authority and NHS working at place through use of new place-based arrangements, from joint committees to lead provides and provider collaboratives.

The full report can be found at https://www.nhsconfed.org/sites/default/files/2022-03/Clinical-commissioning-groups-transferring-the-legacy-into-learning_0.pdf

Recommendation(s)

The Governing Body is requested to:

- **RECEIVE** the Accountable Officer's Report for information.
- **RATIFY** the contract award to Fittleworth Medical Ltd for the provision of a Stoma Appliance Prescription Service for three years, with an option to extend by a further two years.
- **RATIFY** the appointment of KPMG as the CCG's provider of external audit services from 1 April 2022 until disestablishment (subject to legislation).
- **RATIFY:** the contract awards/extensions to the current providers of the Discharge to Assess Pathway One to the value of £6.24 million for a period of six months from 1 April 2022.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	Highlight report from the (virtual) meeting of the CCG's Primary Care Commissioning Committee	Paper Reference:	GB 22 010
Chair of the meeting:	Eleri de Gilbert – Non Executive Director	Attachments/ Appendices:	-
Summary Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/>
			<ul style="list-style-type: none"> • Assurance • Information

Summary of the Meetings

The Primary Care Commissioning Committee (PCCC) met on the 16 February 2022 and 16 March 2022. Due to the current Coronavirus (Covid-19) situation, the meetings were held virtually.

At the February meeting, the Committee:

- **RECEIVED** routine reports in relation to, Primary Care Contracting, finance, quarterly quality briefing and OPEL reporting. OPEL reporting and staff absence are both stabilising following the impact of the Omicron virus in November and December 2021.
- **RECEIVED** an update on the winter access fund. The fund is subject to a high level of scrutiny from NHSE/I.
- **NOTED** that PCN delivery and development has become a focus for the ICS Transition and Risk Committee.
- **RECEIVED** the risk report which included eight risks (two red rated). Members agreed to archive risk 137 related to increased risk of Covid-19 infection to clinically vulnerable staff.

At the March meeting, the Committee:

- **RECEIVED** routine reports in relation to, contract performance and OPEL reporting. OPEL reporting and staff absence continue to improve.
- **RECEIVED** a review of the impact of a reduction in opening hours at Bull Farm surgery, the branch surgery to Oakwood surgery. Members received limited assurance and requested a more extensive and proactive review of the impact is undertaken.
- **RECEIVED** the winter access fund update and noted that additional funding had been made available to be used to deliver the improving access winter plan and long-term plan priorities.
- **RECEIVED** the finance report which detailed the year-to-date position, forecast out-turn position and provided a high-level draft indicative budget for 2022/23.
- **RECEIVED** the risk report noting that two risks remain red rated reflecting pressures on the primary care workforce.

Key messages for the Governing Body

The Committee:

- **APPROVED** the boundary extension to The Practice St Albans & Nirmala.
- **APPROVED** the direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCNs (via GP Federations) for a two-year period from 01 April 2022 until 31 March 2024.
- **RECEIVED** an update on developments related to Primary Care IT. There are lots of changes at a national level in respect of Primary Care IT with four bodies involved in IT coming together as one, to create a national digital strategy. The national strategy describes what good looks like and sets expectations for each ICS. Funding streams for IT have been aligned and there is significant finance available to allow all systems to 'level up' in terms of technology. The aim is to enable information to be shared across all health and care sector boundaries. A revised local primary care IT strategy is being developed with PCN engagement as a key focus. The strategy will be in place by 30 April 2022.
- **RECEIVED** an update on primary care workforce planning noting the concerns in respect of nursing in general practice and the importance of alignment of the workforce strategy with the ICS primary care strategy.
- **RECEIVED** the year-end report on Primary Care Network Development noting the progress made and priorities for 2022/23.
- **NOTED** the NHS England General Practice Contract Arrangements 2022/23 letter and the key requirements for general practice. There has been some negative coverage following publication of the NHSE/I letter.

The ratified minutes of the February 2022 meeting are available in the information items section of the agenda.

The ratified minutes of the March 2022 meeting will be received by the Governing Body in June 2022.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Nottingham and Nottinghamshire Patient and Public Engagement Committee	Date:	06 April 2022
Paper Title:	Highlight report from meetings held on 22 February and 29 March 2022	Paper Reference:	GB 22 011
Chair of the meeting:	Sue Clague	Attachments/ Appendices:	
Summary Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/>
			<ul style="list-style-type: none"> • Assurance • Information

Summary of the Meeting

The Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) has continued to meet virtually and most recently meetings have taken place on 22 February 2022 and 29 March 2022.

The main agenda items considered by PPEC members during the above-mentioned meetings have included:

- Framework for ICS transition for involving people and communities with a focus on governance structures
- Elective Care Recovery
- Tomorrow's NUH/Reshaping Health Service in Nottinghamshire
- Children and Young People Early Intervention Service
- Update on other key areas of work including:
 - Covid vaccination programme
 - Elective recovery plans relating to backlog and waiting list recovery
 - Nottingham and Nottinghamshire Health and Wellbeing Strategy
 - Primary Care Engagement Checklist
 - Long Covid Report

Key Messages for the Governing Body

The key messages that PPEC members agreed to share with the Governing Body from its meeting held on 22 February and 29 March 2022 are:

1. With regard to the ICS Transition: Working with people and communities, PPEC members received an update. As last month, PPEC Members raised concerns around the involvement of patients and citizens at place and neighbourhood level. There remain challenges to ensure that patient engagement is firmly embedded at each part of the new system. PPEC members were also keen to understand the health-based priorities to ensure that patient co-production in pathways is at the heart of all commissioning decisions. It was agreed to keep this item as an ongoing agenda item together with 1:1 conversations with the Chair and PPEC Members.
2. There have been two updates provided at each meeting around Tomorrow's NUH/Reshaping Services in Nottinghamshire at the last meeting a presentation was provided by James Hopkinson and Mark Sheppard around the proposals for this piece of work which was well received by PPEC

members, a good quality discussion took place around issues that need to be addressed. The engagement report will be presented to PPEC members following phase 2 of the engagement.

3. PPEC members received an update on plans in place regarding elective recovery and noted the steps being taken to address the long waiting lists that had occurred due to Covid. PPEC members continue to be concerned around communication on delays, particularly in relation to NUH.
4. Children and Young People Early Intervention services. PPEC received an update around the procurement and mobilisation of the new provider for the service and how the engagement activity fed into this piece of work. PPEC members were delighted with the outcome of this project as a positive demonstration of how patient engagement can make a difference on programmes that are commissioned.
5. Covid – Updates are provided at all meetings to keep the members up to date. Concerns were raised around the availability of free lateral flow testing kits for families on low incomes.

The ratified minutes of Patient and Public Engagement Committee meetings held on 25 January 2022 and 22 February 2022 will be presented to the next Governing Body on 06 April 2022.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	Finance and Resources Committee Highlight report – 23 February 2022 and 23 March 2022.	Paper Reference:	GB 22 012
Chair of the meeting:	Shaun Beebe – Non-Executive Director	Attachments/ Appendices:	None
Summary Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/>
			<ul style="list-style-type: none"> • Assurance • Information

Summary of the Meeting

The Finance and Resources Committee met on 23 February and 23 March 2022. Both meetings were held virtually.

At these meetings, the Committee:

- **RECIEVED** the finance reports for months' ten and eleven, which showed a forecasted breakeven position for the remainder of the year. Areas of overspend continue to be mitigated by the release of primary care delegated reserves and other non-recurrent measures. The Committee approved the reports for onward submission to the Governing Body.
- **RECIEVED** an update on financial planning for 2022/23 at the February meeting. Members were provided with a progress update on the draft plan submissions and the next steps required to submit a compliant plan, including the exploration of new ways of working using emerging architecture and networks, which was incorporated following the System Executive Group meeting on 8 February 2022.
- **ENDORSED** the 2022/23 opening budgets at the March meeting for approval at the Governing Body meeting. Following the discussion around the challenging system financial position, members requested that risks within the 2022/23 CCG Financial Plan be explained at the April Governing Body meeting.
- **RECEIVED** the Cross Provider Reports which provided the in-month position and the year to date position on activity against the H2 plan.
- **RECEIVED** an update on the planning process for the Acute, Independent Sector, Mental Health and Community contracts and received confirmation that NHS England and NHS Improvement required signed contracts to be in place with all providers from 1 April 2022.
- **RECEIVED** the initial findings from the 2021 CCG Staff Survey. The questions had been aligned with the NHS People Promise for the first time and this meant that a baseline had been established for many of the questions. It was emphasised that whilst trends could not be identified for this year, analysis will be possible going forward. The detailed findings will be presented at the April Committee meeting.
- **RECEIVED** the workforce report at the March meeting. Discussions took place around staff wellbeing and ways to provide support to staff dealing with stress/anxiety/depression. An action was taken to raise this at an upcoming Senior Leadership Team meeting. The report also summarised information relating to the CCG's workforce. It was noted that the completion rate for appraisals had dropped

significantly and this was concerning. It was agreed that as a temporary measure, ‘soft appraisals’ would be encouraged, until the establishment of the ICB. This will ensure staff are still supported whilst recognising the pressures faced at present and the impact this is having on completion rates.

Key Workforce Indicators currently stand at:

	Target	Actual (as at end August 2021)
Sickness Absence	2.72%	1.96%
Monthly Turnover	1%	Exceeded 1% in 6 of the last 12 months
Completion of Appraisals	92%	38%

- **DISCUSSED** the System Financial Position and plans to reduce the underlying deficit. Members noted that 2022/23 will be a challenging year for many system partners.
- **CONSIDERED** risks specific to the Committee’s remit.

Key Messages for the Governing Body

The Committee agreed to update the Governing Body on the following matters; -

- 2022/23 System Financial position
- 2022/23 CCG Plans and Budgets
- Key themes from the Workforce Report

The ratified minutes of the January and February 2022 meetings are provided to the Governing Body in the ‘Information Items’ section of this meeting.

The ratified minutes of the March 2022 meeting will be received by the Governing Body on 1 June 2022.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (open session)	Date:	06 April 2022
Paper Title:	Finance Report Month Eleven	Paper Reference:	GB 22 013
Sponsor:	Stuart Poynor, Chief Financial Officer	Attachments/ Appendices:	-
Presenter:	Stuart Poynor, Chief Financial Officer		
Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/>
			<ul style="list-style-type: none"> Assurance Information

Executive Summary

The CCG currently remains under a temporary financial regime due to the continuing pandemic.

The temporary financial regime has split the financial year into two planning periods, H1 April to September and H2 October to March. NHS England/Improvement (NHSE/I) have advised that whilst these periods have been planned separately, the reporting for the financial year will be based on the entire period. As such, at month eleven, the year-to-date position of month one through to month eleven will be reported.

Both the year to date and forecast outturn reported positions are a balanced in year income and expenditure position. This represents an on-plan position for H2.

Key variances within the forecast outturn position include pressures on Continuing Healthcare (CHC) at £3.265 million over plan, the Elective Recovery Fund (ERF) pressure of £3.08 million from H1 noted in previous reports and section 117 placements within Mental Health at £0.764 million over plan.

These pressures are offset by key underspends on delegated Primary Care (£3.413 million), Other Primary Care (£2.526 million), and Prescribing (£0.893 million) and underspends across Estates and Corporate budgets of £0.789 million.

The CCG capital expenditure forecast for the full year is circa £0.97 million, which is broadly in line with last month, giving an undershoot of circa £1.1 million on the total £2.1 million capital allocation. As noted last month, NHSEI are managing the capital resource implications of the undershoot on the Mansfield Supported Living scheme.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	<input type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input type="checkbox"/>
----------------------------------	--------------------------	---	--------------------------

Financial Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input type="checkbox"/>
Performance Management	<input type="checkbox"/>	Procurement and/or Contract Management	<input type="checkbox"/>
Strategic Planning	<input type="checkbox"/>		
Conflicts of Interest:			
<input checked="" type="checkbox"/> No conflict identified <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion and decision <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion, but not decision <input type="checkbox"/> Conflict noted, conflicted party can remain, but not participate in discussion or decision <input type="checkbox"/> Conflict noted, conflicted party to be excluded from meeting			
Completion of Impact Assessments:			
Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not required for this item.
Risk(s):			
None identified.			
Confidentiality:			
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
Recommendation(s):			
1. To NOTE the Finance Report			

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Finance report

Month 11 2021/22

1

Contents

- Introduction and executive summary slide 3
- CCG month 11 financial position slide 4
- Month 11 reporting risks and issues slide 5
- Month 11 Cash/BPPC/Debtors slide 6
- 2021/22 capital plan update slide 7
- Conclusions and recommendations slide 8
- Appendix 1 – month 11 OCS
- Appendix 2 – QIPP

Introduction and executive summary

- The CCG currently remains under a temporary financial regime due to the continuing COVID situation
- The temporary financial regime has split the financial year into two planning periods, H1 April to September and H2 October to March. NHSEI have advised that whilst these periods have been planned separately, the reporting for the financial year will be based on the entire period. As such, at month 11, the year to date position of month 1 through to month 11 will be reported.
- Both the year to date and forecast outturn reported positions are a balanced in year income and expenditure position. This represents an on plan position for H2.
- Key variances within the forecast outturn position include pressures on Continuing Healthcare (CHC) at £3.265 million over plan, the Elective Recovery Fund (ERF) pressure of £3.08 million from H1 noted in previous reports and section 117 placements within Mental Health at £0.764 million over plan.
- These pressures are offset by key underspends on delegated Primary Care (£3.413 million), Other Primary Care (£2.526 million) and Prescribing (£0.893 million) and underspends across Estates and Corporate budgets of £0.789 million
- The CCG capital expenditure forecast for the full year is circa £0.97 million, which is broadly in line with last month, giving an undershoot of circa £1.1 million on the total £2.1 million capital allocation. As noted last month, NHSEI are managing the capital resource implications of the undershoot on the Mansfield Supported Living scheme.

CCG month 11 YTD & FOT financial position

The month 11 financial position is set out below (see appendix 1 for the full OCS):

21/22 Programme Area	Month 11 YTD Ledger			Off Ledger					Full year FOT
	Budget	Actual	Variance	Cum. Surplus	Elective Recovery Fund	Hospital Discharge Programme	ARRS/WAF	Total adjusted variance	Total adjusted variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute	998,346	1,005,313	(6,967)		0			(6,967)	(8,019)
Community	163,285	163,515	(230)					(230)	(249)
Mental Health	184,664	184,929	(265)					(265)	1,419
Continuing Healthcare	111,258	112,894	(1,636)					(1,636)	(3,265)
Primary Care Co-Commissioning	153,102	154,453	(1,352)				2,374	1,022	3,414
Prescribing	147,221	146,252	969					969	893
Other Primary Care	37,749	35,775	1,974					1,974	2,526
Other Programme	86,851	87,927	(1,075)			2,099		1,024	(898)
Total Programme Costs	1,882,476	1,891,058	(8,582)	0	0	2,099	2,374	(4,108)	(4,179)
Running Costs	18,062	17,958	104					104	175
Contingency	0	0	0					0	0
Total prior to planned surplus/(deficit)	1,900,538	1,909,016	(8,478)	0	0	2,099	2,374	(4,005)	(4,005)
Planned Surplus/(Deficit)	14,940	0	14,940	(10,935)				4,005	4,005
Total reported position	1,915,478	1,909,016	6,462	(10,935)	0	2,099	2,374	0	0

The off ledger adjustments are required as follows:

- Cumulative surplus – in month the prior year cumulative surplus has been returned to the CCG so this has been backed out so that the above table shows the in year position
- HDP – an additional allocation is awaited for this
- ARRS/Winter Access Fund - an additional allocation is awaited for this

• The Acute overspend of £8.02m is due to £3.08m of ERF H1 (£2.79m forecast). The net ERF position takes into account the planned surplus of £4.0m in H1.

• The forecast Mental Health underspend includes an overspend on S117 placements of £0.764m. Within the month 12 position there is a release of mental health reserves which drives the net underspend. This underspend does not compromise the achievement of the MHIS standard.

• The CHC overspend of £3.265m is due partly from price increase as a result of the Lang Buisson review, but primarily due to an increase in placements as a higher proportion transferring from discharge than planned. The H2 costs have continued to rise

• The primary care budget is underspent due primarily to unrequired risk reserve of £2.6m at H1, and the further underspends in H2.

• The other primary care budgets have benefitted from planned savings work, specifically retendering GP caretaking at reduced costs, plus some prior year benefits around enhanced services and access payments.

• Other programme spends reflect the release of savings identified to support the in year position. These include planned savings, and non-recurrent slippage on programmes in year. Also included within here is the H2 efficiency challenge that sit in reserves but is offset by the above solutions.

• Other programme also contains HDP claims awaiting reimbursement

• The CCG is reporting a breakeven position in line with the H2 plan approved by NHSE/I in November.

• The forecast outcome for the year is breakeven in line with the reported H1 position plus the final H2 plan

Month 11 reporting risks and issues

Risks/issues.

As we move towards the year end, the risks and issues previously reported are being, or have been, addressed. The main risk here was the H2 efficiency target which was largely unidentified at the beginning of the H2 period. Balance sheet and slippage on allocations schemes have allowed for a one-off delivery of this efficiency target.

The key issue remaining is the receipt of the anticipated allocations in regards to national Covid £3.2 million and ARRS and Winter Access Fund £6.0 million. This is regarded as low risk as these areas have been funded as we have progressed through the H2.

Month 11: Cash, BPPC and Debtors

Cash

- Month 11 cash position is a closing cash balance of £0.142m against a maximum target balance of £1.95m

BPPC

- Based on the thirty-day compliance, the month 11 BPPC statistics are showing compliance above the 95% for value and volume.

Volume / Value invoiced paid within 30 days	Cumulative Quantity/ Value	FEB-22		Non NHS		NHS		TOTAL	
		Quantity/ Value	Quantity/ Value Fails	FEB-22	Cumulative	FEB-22	Cumulative	FEB-22	Cumulative
Volume	35,925	3,650	17	99.52%	96.77%	100.00%	98.70%	99.53%	96.81%
Value	£1,709,174,783	£154,138,796	£88,806	99.81%	98.10%	100.00%	99.98%	99.94%	99.44%

Debtors

- The debt position for the CCG is as follows:

	Not Yet Due		Overdue 1 - 30 Days		Overdue 31 - 60 days		Overdue 60 days +		TOTAL	
	Volume	Value	Volume	Value	Volume	Value	Volume	Value	Volume	Value
Non NHS	27	£686,988	3	£19,840	3	£47,014	36	£354,226	69	£1,108,068
NHS	6	£1,991,196	4	£447,622	2	£30,442	3	£43,284	15	£2,512,544

The key debts noted in table are:

- Non NHS – CHC recharges with 26 companies £240k; Nottinghamshire County Council £239k of which £72k relates to prescribing; Nottingham City Council £369k of which £89.5k relates to prescribing; Prescribing recharges £178k; £82k other.
- NHS – Recharges with 3 NHS FTs £503k; Recharges with 2 NHS Trusts £29k; Recharges with 6 CCGs £125k; Recharges with NHS England & Improvement £1,856k.
- None of these debts are expected to be at risk.

CCG 2021/22 Capital Resource Limit and Capital Plan

The CCG has an overall CCG has a capital resource limit of £2.135 million; The capital spend lines being:

- GP premises grants £0.6 million
- GP IT £0.306 million
- Grants to support estates rationalisation £0.126 million
- Mansfield supported living (LD premises grant) £1.103 million.
- Due to delays in primary care as a result of Covid pressures and also supply chain issues, it is forecast that the GP premises grants schemes, together with estates rationalisation, will not deliver against the full planned capital resource limit, circa £0.583 million. We are currently discussing with NHSEI about how this is best managed
- The Mansfield Supported Living scheme payment for the land has been made by NHSEI in February £483.5k. The NHSEI officer overseeing the scheme has advised that contractors Have started on site and there will be a small level of expenditure in relation to this of circa £34.4k. The scheme will therefore underspend this year by £585k, with an expectation that the scheme will now run into 2023/24. The capital allocation for this scheme from 2022/23 (and 2023/24) is being met through a national allocation and will not be deducted from the CCG's capital allocation for these years.
- The GP IT expenditure has been incurred.

Planned spend and profile £000			
Scheme	Annual Plan	YTD	Mar
Mansfield Supported Living (LD Premises Grant)	1103	1103	
GP Premises grants	600	400	200
GPIT	306	306	
Grants to support estates rationalisation	126	100	26
Total	2135	1909	226
Actual monthly spend £000			
Scheme	Annual Forecast	YTD	Mar
Mansfield Supported Living (LD Premises Grant)	517.9	483.5	34.4
GP Premises grants	143	0	143
GPIT	306	306	0
Grants to support estates rationalisation	0	0	0
Total	966.9	789.5	177.4
Variance £000 Under / (Over) Plan			
Scheme	Annual Variance	YTD	Mar
Mansfield Supported Living (LD Premises Grant)	585.1	619.5	-34.4
GP Premises grants	457	400	57
GPIT	0	0	0
Grants to support estates rationalisation	126	100	26
Total	1168.1	1119.5	48.6

Conclusion and recommendations

- The CCG is reporting an on plan position against the combined H1 and draft H2 year-to-date financial plan
- CCG is also forecasting to deliver an on plan financial position, and breakeven in I&E terms
- The CCG is reporting year to date ERF financial pressures of £2.79 million
- Non-ERF financial pressures are mainly within CHC expenditure, with a forecast overspend of £3.27 million
- These pressures are fully mitigated by the use of delegated primary care reserves and non-recurrent balance sheet measures
- The CCG capital plan remains at £2.1 million and at this stage of the year is forecast to be underspent by £1.17 million

The Governing Body is recommended to:

- **Note** the financial position for the reporting period
- **Approve** the finance report

Ian Livsey
Deputy Director of Finance
March 2022

Operating Cost Statement: M11

NOTTINGHAM & NOTTINGHAMSHIRE CCG	YEAR TO DATE			FORECAST		
	Plan £m	Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Acute Services						
Nottingham University Hospitals	584.59	584.59	0.00	637.64	637.64	0.00
Nottingham University Hospitals - Treatment Centre	0.00	0.00	0.00	0.00	0.00	0.00
Nottingham University Hospitals - Non Core	41.98	41.98	0.00	41.98	41.98	0.00
Sherwood Forest Hospitals	277.93	277.93	0.00	303.28	303.28	0.00
Sherwood Forest Hospitals - Non Core	12.71	12.71	0.00	12.71	12.71	0.00
East Midlands Ambulance Service	37.74	37.74	0.00	41.16	41.16	0.00
University Hospitals Of Derby And Burton	6.29	6.29	(0.00)	6.86	6.86	0.00
United Lincolnshire Hospitals	5.07	5.07	0.00	5.53	5.53	0.00
Doncaster & Bassetlaw	3.32	3.32	0.00	3.62	3.62	0.00
University Hospitals Leicester	1.91	1.91	0.00	2.08	2.08	0.00
Sheffield Teaching	1.21	1.21	0.00	1.32	1.32	0.00
Chesterfield Royal	0.00	0.00	0.00	0.00	0.00	0.00
Acute - NHS - Other Block Contracts	0.00	0.00	0.00	0.00	0.00	0.00
Acute - NHS	0.00	0.00	0.00	0.00	0.00	0.00
Acute Contracts - Position on Prior Year	0.00	(0.00)	0.00	0.00	(0.00)	0.00
Other NHS - NCA's	1.63	2.47	(0.84)	1.81	2.79	(0.98)
Ramsay Woodthorpe	12.71	10.68	2.04	13.76	11.73	2.03
BMI Healthcare	8.37	6.60	1.77	8.98	7.33	1.66
Barborough	0.77	0.44	0.34	0.83	0.48	0.35
Spire	2.96	1.72	1.24	3.12	1.88	1.24
Other Non NHS - Acute	0.56	0.63	(0.07)	0.62	0.72	(0.10)
Cancer Monies	6.20	6.12	0.08	6.38	6.29	0.09
Diabetes Projects	0.53	0.53	0.00	0.53	0.53	(0.00)
CDH Projects	0.00	0.00	0.00	0.00	0.00	0.00
Tobacco Projects	0.24	0.24	0.00	0.24	0.24	0.00
Resilience	0.00	0.00	(0.00)	0.00	0.00	(0.00)
Urgent Care Centres	2.80	2.83	(0.03)	3.05	3.08	(0.03)
Acute Investment QIPP	0.00	0.00	0.00	0.00	0.00	0.00
Activity - Other	0.21	0.20	0.01	0.21	0.20	0.01
Acute - COVID	0.00	0.00	0.00	0.00	0.00	0.00
ERF ICS system adjustment budget	(11.37)	0.12	(11.49)	(12.15)	0.12	(12.27)
ERF ICS system income requirement	0.00	0.00	0.00	0.00	0.00	0.00
Total Acute Services	998.35	1,005.31	(6.97)	1,083.54	1,091.56	(8.02)
Community Services						
Nottinghamshire Healthcare - General Health	91.27	91.27	0.00	99.24	99.23	0.01
Sherwood Forest Hospitals	9.74	9.74	(0.00)	10.61	10.61	0.00
Sherwood Forest Hospitals - Activity Reserve / QIPP / FRP	0.00	0.00	0.00	0.00	0.00	0.00
Other NHS - Community	3.09	3.04	0.05	3.37	3.31	0.06
Other Non NHS - Community	56.59	56.17	0.42	61.72	60.72	1.00
End of Life	1.65	1.64	0.01	1.79	1.79	0.01
Community QIPP not transacted	0.00	0.00	0.00	0.00	0.00	0.00
Community Investment QIPP	0.00	0.00	0.00	0.00	0.00	0.00
Community - Other	0.00	0.00	0.00	0.00	0.00	0.00
Community - COVID	1.38	1.65	(0.28)	1.54	1.83	(0.29)
Community - QIPP	(0.43)	0.00	(0.43)	(1.03)	0.00	(1.03)
Community - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Community Services	163.29	163.51	(0.23)	177.25	177.50	(0.25)
Mental Health Services						
Nottinghamshire Healthcare - Mental Health	130.75	130.75	(0.00)	143.93	143.93	0.00
Other NHS - Mental Health	0.77	0.77	(0.00)	0.84	0.84	0.00
Other Non NHS - Mental Health	24.62	24.78	(0.16)	26.26	26.42	(0.16)
S117 Placements	28.02	28.17	(0.15)	30.56	31.33	(0.76)
Mental Health QIPP not transacted	0.00	0.00	0.00	0.00	0.00	0.00
Mental Health Investment QIPP	0.00	0.00	0.00	0.00	0.00	0.00
Mental Health - Other	0.00	0.00	0.00	0.00	0.00	0.00
Mental Health - COVID	0.02	(0.02)	0.04	0.02	(0.02)	0.05
Mental Health - Reserves	0.48	0.48	0.00	2.70	0.40	2.29
Mental Health - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Mental Health Services	184.66	184.93	(0.27)	204.32	202.91	1.42
Primary Care Services						
Primary Care Contracting	153.10	154.45	(1.35)	169.09	171.65	(2.55)
Primary Care Contracting - Balancing Adjustments to NHSE/II Model	0.00	0.00	0.00	0.00	0.00	0.00
Prescribing	147.22	146.25	0.97	160.64	159.74	0.89
Prescribing - QIPP	0.00	0.00	0.00	0.00	0.00	0.00
Medicine Management - Clinical	3.06	2.61	0.45	3.34	2.87	0.47
CCG Pathways	0.00	0.00	0.00	0.00	0.00	0.00
EH - Primary Care	1.62	1.61	0.01	2.04	2.03	0.01
PC Transformation	8.63	8.36	0.27	9.38	9.10	0.28
Enhanced Services	9.51	9.71	(0.20)	10.38	10.59	(0.21)
Practice Transformation fund	0.00	0.00	0.00	0.00	0.00	0.00
GPIT	0.99	0.20	0.79	1.07	0.27	0.81
Out of Hours	11.16	10.60	0.56	12.27	11.21	1.07
Primary Care - Other	0.48	0.44	0.04	0.52	0.48	0.04
Primary Care - COVID	2.29	2.24	0.05	2.31	2.25	0.06
Primary Care - Balancing Adjustments to NHSE/II Model	0.00	0.00	0.00	0.00	0.00	0.00
Primary Care - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Primary Care Services	338.07	336.48	1.59	371.03	370.17	0.87
Other Healthcare						
Continuing Care & Free Nursing Care	96.65	98.31	(1.66)	105.84	109.12	(3.27)
City Care CHC Assessment	2.53	2.50	0.03	2.74	2.73	0.01
Continuing Care - COVID	12.08	12.08	(0.00)	13.19	13.19	(0.00)
Continuing Care - Balancing Adjustments to NHSE/II Model	0.00	0.00	0.00	0.00	0.00	0.00
Continuing Care - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Healthcare Costs	111.26	112.89	(1.64)	121.78	125.04	(3.26)
TOTAL PROGRAMME HEALTHCARE COSTS	1,795.62	1,803.13	(7.51)	1,957.93	1,967.17	(9.25)

Other Contracts						
Other Non-NHS Services	0.62	0.57	0.06	0.67	0.61	0.06
Patient Transport	6.77	6.61	0.16	7.38	7.32	0.06
Other Non-NHS Services - 111	5.25	5.12	0.13	5.73	5.53	0.21
HDP - COVID	11.71	13.80	(2.10)	11.71	14.89	(3.19)
Social Care	33.11	33.11	0.00	36.12	36.12	0.00
Other - COVID	1.02	0.85	0.17	1.12	0.94	0.18
HDP - Local	2.17	1.28	0.89	2.41	1.28	1.13
Other - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Contracts	60.65	61.34	(0.69)	65.14	66.69	(1.55)
Corporate Non-Running Costs						
Corporate - Estates	13.30	13.34	(0.04)	14.37	14.11	0.26
Corporate Costs - Chief Officer	1.18	0.94	0.24	1.29	1.02	0.27
Corporate Costs - Chief Commissioning Officer	6.57	6.64	(0.06)	7.23	7.32	(0.09)
Corporate Costs - Chief Finance Officer	0.00	(0.00)	0.00	0.01	(0.00)	0.01
Corporate Costs - ICS	5.21	3.18	2.03	5.73	5.73	0.00
Corporate Costs - ICS - Income	(3.26)	(1.23)	(2.03)	(3.59)	(3.59)	0.00
Corporate Costs - Chief Nurse	3.78	3.93	(0.16)	4.15	4.33	(0.19)
Corporate - COVID	0.00	(0.00)	0.00	0.00	(0.00)	0.00
Corporate - Balancing Adjustments to NHSE/I Model	0.00	0.00	0.00	0.00	0.00	0.00
Corporate - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Vaccination Costs	0.14	0.14	(0.00)	0.14	0.14	(0.00)
Depreciation, provisions & technical adjustments	0.00	(0.35)	0.35	0.00	(0.35)	0.35
Total Corporate Non-Running Costs	26.93	26.59	0.33	29.32	28.71	0.61
Programme Reserves						
Risk Reserves (inc. running cost headroom)	0.00	0.00	0.00	0.00	0.00	0.00
PCCC	0.00	0.00	0.00	0.00	0.00	0.00
QJPP	0.00	0.00	0.00	0.00	0.00	0.00
Other Reserves	0.00	0.00	0.00	0.00	0.00	0.00
Reserves - COVID	0.00	0.00	0.00	0.00	0.00	0.00
Other Reserves - Balancing Adjustments to NHSE/I Model	(0.72)	0.00	(0.72)	(3.05)	0.10	(3.15)
Other Reserves - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
Total Programme Reserves	(0.72)	0.00	(0.72)	(3.05)	0.10	(3.15)
TOTAL PROGRAMME NON- HEALTHCARE COSTS	86.85	87.93	(1.08)	91.41	95.50	(4.09)
TOTAL NET OPERATING EXPENDITURE - PROGRAMME	1,882.48	1,891.06	(8.58)	2,049.34	2,062.68	(13.34)
Planned Surplus	14.94	0.00	14.94	15.93	0.00	15.93
TOTAL AVAILABLE RE SOURCE - PROGRAMME	1,897.42	1,891.06	6.36	2,065.27	2,062.68	2.60
Running Costs						
Running Costs	0.00	0.00	0.00	0.00	0.00	0.00
Running Costs - Chief Officer	1.44	1.26	0.18	1.57	1.37	0.21
Running Costs - Chief Finance Officer	6.19	6.11	0.08	6.64	6.53	0.11
Running Costs - Chief Commissioning Officer	5.47	5.51	(0.05)	5.96	5.98	(0.03)
Running Costs - Chief Nurse	1.22	1.29	(0.06)	1.33	1.40	(0.06)
Running Costs - Special Projects	1.04	1.05	(0.01)	1.13	1.14	(0.01)
Running Costs - Communications	0.57	0.60	(0.02)	0.62	0.65	(0.02)
Running Costs - Estates	2.13	2.14	(0.02)	2.28	2.30	(0.01)
Running Costs - Reserves	0.00	0.00	0.00	0.00	0.00	0.00
Running Costs - COVID	0.00	(0.00)	0.00	0.00	(0.00)	0.00
Running Costs - Balancing Adjustments to NHSE/I Model	0.00	0.00	0.00	0.00	0.00	0.00
Running Costs - CCG Coding Change Adjustments	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL AVAILABLE RE SOURCE - ADMIN	18.06	17.96	0.10	19.54	19.36	0.17
TOTAL	1,915.48	1,909.02	6.46	2,084.81	2,082.04	2.77

Reconciliation to in year breakeven:

	YTD £M	FOT £M
Ledger Total Variance include surpluses	6.46	2.77
Cumulative surplus	-10.94	-11.93
ARRS / WAF funding	2.37	5.96
HDP and vaccination funding	2.10	3.19
Adjusted total	0.00	0.00

Appendix 2 – CCG efficiency

	H2 Plan	Delivery Risk Rating	M10 Ytd	M10 H2 Forecast	M11 Ytd	M11 H2 Forecast
	£'m		£'m	£'m	£'m	£'m
21/22 Target	10.45					
Transacted:						
CHC	1.39	G	0.93	1.39	1.16	1.39
Corporate VF	1.33	G	1.12	1.79	1.34	1.79
Prescribing	0.50	G	0.33	0.50	0.42	0.50
Community	0.65	G	0.43	0.65	0.54	0.65
Primary Care						
Identified Non-recurrent Opportunities	3.20	G		6.58	5.48	6.58
Unidentified Non-recurrent Opportunities*	3.38	G		-		-
	10.45		2.81	10.91	8.94	10.91

- The table provides an update of the current CCG QIPP plans for 2021/22 H2 which are monitored through the Financial Savings Group of the CCG.
- Identified non-recurrent savings have been developed through review of budgets, and allocations for slippage, and non recurrent review of in year accruals.
- *The unidentified non-recurrent plans reflected the balance of assessed recurrently delivered non-recurrent savings each year that have yet to be identified to a specific source. These savings are normally delivered through budget reviews, slippage against commitments, and unutilised accruals. At month 9 the reviews were complete enough to identify enough opportunity to meet the unidentified gap, and this has been transferred to identified.
- The non-recurrent opportunities are profiled towards the end of the financial year, and will be released within the last 3 months of the year.
- Due to the basis of allocation for H2, the corporate vacancy factor has been maintained at the H1 levels of 10%. The CCG has reviewed its controls in this area to support ongoing delivery, and ensure required posts are approved for recruitment as needed.
- The current over performance in the CHC position is not due to CHC under delivery of QIPP. The QIPP delivery is providing increased mitigation preventing an increased overspend.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022					
Paper Title:	2022/23 Draft Financial Plans and Budget Setting	Paper Reference:	GB 22 014					
Sponsor:	Stuart Poynor, Chief Finance Officer	Attachments/Appendices:	-					
Presenter:	Stuart Poynor, Chief Finance Officer							
Purpose:	Approve	<input checked="" type="checkbox"/>	Endorse	<input type="checkbox"/>	Review	<input type="checkbox"/>	Receive/Note for:	<input type="checkbox"/>
							<ul style="list-style-type: none"> Assurance Information 	

Executive Summary

The purpose of this paper is to provide an update on the Nottingham and Nottinghamshire CCG 2022/23 draft financial plans which will form part of the Nottinghamshire Integrated Care Board (ICB) system draft plan submission to NHS England and Improvement (NHS EI) on 17 March 2022 and seek approval for the Opening Budgets of the financial year.

The plans cover the full 12 months of the financial year and acknowledges that the first three months will be as the CCG and the remaining nine months as a full ICB. As such the ICB portion of these financial plans will need to be consolidated with the Bassetlaw CCG financial plan in due course in line with relevant legislation (awaiting to be passed). The ICB, once established, will be required to approve the ICB element in due course.

At the time of writing the CCG has a balanced financial plan. However, elements of the allocation, which is being managed on a system wide basis, have yet to be fully confirmed as being allocated to the CCG. In addition, to deliver a balanced plan there are elements of the savings/efficiency requirement that are, as yet, unidentified.

There are several areas of risk that have not been included in the plan but have been detailed within the paper.

The paper also presents the draft business as usual (BAU) draft capital plan for both Bassetlaw CCG and Nottingham and Nottinghamshire CCG set against the joint capital resource limit provided by NHSEI.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	<input type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input checked="" type="checkbox"/>
----------------------------------	--------------------------	---	-------------------------------------

Financial Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input type="checkbox"/>
Performance Management	<input type="checkbox"/>	Procurement and/or Contract Management	<input type="checkbox"/>
Strategic Planning	<input type="checkbox"/>		
Conflicts of Interest:			
<input checked="" type="checkbox"/> No conflict identified <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion and decision <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion, but not decision <input type="checkbox"/> Conflict noted, conflicted party can remain, but not participate in discussion or decision <input type="checkbox"/> Conflict noted, conflicted party to be excluded from meeting			
Completion of Impact Assessments:			
Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not applicable to the report
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not applicable to the report
Risk(s):			
Stated in the report			
Confidentiality:			
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (please indicate why it is confidential by ticking the relevant box below)			
Recommendation(s):			
1. To APPROVE the 2022/23 Opening Budgets as noted in this paper.			
2. To NOTE an update on any changes to these Opening Budgets will be provided to the committee in due course.			
3. To APPROVE the 2022/23 Business as Usual Capital Plan for the Nottingham and Nottinghamshire CCG component and note the Bassetlaw CCG component for information.			

2022/23 Draft Financial Plans & Budget Setting

1. Introduction

- 1.1. The purpose of this paper is to provide an update on the Nottingham and Nottinghamshire CCG 2022/23 draft financial plans which will form part of the Nottinghamshire ICS system draft plan submission to NHS England and Improvement (NHS EI) on 17 March 2022.
- 1.2. The plans cover the full 12 months of the financial year, acknowledging that at the time of writing the plan will require splitting into three months April to June representing the CCG and the subsequent nine months July to March representing the ICB financial plan where the Bassetlaw CCG nine-month plan will be combined to form an overall ICB financial plan in due course in line with relevant legislation (awaiting to be passed). The ICB, once established, will be required to approve the ICB element.
- 1.3. Allocations for 2022/23 have been provided on a system wide basis. This has required an ICS system wide approach to firstly splitting the allocation between Nottingham and Nottinghamshire CCG and Bassetlaw CCG. Secondly, the approach to the allocation growth that has been received has been to allocate this based on agreed percentage uplifts (see table in 2.3 below) and then the residual growth allocation to be split out between the system partners on an agreed basis.
- 1.4. The CCG has a balanced financial plan for the full 12-month period. However, this assumes a certain level of residual growth allocation being allocated by the ICS and agreed by the system. In addition, it requires a £31.8 million (3.3%) efficiency requirement, the plan to deliver this efficiency is in development and not yet fully identified. The financial plan includes elements of investment to deliver the MHIS standard, however, several areas of risk of investment are not included in the financial plan, in turn giving a risk to delivery of the balanced position.
- 1.5. In line with the agreed financial framework across the system, the main provider contracts within the system remain on a block contract basis. Elective recovery funding (ERF) is again available to the system. The bulk of the ERF activity and associated funding sits with Nottingham University Hospitals Trust (NUHT) and Sherwood Forest Hospitals Trust (SFHT). A small element of ERF funding sits with the CCG, this has associated risk if the respective activity is not undertaken.
- 1.6. The CCGs (including Bassetlaw) have received £2.018 million business as usual (BAU) capital funds. A plan to utilise the full allocation has been drawn up in conjunction with estates, primary care, and IT colleagues.

2. Allocations, Business Rules and Planning Assumptions

- 2.1. The allocation for 2022/23 is a system wide allocation based on the recurrent allocation received in H2 2021/22. A convergence adjustment (reduction) has been applied nationally to all CCGs as a step towards fair shares allocations. Growth has been applied at a system level, an element of this has been held back at the ICS level for subsequent distribution (the balanced plan presented below assumes an element of this system growth being allocated to the CCG). Non recurrent Covid funds have been made available to the system, albeit at circa 50% of the level received in the last financial year. Finally, non recurrent funds for service development funds (SDF) have been notified and built into the plan with associated and matched expenditure. The table below summarises the allocation issued in the draft CCG financial plan.

NHS Nottingham and Nottinghamshire 2022/23 allocation			
£000	Recurrent	Non-recurrent	Total
<u>Programme</u>			
2021/22 H2	£1,636,761	£0	£1,636,761
Growth	£66,413		£66,413
Convergence	-£819		-£819
Other adjustments	£1,859		£1,859
Non recurrent	£0	£112,952	£112,952
Total programme	£1,704,214	£112,952	£1,817,166
<u>Delegated primary care</u>			
2021/22 H2	£165,373	£0	£165,373
Growth	£10,916	£0	£10,916
Convergence	-£785	£0	-£785
Total delegated primary care	£175,504	£0	£175,504
<u>Admin/running costs</u>			
2021/22 H2	£19,761		£19,761
Growth	£0		£0
Other	£147		£147
Total running costs	£19,908	£0	£19,908
Total	£1,899,626	£112,952	£2,012,578

- 2.2. The national planning guidance sets out a number of finance assumptions and business rules. Those assumptions and rules are detailed below, showing what is included in the CCG Financial Plan:-

- Minimum 0.5% Contingency, where affordable
- Remain within the Administration Costs Allocation
- Achievement of the Mental Health Investment Standard
- Plan for minimum Better Care Fund contribution
- Plan to spend PCCC allocation in full

At this stage the contingency of 0.5% is not included in the CCG plan as it is not considered affordable.

- 2.3. The planning assumptions used in the planning model are those generally set by the planning guidance from NHS EI. A summary of the key assumptions are below:

Assumptions	22-23					
	Inflation			Growth		
	Gross	CIP	Net	Demo	Non Demo	Growth
Acute	2.80%	-1.10%	1.70%			0.00%
Mental Health	2.80%	-1.10%	1.70%			0.00%
Community	2.80%	-1.10%	1.70%			0.00%
Ambulance	2.80%	-1.10%	1.70%		0.00%	0.00%
Prescribing	2.80%	-1.10%	1.70%		1.45%	1.45%
CHC	6.60%	-1.10%	5.50%		3.00%	3.00%
CHC MH	6.60%	-1.10%	5.50%		3.00%	3.00%
CHC LD	6.60%	-1.10%	5.50%		3.00%	3.00%
FNC	6.60%	-1.10%	5.50%		3.00%	3.00%
S117 MH	6.60%	-1.10%	5.50%		3.00%	3.00%
S117 LD	6.60%	-1.10%	5.50%		3.00%	3.00%
Social Care BCF	2.80%	-1.10%	1.70%		3.60%	3.60%
Corporate pay awards	3.00%	0.00%	3.00%			0.00%
Corporate non pay	2.70%	0.00%	2.70%			0.00%
PCCC	0.00%	0.00%	0.00%			0.00%
Other Primary Care	2.80%	-1.10%	1.70%			0.00%
Other Non NHS	2.80%	-1.10%	1.70%			0.00%
Patient Transport	2.80%	-1.10%	1.70%			0.00%
Non NHS 111	2.80%	-1.10%	1.70%			0.00%
Locked Rehab Non NHS	6.60%	-1.10%	5.50%			0.00%

3. Key Planning Outputs

3.1 The CCG 2022/23 draft Financial Plan:

- Delivers in year £breakeven – see below.
- Has an underlying deficit of c £13.5 million
- Requires £31.8 million QIPP savings (excluding block contracts, 3.3%)

	(Surplus) / deficit £000
2021/22 forecast outturn	0
Adjust for non-recurrent	17,927
2021/22 exit UDL	17,927
Inflation & Growth uplifts (per agreed assumptions)	7,470
Non Demographic Growth uplifts	6,980
Covid costs	3,504
CHC (previously Hospital Discharge Programme)	1,193
Urgent treatment unit investment	1,000
Additional funding for 22/23 (Growth, Covid, ERF)	-19,937
Additional efficiency (not included in the exit UDL or within the tariff inflation)	-18,136
Total	0

4. Efficiencies

4.1 The efficiency requirement within the plan is £31.8 million. This is comprised of the following:

Identified efficiencies:

- Vacancy factor £2.6 million (non-recurrent)
- 1.1% efficiency embedded in inflation uplift £6.4 million (recurrent)
- Prescribing stretch £1.0 million (recurrent)
- CHC stretch £4.2 million (recurrent)
- Primary Care stretch £3.0 million (recurrent)

Unidentified efficiencies:

- Year on year non-recurrent solutions £10.0 million (recurrent)
- Non-recurrent solutions £4.6 million (non-recurrent)

4.2 The unidentified efficiencies form a material planning risk to the CCG/ICB. Initial solutions to these will include balance sheet review, slippage on investments, slippage on further allocations. The £10m year on year non-recurrent efficiency has been based on levels achieved in previous financial years. It is expected this will be identified through the year based on inclusion in the last two years plans.

5. Risks & Mitigations

- 5.1. There are a number of risks within the plan. The main risk is the level of efficiency savings required. As noted above there is an efficiency program of £31.8 million to be delivered and at this stage there is not a fully worked up programme to deliver this.
- 5.2. Whilst the plan includes a level of growth for prescribing, no specific investment has been built in for new medications that are expected to be available during the financial year. The risk value is estimated at c£1.8m.
- 5.3. There is no growth/investment built into the EMAS contract, this remains a risk whilst negotiations with EMAS are yet to conclude by the lead Commissioner (Derbyshire CCG). The value is estimated at c£2m.
- 5.4. The plan includes funding for the delivery of the 104% ERF activity target. As noted above there is a risk that required activity levels may not be achieved.
- 5.5. CHC costs, whilst inclusive of inflationary pressures and growth, remain a risk to the CCG given that the nature of CHC packages are low-volume and high cost.
- 5.6. There are minimal mitigations within the financial plan. As with previous years, residual budget on delegated primary care, balance sheet flexibility and slippage on non-recurrent allocations will be key areas of mitigation. The more likely risks are currently being assessed against the review of these areas.

6. 2022/23 Opening Budgets

- 6.1. The 2022/23 draft opening budgets, by programme heading are shown below. Further work is required to fully allocate efficiency savings to Programme budgets.
- 6.2. It is also recognised that the full 12 month budget presented below will require splitting into the three months CCG budget (also presented below) and the subsequent nine month ICB budget (this ICB budget will require amalgamation with the Bassetlaw CCG financial plan/budget).

Nottingham & Nottinghamshire £'000	2022/23 Plan		
	Recurrent	Non Recurrent	Total
Allocation	£1,899,626	£112,952	£2,012,578
Acute Services	£938,479	£0	£938,479
Community Services	£169,783	£3,822	£173,604
Mental Health Services	£200,229	£12,060	£212,289
Primary Care Contracting	£175,503	£0	£175,503
Prescribing	£165,638	£0	£165,638
Other Primary Care Services	£35,107	£7,008	£42,115
Total Other Healthcare Costs	£136,421	£0	£136,421
Other Contracts	£51,828	£1,500	£53,328
Corporate Non-Running Costs	£21,231	£0	£21,231
Programme Reserves	£14,530	£79,169	£93,699
Unallocated Efficiency*	-£8,217	-£9,920	-£18,137
Running Costs	£18,406	£0	£18,406
TOTAL	£1,918,939	£93,639	£2,012,578

* note, the unallocated efficiency will need to be allocated to specific programme budgets

Nottingham & Nottinghamshire £'000	2022/23 Plan - 1 April to 30 June		
	Recurrent	Non Recurrent	Total
Allocation	£474,907	£28,238	£503,145
Acute Services	£234,620	£0	£234,620
Community Services	£42,446	£955	£43,401
Mental Health Services	£50,057	£3,015	£53,072
Primary Care Contracting	£43,876	£0	£43,876
Prescribing	£41,409	£0	£41,409
Other Primary Care Services	£8,777	£1,752	£10,529
Total Other Healthcare Costs	£34,105	£0	£34,105
Other Contracts	£12,957	£375	£13,332
Corporate Non-Running Costs	£5,308	£0	£5,308
Programme Reserves	£3,633	£19,792	£23,425
Unallocated Efficiency*	-£2,054	-£2,480	-£4,534
Running Costs	£4,601	£0	£4,601
TOTAL	£479,735	£23,410	£503,145

7. Capital

- 7.1 The CCG has been allocated £2.018 million for BAU capital in 2022/23. This allocation is to cover Bassetlaw CCG requirements. A capital plan has been put together with colleagues from both CCGs as follows, which utilises the full allocation. The Nottingham and Nottinghamshire CCG element is presented for approval, the Bassetlaw CCG element presented for noting.

CCG	Category	Scheme	2022/23 £000
Notts	GPIT	Remote working	125
Notts	GPIT	Hardware refresh	158
Notts	CCG IT	Meeting room kit	40
Notts	CCG IT	Hardware refresh	20
Notts	GPIT	WLAN refresh	200
Bassetlaw	GPIT	Hardware replacement	300
Bassetlaw	GPIT	GPIT growth	40
Bassetlaw	GPIT	ARRS growth	30
Bassetlaw	GPIT	Newgate development GPIT equipment	0
Bassetlaw	PC estates	Kilton Forest	100
Notts	PC estates	Greenfields Medical Practice	33
Notts	PC estates	Forest Medical	160
Notts	PC estates	Roundwood Surgery	46
Notts	PC estates	Westdale Lane	11
Notts	PC estates	Castle Healthcare Practice	28
Notts	PC estates	Deer Park	127
Notts	PC estates	To be confirmed – out to liaison with practices	600
Total			2018

- 7.2 Not included in the above plan are two potential schemes within Bassetlaw CCG (Larwood and Lakeside health centre developments). At this stage it is not clear whether these two schemes will be approved and whether given the size (at £800,000 plus) they would be funded from the BAU capital or whether a strategic funding source from NHSEI would be available. Should they need to be approved from the above capital allocation this will need managing in year, dependent upon slippage on the above plan.

8. Recommendations

- 8.1 Recognising that the plans are still subject to challenge and confirmation by both the ICS and NHS EI the Governing Body is asked to:
- **Approve** the 2022/23 opening budgets as noted in this paper
 - **Note** an update on any changes to these opening budgets will be provided to the committee in due course
 - **Approve** the Nottingham and Nottinghamshire CCG element of the 2022/23 capital plan, and note the Bassetlaw CCG element



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	Highlight Report from the meeting of the CCG's Quality and Performance Committee	Paper Reference:	GB 22 015
Chair of the meeting:	Eleri de Gilbert, Non-Executive Director	Attachments/ Appendices:	None
Summary Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/>
			<ul style="list-style-type: none"> Assurance Information

Summary of the Meetings

The Quality and Performance Committee met on 24 February 2022 and 24 March 2022. Due to the current Coronavirus (Covid-19) situation, the meetings were held virtually.

At its February meeting the Committee:

- **RECEIVED** the quarterly Nursing and Quality report which detailed system operational challenges, an update on serious incident reporting and investigations, the CCG position in terms of statutory responsibilities and detail of quality and transformation programmes. Members agreed to receive a detailed report on NUH performance in March 2022.
- **RECEIVED** the annual statutory Safe Management of Controlled Drugs report for the period April 2020 to March 2021. The report provided assurance that the CCG has discharged its statutory responsibilities. The report also included planned areas for development for 2021/22 which will include a focus on the prescribing of pregabalin, gabapentin and temazepam. Members noted and commended the team for their significant contribution during the Covid-19 pandemic.
- **RECEIVED** the updated risk register for February 2022. The risk register includes nine risks, five of which are rated red. Members agreed to review the narrative and score of risk RR 129 (generic risk linked to increased waiting lists) as more is known about the causes and effects of prolonged waits. In addition, the narrative of risk RR 004 will be reviewed in order that the risk reflects wider urgent care pressures.

At its March meeting the Committee:

- **RECEIVED** the updated risk register for March 2022. Risk 129 has been replaced with two specific risks related to system elective recovery and cancer care recovery following the focus in February 2022.
- **RECEIVED** the Joint Carers Strategy and agreed to receive further background material to detail the development of the strategy. It was agreed the strategy will benefit from a review by the ICS Co-production Board.
- **RECEIVED** a report on the findings following the ReSPECT audit. A number of areas for improvement have been identified and the audit will be repeated in twelve months. The learning

from the audit has been shared across the CCG. The Clinical Executive Group (CEG) will be asked to consider appropriate action to encourage compliance with ReSPECT by NUH.

Key messages for the Governing Body:

The Committee:

- **RECEIVED** a revised Integrated Performance Report. In response to discussion at the Governing Body, the report has been modified to include more detail to describe system pressures. The planned care section of the report now includes the forecast position. Members were informed that the planned care waiting list continues to increase. The position with regard to 52-week waits is stabilising although 104-week waits remain of concern. Issues affecting the ability to discharge patients following an acute episode of care are contributing significantly to capacity constraints and pressures on urgent care services. Mental health services continue to experience increased demand. Members agreed to take a deep dive review of mental health services at a future meeting.
- **RECEIVED** a detailed assurance report in respect of 104 week waits and Cancer performance. The report included plans for recovery, investment and detailed the associated risks. Initiatives designed to lead to system recovery and increased capacity were described. This includes use of the independent sector and insourcing. The aim being to create ring-fenced capacity for elective activity. Elective recovery plan was presented along with plans to increase elective capacity. The system has developed outline plans and submitted bids to establish a hub and spoke model in Nottinghamshire.
- **RECEIVED** an update on NUH performance. NUH remains at System Oversight Framework level 4 (SOF 4) which involves mandated intensive support delivered through the Recovery Support Programme. There are concerns related to the fragility of some services, primarily the Emergency Department (ED), with lots of input taking place to address flow out of the hospital to reduce the pressure in the ED. There are some concerns in relation to Gynaecological Services following an increase in reported serious incidents highlighting concerns around governance and supervision. In respect of maternity services, there are some very positive developments and a much greater understanding of data. Concern remains that change is not happening at the pace and depth required to have the level of impact necessary. This is the opinion reported for a number of months. NUH were subject to an unannounced CQC inspection of maternity services between 01 and 04 March 2022. Initial feedback suggests improvements were seen, particularly in respect of leadership although a number of areas of significant concern were also identified. A further update will be provided following publication of the CQC report.
- **RECEIVED** the report on the Nottinghamshire Multi Agency Safeguarding Hub following a 360 Assurance audit review and noted the recommendations. As requested by the Audit and Governance Committee the Quality and Performance Committee will oversee the action plan associated with the recommendations.

The ratified minutes of the February 2022 meeting are available in the 'Information Items' section of this agenda.

The ratified minutes of the March 2022 meeting will be received by the Governing Body at a future meeting.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)		Date:	06 April 2022					
Paper Title:	Nursing and Quality Quarter Three Report		Paper Reference:	GB 22 016					
Sponsor: Presenter:	Rosa Waddingham Chief Nurse - Nottingham and Nottinghamshire Integrated Care System and CCG Rosa Waddingham		Attachments/ Appendices:	-					
Purpose:	Approve	<input type="checkbox"/>	Endorse	<input type="checkbox"/>	Review	<input checked="" type="checkbox"/>	Receive/Note for:	<input checked="" type="checkbox"/>	
							<ul style="list-style-type: none"> Assurance Information 		
Executive Summary									
<p>This 2021/2022 Quarter Three report provides assurance to the Governing Body in relation to the activity of the Nursing & Quality Team and its statutory duties, in addition to highlighting the main quality and safety issues of individual providers and the impact this is having on the wider system.</p> <p>Delays in access to emergency, elective and mental health care continue to be highlighted as a system-wide area of focus, which is evidenced through incident reporting, workforce pressures and an increase in demand in the urgent care and home care sector.</p> <p>During Quarter Three (Q3) Covid outbreaks and responses affected all services, alongside the redeployment of staff into vaccination services.</p> <p>Highlights from Q3 include the team:</p> <ul style="list-style-type: none"> Monitoring operational challenges and supporting providers are facing in relation to the impact of COVID19 on their services Working with Nottingham University Hospitals (NUH) and system partners to implement actions in response to the CQC report; aligning other improvement plans which are interdependent Progressing the triangulation and intelligence relating to harms associated with delays. Developing a Standard Operating Procedure as part of the refreshed approach to the oversight and management of Serious Incidents (first phase) Leading on a system wide Infection Prevention and Control (IPC) SOP for the reporting of COVID19 Nosocomial related Serious Incident's (SI's) Working in partnership with Local Authority colleagues through the system Care Homes Taskforce to monitor and support providers and their residents. 									
Relevant CCG priorities/objectives:									
Compliance with Statutory Duties	<input type="checkbox"/>	Wider system architecture development (e.g., ICP, PCN development)					<input checked="" type="checkbox"/>		

Financial Management	<input type="checkbox"/>	Cultural and/or Organisational Development	<input type="checkbox"/>
Performance Management	<input checked="" type="checkbox"/>	Procurement and/or Contract Management	<input type="checkbox"/>
Strategic Planning	<input type="checkbox"/>		
Conflicts of Interest:			
<input checked="" type="checkbox"/> No conflict identified <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion and decision <input type="checkbox"/> Conflict noted, conflicted party can participate in discussion, but not decision <input type="checkbox"/> Conflict noted, conflicted party can remain, but not participate in discussion or decision <input type="checkbox"/> Conflict noted, conflicted party to be excluded from meeting			
Completion of Impact Assessments:			
Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not required for this paper.
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/> Not required for this paper.
Risk(s):			
Please highlight any risks identified within the paper or state that there are no risks identified			
Confidentiality: (please indicate whether the information contained within the paper is confidential)			
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (please indicate why it is confidential by ticking the relevant box below)			
Recommendation(s):			
1. To RECEIVE the Q3 Report and support the actions outlined.			

Nottingham and Nottinghamshire CCG

Nursing & Quality

Quarter 3 Report

2021/2022

CONTENTS

PART 1A – SYSTEM CHALLENGES (pg4)

- Harms associated with delays
- Covid outbreaks & Impact
- Discharge

PART 1B – SYSTEM QUALITY & SAFETY REPORT (pg7)

- Serious Incidents & Never Events

PART 2 - PROVIDER QUALITY & SAFETY REPORTING (pg11)

- Enhanced Surveillance: Nottingham University Hospitals, Nottinghamshire Healthcare, Mediscan
- Routine Monitoring: Sherwood Forest Hospitals, Citycare, EMAS
- Primary Care, Care Sector

PART 3 - CCG STATUTORY RESPONSIBILITY (pg26)

- CHC CYP Continuing Care
- Safeguarding / LAC / SEND

PART 4 – QUALITY & TRANSFORMATION (pg32)

- Local Maternity & Neonatal System
- Learning Disabilities and Autism

PART ONE A: SYSTEM CHALLENGES

Delays in access to emergency, elective and mental health care are well rehearsed across the system and reflected in the CCG Integrated Performance Report (IPR). This section of the Quarter 3 (Q3) Nursing & Quality Report will consider how the CCG Quality Assurance & Quality Intelligence (QA/QI) team has worked with providers to build on this intelligence to highlight, mitigate and escalate risks; and share best practice.

1. Harms associated with delays

During Q3 further progress was made regarding the triangulation and intelligence relating to harms associated with delays.

- Terms of reference were proposed in collaboration with the ICS Planned Care Programme Board although work was paused due to an NHSEI survey circulated in December 2021; outputs from this survey are expected to help inform delivery of Covid recovery plans, share good practice, and support the development of a consistent approach. A system quality lead has now been identified to follow up on the survey findings, scope other system approaches, and work with the ICS Patient Safety Specialist Steering Group (PSSSG) to propose and agree next steps.
- To date both Nottingham University Hospitals (NUH) and Sherwood Forest Hospitals (SFH) have reported through their patient safety committees that harms related to delays are monitored, however these approaches are heterogeneous and learning opportunities are not anticipated to be applicable across different settings.

In November 2021, the Association of Ambulance Chief Executives published a national report on patient harm as a direct result of delayed handovers¹. East Midlands Ambulance Service (EMAS) benchmarking against this report provided limited evidence of direct harm due to reporting systems, however there was clear evidence of harm because of 'lost hours.'

EMAS have repeatedly identified in their quality reports that, '*because of prolonged levels of higher than planned activity, hours lost through hospital handover delay and staff abstractions there have been times ... when it has not been possible to provide a consistently safe service.*' There were four Serious Incidents (SIs) reported during Q3 which related to Nottinghamshire patients due to long delays waiting for an ambulance, investigations are underway. The QA/QI team participated in a focused harms review with EMAS and the lead commissioners in early December 2021. Nationally validated methodology was employed which focused on a cross section of patients initially identified as Category 2. The review identified that no harm had occurred to the patients, and there was evidence of good clinical practice which focused on avoiding unnecessary conveyance to hospital and the availability of alternative treatment pathways.

2. Covid outbreaks and impact on access to care

Covid outbreaks and response impacted all services during Q3, particularly towards the end of the Quarter when staff were redeployed into vaccination services to accelerate the booster programme.

¹ <https://aace.org.uk/news/handover-harm>



The new VOC Omicron was identified across the county with confirmed community transmission.

Nottinghamshire Healthcare Trust (NHT) were significantly affected in both Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP), with up to 36 areas across all divisions closed to admissions at the peak of the outbreaks. NHT responded to the increased incidence of Covid in their staff and patient populations through co-ordinated executive oversight of their outbreak meetings. System flow was maintained using dynamic risk assessments and bespoke patient centred approaches which considered patient factors (cognition, vaccination status, adherence to Personal Protective Equipment (PPE) and isolating) and environmental factors (patient group, the built environment). All three divisions have since reopened to admissions.

There was a focus during Q3 on developing a Covid-19 System Support and Discharge Standard Operating Procedure (SOP). This was undertaken by the Infection Prevention & Control (IPC) System Assurance Group facilitated by the CCG Head of IPC. Application of the SOP resulted in three approved derogations during Q3 with no unintended consequences reported.

In addition to this, IPC teams have supported with risk assessments to enable hospital discharges back into care homes. 83% of appropriate referrals to IPC from Nottingham University Hospitals (NUH) had the discharge approved, and 100% of Sherwood Forest Hospitals (SFH) referrals were supported. There was a positive impact on patient flow across the system as a result, and appropriate patient placement was supported.

3. Discharge from the acute setting

Due to limited homecare capacity, and to prevent further delays, additional interim beds were commissioned to facilitate timely discharge for medically safe for discharge (MSFD) patients. Despite mitigations, the number of MSFD patients in acute beds remains above H2 planning. The Local Authorities continued to report many hours of unmet needs across Home Care which has a significant impact on flow across the system and links directly to the discharge of patients from acute environments.

Several actions were taken to address:

- Encouraging provider collaboration / mutual aid, supplemented by increased in-house operational service capacity within Local Authorities
- Increased reablement capacity has been put in place, like the model previously used for care homes
- Ongoing development of recruitment and social media campaigns
- Assessment capacity has been relocated using external agency support
- Continue system wide approach to business case development with different uplift options; commissioning of interim beds across all localities; bespoke categorisation of patients awaiting discharge from acute settings to scope alternative support services

High numbers of care homes reported Operational Pressures Escalation Levels (OPEL) Level 4 due to COVID-19 outbreaks, consequently, there has been an additional impact on system flow due to bed availability. Social care capacity issues were further exacerbated by sickness, mandatory vaccine requirements and recruitment challenges; admission into interim beds has been hindered by Covid outbreaks across all settings.

Daily Multidisciplinary Team (MDT) and Multiagency discharge meetings were established with system-wide input, however due to the challenges described above there has consequently been limited impact on overall MSFD numbers.

4. Impact across Primary Care - General Practice

General Practices across all three Localities (PLACE-based) continued reporting their OPEL levels daily enabling the CCG and system partners to understand where there are pressures in relation to service delivery across General Practice each day. As part of planning for the impact on staffing due to the Omicron variant, General Practices were asked on 29 December 2021 to start to report additional information in relation to staff absence (GPs, Other Clinicians and Admin Teams) as part of the daily OPEL reporting, this included: COVID related sickness; Other sickness; Other absence.

5. Impact across Children & Young Persons (CYP) Services

During Q3 a quality assurance collaboration was proposed between system partners with involvement in CYP services, recognising that commissioning, contracting and clinical services are pathway based rather than provider focused and there is a risk of quality and safety concerns being overlooked or addressed inconsistently. Early areas for focus were identified during December 2021 and include:

- Provision of specialist assessment and support services for children with autism or ADHD
- Staffing challenges in all CYP services in Nottingham City due to vacancies and absences
- Staffing challenges and inpatient availability in Children & Adolescent Mental Health Services (CAMHS), affecting patients with eating disorders

Service derogations due to redeployment during Level 4 Incident Response will be explored further in the Q4 report.

QUARTER 4 (2021/2022) OPERATIONAL FOCUS

FEBQP01: (HARMS)	Update regarding Harms associated with Covid & Delays/Waits via PSSSG (March 2022)
FEBQP02: (OUTBREAKS)	IPC focus remains on: <ul style="list-style-type: none"> • COVID-19 outbreak management • IPC capacity and maintaining wellbeing • Preventing and reducing HCAI including nosocomial COVID-19
FEBQP03: (12HR BREACHES)	Continue to work with NUH through the Quality Assurance (ED Subgroup) to ensure learning from 12hr breaches is cascaded and informs future planning
FEBQP04: (DISCHARGE)	Continue to seek and maintain assurance that patients are in receipt of safe and effective care in all settings including interim beds. Evaluate system wide discharge planning SOP using intelligence around actual and 'near miss' incidents
FEBQP05: (DEROGATION/SERVICE CHANGE)	Evaluate the community response to the derogation's framework published in January 2022, including service changes, EQIA and harms review

FEBQP06a: (CARE SECTOR)	Continue momentum and ensure where required Care Homes have access to IPC training.
FEBQP06b: (CARE SECTOR)	Continued provider support and assurance, issues identified via the ICS Care Sector Taskforce and agreement of support offer to be made, continue to undertake virtual reviews to gain assurances when services are in outbreak and to undertake quality visits where required.
FEBQP06c: (CARE SECTOR)	Market engagement and building capacity – work to be undertaken across the system to ensure suitable provision for the local population. Stronger links to be formed with Mental Health Commissioning and Learning Disabilities and Autism work streams. Plus continue to build and strengthen relationships/ alignment with Place and PCNs

PART ONE B: SYSTEM QUALITY & SAFETY REPORTING

This report should be read in conjunction with the CCG Integrated Performance Report (IPR)

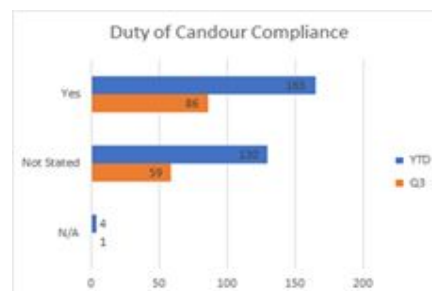
6. Serious Incident (SI) & Never Events (NE)

Update on Q2 Focus & Actions

NOVQP02: A Standard Operating Procedure has been formulated and approved in draft by the CCG Quality Team Assurance Meeting in relation to the process for reporting, reviewing, and signing off Serious Incidents. The SOP reflects specifically the alignment with the national patient safety strategy, including CCG attendance at Trust scoping and sign off; the explicit inclusion of subject matter experts in CCG panel review; and a clear and intuitive approach to the matter of extensions. Once ratified at the System Quality Assurance & Improvement Group, a six-month review date is proposed in anticipation of further national direction regarding Patient Safety Incident Response Framework (PSIRF)²

NOVQP03: A system wide IPC led SOP for the reporting of COVID-19 nosocomial related serious incidents has been agreed. SI provider reporting is now aligned across the system. These cases are reported on STEIS, all receive individual review, duty of candour requirements are met and learning is shared across the system via the IPC system assurance group and monthly Route Cause Analysis (RCA) meetings in order to generate and sustain improvements across the system. There is a lag in some of this work due to the ongoing capacity issues resulting from the surge in COVID-19. This SOP is referenced in and aligns to the over-arching SI SOP above.

NOVQP04: Duty of Candour (DoC) compliance data is illustrated in the chart. Review of the 'not stated' position reflects a data quality issue rather than non-compliance. Datix thresholds are set intentionally low which renders them sensitive but not specific. Staff reporting incidents do not always recognise the criteria for DoC and the status is often



² <https://www.england.nhs.uk/patient-safety/incident-response-framework/>

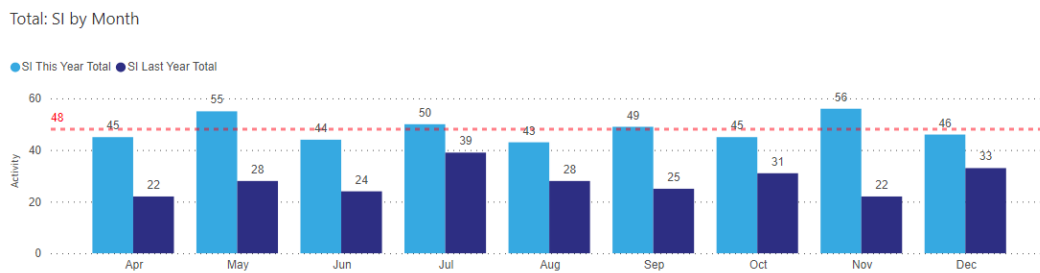
updated after internal specialist review. The improved collaboration between the CCG QA/QI team and provider colleagues will contribute to the ongoing deliberations around DoC at provider level.

SI Reviews & Backlogs

Serious Incident investigation backlogs persist, particularly for NUH and NHT. The QA/QI team are actively involved with patient safety teams at NUH, NHT and SFH with the early review of incidents, discussions around key lines of enquiry. Regular touchpoint meetings are in place which enable continued support and oversight regarding incident themes.

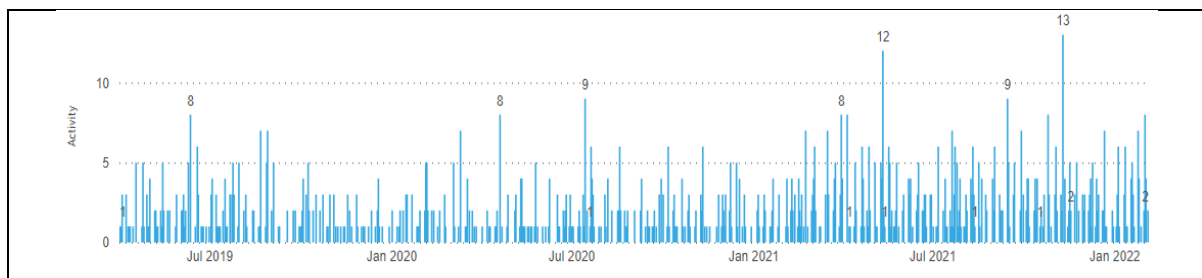
SI Activity

During Q3 147 Serious Incidents were reported which is a 71% increase compared to the same period the previous year.

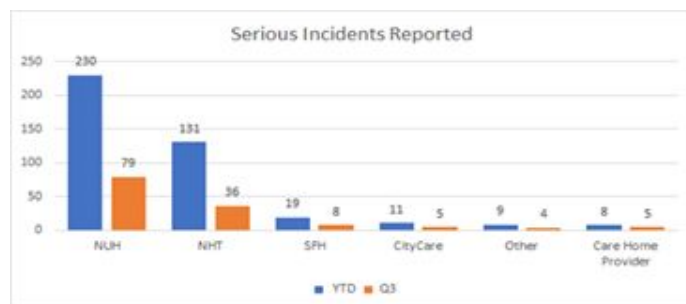


It's important to note caution when comparing reporting periods particularly recent years recognising the unusual set of circumstances during the pandemic, in addition to improved reporting following awareness and training. The impact of retrospective reporting can still be seen: 58% of the total incidents reported in Q3 occurred prior to October 2021.

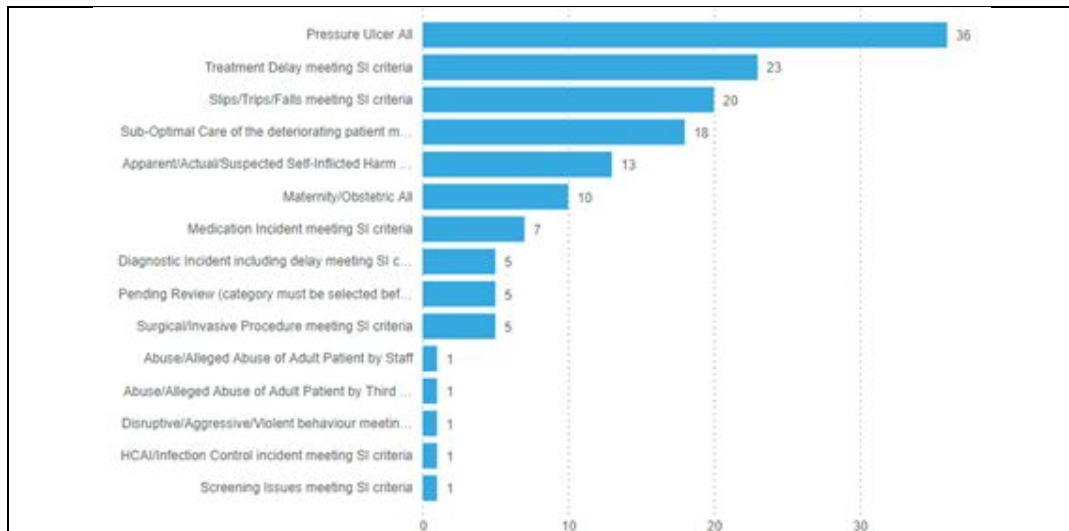
Below illustrates an increase overall of the incidents reported. Further work is required to explore the impact of recommendations and learning from SI investigations.



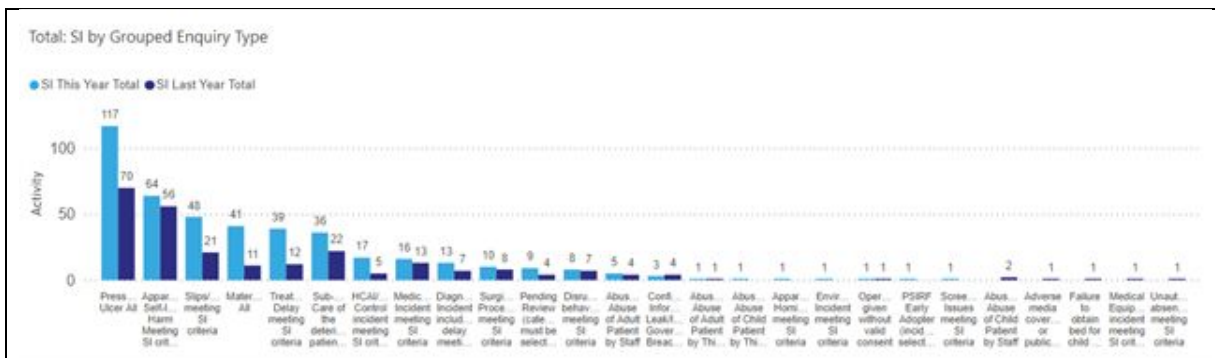
54% of incidents were reported by NUH followed by 24% from NHT.



Pressure Ulcer Incidents continue to be the largest number of reported incidents during Q3, followed by Treatment Delay, Slip/Trips/Falls, and Sub-optimal Care of the Deteriorating Patient.



The chart below illustrates that reporting has increased across every category this year.



Several themes will be applicable across all settings which contributes to high reporting numbers (pressure ulcers and falls are a good example of this).

The ICS Patient Safety Specialist Steering Group (PSSSG) has had a focus on pressure ulcers during Q3 and will be supporting the establishment of a system wide community of practice which brings together subject matter experts to share learning and approach to pressure ulcer prevention.

The number of SIs relating incidence of self-harm and suicides continue to be under scrutiny. In addition, the team are working with providers to further understand the nature of the SIs identified as 'treatment delay' and contributing factors and whether there are links to COVID-19, operational demand, or waiting times (39 SIs relating to treatment delays between April – December 2021, compared to 12 reported during the same period the previous year).

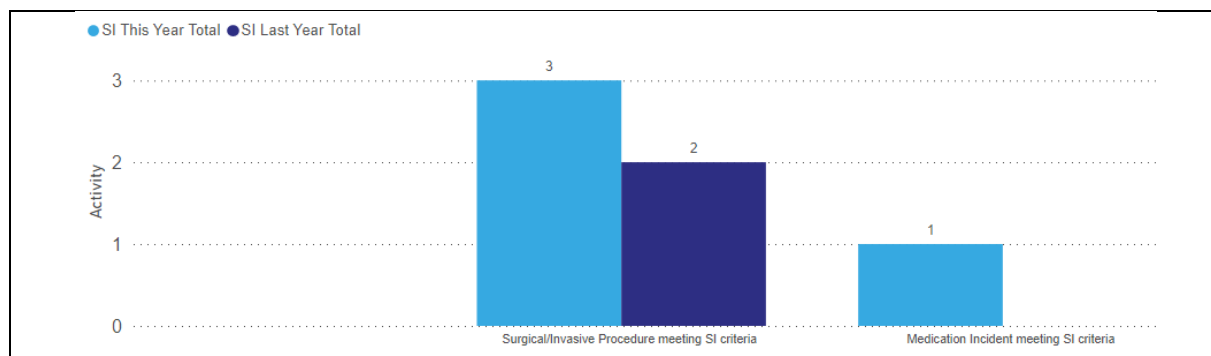
The actions and recommendations from these investigations are beginning to demonstrate a more structured and systematic approach to developing the environment in which clinicians and their patients meet, with a focus on handover, dynamic risk assessments, clear escalation processes and

separate and proactive attention to patients who have cancelled appointments or been removed from waiting lists.

Timely investigation of serious incidents remains a considerable challenge across the system – exacerbated by the availability of suitably trained subject matter experts, and the volume of work.

Never Event (NE) Activity

During Q3 4 Never Events have been reported, all 4 at NUH, in comparison to Q3 2020/2021; 2 Never events were reported, 1 at NUH, and 1 at SFH.



QUARTER 4 (2021/2022) FOCUS

FEBQP07a: (SI/NE)	Understand the combined system position in numbers of nosocomial COVID-19 HCAI cases; large numbers anticipated to be reported as serious incidents
FEBQP07b: (SI/NE)	Work with partners via the ICP SAG to agree efficient and effective approach to managing the nosocomial, adopting PSIRF principles for learning.
FEBQP07c: (SI/NE)	Work with NUH to conduct trust wide audit of DoC and support with action planning; evaluate other providers, especially those with high numbers of serious incidents
FEBQP07d: (SI/NE)	PSSSG presentation to ICS Clinical Executives Group during Q4 to raise profile and propose approach to adoption of PSIRF during 2022/23
FEBQP07e: (SI/NE)	Work with the Providers to address Backlogs and Reviews in order to draw out themes and learning.

PART TWO: PROVIDER QUALITY & SAFETY REPORTING

The report should be read in conjunction with the CCG Integrated Performance Report (IPR)

NHS England and NHS Improvement (NHSEI) have been progressing working on a Quality Toolkit. This toolkit provides a standardised and centralised repository of data which can be interrogated up to a point. It is intended to avoid confusion and duplication by replacing piecemeal data reports with ‘one version of the truth’ using validated, automated, and sustainable data. Due to the validated objectivity of the toolkit, the CCG QAQI team will commence using the information to support the

development of updated quality and risk profiles for providers within the system, to inform a focused and responsive support offer whilst reducing reliance on reactive approaches of quality surveillance.

The QAQI team have been developing supplementary approaches to the identification, collection and most importantly sharing of intelligence using a variety of methods³. The ‘virtual water-cooler’ is a work in progress that has created a space outside of formal meetings for semi focused conversations, using the MS Teams chat and whiteboard functions.

7. Workforce

The most significant concern across the system for Q3, and emerging into Q4, is staff sickness absence rate, with the most recent data showing a rate of 5.4%. Across the Midlands Region the rate varies between 4.6% and 6.2%.

Data from the NHSEI Quality Toolkit is already supporting with local intelligence. The toolkit indicates that staff working in Nottingham and Nottinghamshire ICS are more likely to recommend their organisation as a place to receive care (84.5%) than as a place to work (72.6%). The table below provides more context around the indicators and outcomes of the national workforce tool:

	Staff rec. for Care and Treatment	Staff rec. as a place of work	Staff engagement	Sickness and absence	Staff turnover
National	80.7%	62.4%	7.1	2.5%	0.9%
Regional	80.6%	62.4%	7.1	5.4%	0.9%
ICS	84.5%	72.6%	7.2	5.4%	0.8%
NUH	82.8%	80.2%	7.0	5.2%	0.8%
SFHT	87.3%	75.0%	7.4	4.7%	0.6%
NHT	71.7%	56.6%	7.1	6.4%	1.0%

Limitations of the historical data (2021) are recognised; however, it provides useful and objective metrics to inform the individual provider quality and risk profiles currently being developed by the QAQI team. Further detail around the NHT data will be provided in the ‘Provider Focus’ section below.

Staffing in the care home and home care sector presents continued challenge. Both nurse staffing banks (NHS Professionals and SFH Nurse Bank) have agreements in principle to support the care and social care sector, however there are limited resources.

A system workforce oversight group which has the following workstreams and projects underway:

- Mapping recruitment and retention funding opportunities
- International / Domestic recruitment (see further details below)
- Collating training offers across the system with the aim to offer equitable access
- Advertising vacancies on buses
- Work ongoing to increase the number of Trainee Nursing Associates in LD and Autism services across the Nottingham and Nottinghamshire ICS
- Recruitment and retention bulletin to share recruitment hints and tips, good news stories, show what is working well and encourage provider participation
- ICS wide recruitment event
- Rebranding to ICS Workforce Development website

³ <https://www.sciencedirect.com/science/article/pii/S0277953615300435>

Discussions have taken place with NHSEI recruitment teams and with NUH/SFH to scope options for internal recruitment. System support is available for the induction and competency assessment of international nurses, including those who intend to work in social care.

8. Provider Focus – ENHANCED SURVEILLANCE

NOTTINGHAM UNIVERSITY HOSPITALS



CQC Inspection September 2021



Following the CQC published report and receiving notice under Section 29a⁴⁵, an overarching NUH Quality Assurance Group (QAG) was established co-chaired by ICS/CCG Accountable Officer and NHSEI Regional Medical Director. 3 sub-groups were formed for progression of the relevant action plans: Emergency Department; Maternity⁶; and Well-Led / Governance. The QAG is accountable for gaining assurance for the delivery of the actions being taken to address the CQC conditions and Trust-Wide Improvement Programme. The oversight mechanism does not replace the statutory accountabilities of the Trust, CCGs, or partner organisations. Membership includes CCG/ICS, associate commissioners, NHSEI, CQC, NUH, HEE, Professional Bodies, Healthwatch, and Local Authority.

All subgroups met during December and agreed Terms of Reference and scope.



NUH remains on an ‘enhanced’ level of quality surveillance with NHSEI SOF 4 support⁷.

⁴ <https://www.cqc.org.uk/location/RX1RA>

⁵ <https://www.cqc.org.uk/location/RX1CC>

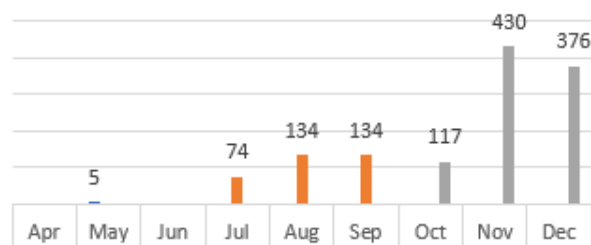
⁶ Maternity QAG in place since January 2021

⁷ <https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/>

Key messages from QAG will be included within the Q4 Report

Emergency Department 12hour breaches (NUH): Limited assurance has been received regarding the quality of care to patients enduring long waits for admission during Q3. It has been acknowledged that individual root cause analysis investigations provide little value given the volume of breaches (see below)

NUH ED 12-hour DTA breaches 2021-22 Q1-Q3



Regular touchpoint meetings are in place with NUH to monitor safety utilising existing rounding metrics, and ongoing regarding thematic review. The topic is also discussed at the NUH Quality Assurance Group (QAG) Emergency Department (ED) subgroup and received focused consideration as part of a system wide discussion around prevention of pressure ulcers at a recent ICS Patient Safety Specialists Steering Group meeting.

An emerging concern has been raised which will receive further focus during Q4, regarding the risk and occurrence of moral injury to staff working at NUH ED.

NUH Serious Incidents and Duty of Candour: NUH continue to engage with the CCG QA/QI team and the increased frequency of meetings with NUH patient safety colleagues (in the Governance and Harms Free Care teams) has allowed for regular discussion of progress with serious incident investigations and reasons for delays; closer monitoring of Duty of Candour (DoC) compliance and better understanding of the issues; discussion and identification of themes; and increased oversight of actions being taken as a result.

There is a demonstrable improvement in the quality of investigation reports around pressure ulcers and falls with harm, and fewer reports are being returned for further assurance.

Maternity SI reports remain problematic due to challenges around availability of expert panel members from the Trust. The Local Maternity & Neonatal System SI Group is in place to provide additional oversight.

Fragile Services: The CCG QA/QI team continue to work with NUH supporting fragile services, and improvement has been noted in chemotherapy and urology services.

Maternity Services: NUH continue to report 'extraordinary pressure' on maternity services, which is reflected across the country. COVID-19 remains challenging in terms of workforce and service provision with a peak of admissions to the virtual Covid ward at the end of Q3. The service wide Maternity Improvement Programme continues to progress, and the NUH QAG subgroup described above has received assurances across medicines management and foetal monitoring training.

Further work is required to support improvements in the management of postpartum haemorrhage, Infection Prevention and Control (IPC) and appropriate escalation.

Limited assurances have been gained across culture and workforce, and this will be the focus of the group when it meets in February 2022.

Maternity service thematic review: The full review team is now in place and actively working with the agreed terms of reference⁸. The process will broadly follow the 'Windrush' thematic methodology and is anticipated to be complete by November 2022.

IPC and the Board Assurance Framework (BAF): NUH continue to report partial assurance on the monthly BAF in the following areas:

- Ventilation - A Ventilation Technical Assurance Group (VTAG) is in place with investment in portable High Efficiency Particulate Arrestance (HEPA) filtration units to mitigate areas of poor ventilation in old estate. New developments include ventilation as a key area requiring consideration
- Patients are still moving beds frequently -the focus on unnecessary patient bed moves remains in place with daily meeting that include IPC
- Mandatory IPC training with overall fall noted December to 65%
- IPC workforce- plan to increase staffing to support extended service provision
- Audits post outbreaks

An improvement plan is in place to address and mitigate areas not meeting full compliance

A recent UK Health Security Agency (UKHSA) supported independent review found that the Trust is not an outlier despite increased Methicillin-Sensitive Staphylococcus Aureus (MSSA) British Standards Institute (BSI) rates. The increase was felt to be in line with increased testing taking place.

The overarching system IPC group continues to support the work around Healthcare Associated Infections (HCAI).

Patient Experience & complaints (reported to CCG Patient Experience Team - PET): There has been an increase in complaints during Q3 in comparison to Q2, and to the same period last year. The most significant theme is around treatment and care, with 'hospital treatment' the highest category sub-theme. The team continue to investigate complaints whilst sharing learning across the wider quality team and with providers.

Safeguarding / Mental Capacity Act (MCA) & DOLs: Safeguarding and MCA training has recently been reported as low across the Trust, particularly in Medicine and Family Health divisions. Face to face training was suspended during Q3 due to Covid pressures but this is scheduled to resume. Safeguarding activity appears maintained with an increasing trend.

There was a significant increase (around 25%) in urgent Deprivation of Liberty (DOLs) referrals during Q3 – the reason for this is currently unclear and any relevant themes/trends will be highlighted in Q4.

⁸ <https://independentmaternityreviewnotts.nhs.uk/>

QUARTER 4 (2021/2022) NUH FOCUS

FEBQP08a: (NUH)	CCG Quality Risk Profile (QRP) to be complete by end of Q4
FEBQP08b: (NUH)	Insight Visit with ICS Chair Designate scheduled for Q4 (delayed from Q3)
FEBQP08c: (NUH)	Remain on enhanced surveillance and Q4 update on maternity SIs, 12hr breaches and ED subgroup Feb 2022
FEBQP08d: (NUH)	System & Regulatory Oversight & Support to continue

NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST



CQC Inspected May 2020



The most recent CQC rating was in May 2020⁹. The Trust remains on enhanced surveillance with continued focus on three key areas:

- Workforce / staffing fragility
- Embedding and sustainability of governance & oversight arrangements
- Application of strategic and systemic organisational learning

NHT Workforce: The Trust continues to report significant staffing challenges across all three divisions, with resulting impact on clinical supervision, appraisals, and mandatory training. Safe staffing surveillance shows an increased reliance on temporary staffing (bank and agency) along with a reduced fill rate, with some services staffed at <85% despite escalations and mitigations. The highly specialised skills required for some areas at the Trust are not available at volume and at short notice.

The Trust provide good assurance around their oversight and governance arrangements in place at division and service line levels to inform an accurate narrative. Further assurances are required around the impact on quality, patient safety and staff and patient outcomes.

Governance & oversight arrangements: The NHT Quality Assurance Group (QAG chaired by ICS/CCG Chief Nursing Officer (CNO)) continued to meet monthly during Q3. NHT provided significant assurance around internal governance arrangements and in particular the attention to quality oversight within Trust services. The meeting was moved from monthly to quarterly and will next take place in March 2022. Focus is requested on workforce and culture, with the Trust presenting a deep dive into these areas in Q4.

⁹ <https://www.cqc.org.uk/provider/RHA>

Further assurance is required regarding the arrangements for quality oversight of subcontracted services (separate to IMPACT). Priory Arnold received two CQC warning notices in December 2022 and a Trust action plan is anticipated at the next QAG.

Strategic and systemic organisational learning: NHT are active participants in the PSSSG and fully engaged with the system wide journey towards PSIRF. This is relevant to discussion around the management and oversight of serious incident investigations. The Trust's position around serious incidents investigation, reporting and action planning is demonstrated below:

	Overdue	Live
AMH	44	82
CHS	0	8
FORENSICS	2	49
Total	46	139

The Trust has increased investigation capacity by facilitating several sessions of SI investigation training which has been well received by 75 members of staff – further sessions are planned throughout Q4 using an external training provider. There are eleven bank staff recruited specifically to support investigations while training is underway.

The Trust is prioritising those incidents where death was the outcome so that reports are finalised prior to inquest. A Section 28 (Preventing Future Deaths) notice was served by the Coroner in January 2022 following the death of a patient on Lucy Wade Ward in May 2021. The notice was issued prior to full inquest due to significant concerns around the management of deteriorating patients and access to appropriate care. A scoping exercise has been conducted by the QAQI team and a quality insight visit is planned for Q4

The CCG QAQI team are active participants in the Trust's weekly serious incident review group, supporting key lines of enquiry and joining robust oversight of the SI backlog. This approach reflects proactive engagement work which took place during Q2 and has significantly increased the CCG's quality assurance profile working in partnership with Trust colleagues.

Three family liaison officers have been recruited to ensure ongoing engagement and involvement with patients and their families affected by serious incidents. These posts will be filled during Q4.

Suicide and self-harm: From April 2021 to date 45/150 SIs reported at NHT were categorised as 'apparent self-harm / suicide resulting in unexpected death.' The Trust continued to take targeted action to address and prevent incidents of suicide, including the alignment of Trust processes to themes and learning from the National Confidential Inquiry into Suicide and Safety¹⁰. Several supporting workstreams and initiatives have been implemented in response to this, including workforce training led by the Trust's suicide prevention lead.

¹⁰ <https://www.hqip.org.uk/resource/suicide-safety-mental-health-report-2020/>

A Suicide and Self-Harm Strategy Group is in development, with first meeting to ratify terms of reference scheduled for February 2022. The group includes subject matter clinical experts and CCG QA colleagues

Current oversight is maintained by the QAG with update scheduled for March 2022

Restrictive practices: Key priorities for the Trust are detailed below:

- Launch Strategy to Prevent and Reduce Violence and Restrictive Interventions
- Roll out proactive methodologies and approaches
- Establish robust system for patient advanced statement in relation to restrictive interventions
- Provide post incident debriefs for patients
- Engage ward teams in developing QI plans
- Promote consistency across all areas with regards to the use of blanket restrictions

Q3 report to NHT Quality Committee demonstrates overall reduction in the use of restrictive practices; the highest use of restraint is seen in women's services and in CAMHS and work is ongoing to understand and mitigate this. Active collaboration between NHT and the East Midlands Patient Safety Collaborative is in place to support wards across the Trust with QI initiatives relating to restraint and restrictive practices.

Open/closed cultures: The Trust has undertaken a focused approach to the promotion of 'open cultures' in clinical environments which can lend themselves to closed cultures. The key elements include quality standards, quality improvement, culture, and employee relations. Work completed so far includes:

- Creation of Open Cultures working Group – a patient with lived experience co-chairs this group
- Healthcare Assistant (HCA) support days
- Intellectual and Development Disabilities (IDD) IMPACT Tool testing
- Collaborative working to align with Just Cultures work
- Focus on Kindness, Civility and Wellbeing
- Vision 27 Leadership
- Cultural diagnostics across the Trust

The aim is to develop an open culture which supports staff and patients to speak openly and transparently about their experiences. Significant improvements are expected to be visible by December 2022.

IPC and the board assurance framework: The Infection Prevention Matron post became vacant in December and has been recruited to (start anticipated Feb 2022). The existing BAF has not been updated due to Covid pressures and reduced capacity in the team – partial compliance continues to be reported.

The Trust has experienced a surge in outbreaks during Q3 and into Q4 and particularly high numbers in mental health and forensics/secure services. The high transmissibility of the Omicron variant, and the challenges with IPC compliance amongst these vulnerable patients, have exacerbated outbreak numbers. Additionally, national testing capacity was reduced during December which affected staff and patient screening. Other factors identified include variable staff compliance with lateral flow

testing; reduced staffing contributing to staff moves between areas; ventilation in old estate which is mitigated in part using air sentry units.

The Trust have introduced derogations around the use of enhanced PPE (FFP3 masks) and made these more readily available in areas of high patient throughput and on outbreak wards.

Physical healthcare: The Trust is taking action to address the issue of recognition and response to the deteriorating patient, and the Adult Mental Health (AMH) Services Head of Nursing is identified as the Trust's physical healthcare lead. The Physical Healthcare Group meets monthly to oversee progress and assurances, including effective implementation of policy or guideline updates. The Trust continues to develop digital capacity and capability (including training) around the electronic recording of NEWS2, with training for Q3 varying across divisions between 78 and 88%. The group's report proposes limited assurance to the NHT Quality Committee and is considered 'work in progress.'

CAMHS: During Q3 the following concerns arose relating to CAMHS provision:

- Concern from police that Children and Young People (CYP) who require Section 136 beds/facility are not available and that a Family Room is being used for CAMHS patients were not being used appropriately on occasion due to adult occupancy. This meant that CAMHS patients were then managed in the family room which is an inappropriate setting due to lack of supervision and increasing support required from the policy for restraint and de-escalation. The Trust is undertaking an audit of S136 use for <18s to evaluate and respond to this concern.
- Social Care colleagues requested clarification regarding the Trust's policy for undertaking DBS checks amongst CAMHS staff, this clarification was provided via QAG in Q3 (November 2021).
- Increased complexity of cohort (acuity) and workforce challenges have been highlighted at the Hopewood Centre

Wells Road Centre / Seacole ward: The Quality Improvement Plan was reviewed in November 2021 with positive updates received around the issues below:

- Active engagement with NHT self-harm and suicide prevention training
- Assurances regarding acuity on Seacole Ward, in the context of staffing, supervision and training
- Patient feedback during quality insight visits
- IPC practices

The group agreed to recommend a reduction in surveillance rating, acknowledging additional monitoring which takes place via regular contract meetings and routine contact with Seacole Ward manager

Priory Arnold (NHT Subcontracting): Following a CQC inspection in December 2021, Priory Arnold was issued with a warning notice under Section 29 in relation to the following concerns:

- Ligature risks
- Documentation
- Clinical risk assessment
- Emergency equipment
- Restrictive practices

NHT are working directly with the provider to ensure actions are taken and appropriate evidence provided to the CQC in response to the warning notice. NNCCG Quality colleagues in regular contact with NHT at planned meetings and touchpoints and support has been offered.

QUARTER 4 (2021/2022) NHT FOCUS

FEBQP09a: (NHT)	Evaluate impact of reduced staffing on quality, safety, experience, and outcomes
FEBQP09b: (NHT)	QAG Update Required: Culture/workforce; Priory Arnold; Suicide & self-harm; Quality Insight visit to Lucy Wade ward
FEBQP09c: (NHT)	Update from NHT Physical Healthcare Group regarding use of NEWS2 and the deteriorating patient
FEBQP09d: (NHT)	Update regarding staffing concerns and acuity at Hopewood Centre

MEDISCAN (NON-OBSTETRIC ULTRASOUND)



CQC Inspected November 2021



All the Nottingham and Nottinghamshire patients identified as affected by the suspension of Mediscan services in Q2 have now been followed up by their referrers. No harms have been noted although the service will remain on 'enhanced' surveillance until end Q4 to allow for this follow up.

In November 2021 the CQC suspension that was in place lapsed although warning notices were served in December 2021 regarding patient safety and governance.

NNCCG has suspended its contract with Mediscan; the contract expires end March 2022.

The company have engaged with an external agency to support their response to the warning notices and a portfolio of evidence has been submitted to CQC which is currently under review. Evaluating the updated policies and procedures in practice is challenging as no clinical activity is currently underway.

Mediscan have been invited to present to the next Single Item Quality Surveillance Group (QSG) on 28 February hosted by the NHSEI North West Region.

QUARTER 4 (2021/2022) FOCUS

FEBQP10: (MS)	Feedback following February 2022 QSG
---------------	--------------------------------------

9. Provider Focus – ROUTINE MONITORING

SHERWOOD FOREST HOSPITALS



CQC Inspected May 2020



Healthcare acquired infections (HCAI): SFH have breached the year-end target for *C. difficile*, Methicillin-resistant *Staphylococcus aureus* (MRSA), *Pseudomonas* and *Klebsiella* bloodstream infections. Case reviews are underway and system IPC support is in place. A slight improvement was noted in December following a focus on cleaning and decontamination. The Trust IPC group is attended by the QA/QI team and continues to identify learning from new cases.

An NHSE/IPC assurance visit was conducted in November with no new actions identified – the Trust were de-escalated to ‘amber’ following this visit and a follow up visit is planned for March/April 2022.

The IPC Board Assurance Framework reports partial compliance. Actions underway to meet recommendations include:

- Focus group established to progress work on ventilation
- Air sentry units purchased to support areas in need of increased ventilation

Covid outbreaks amongst patients and staff increased during Q3, with patient screening and staff lateral flow testing noted as factors.

Cardiac Arrest rate: The cardiac arrest rate (using data per 1000 admissions) showed an increase in month during November, the actual rate was 1.09 against an actual quarterly rate of 1.26.

Two of the six cardiac arrests during November were deemed unavoidable following review. However further investigations have highlighted discrepancies with ReSPECT forms which resulted in lack of clarity. Actions taken as a result:

- Working group established to review and update processes for ReSPECT
- Further training and education proposed around completion of ReSPECT forms
- Planned implementation of the NerveCentre alert system

Length of stay: Increased length of stay was noted during Q3 and the following actions were taken:

- RCA completed on a subset of admitted patients who had an increased length of stay
- ED and medical admission notes reviewed
- Findings indicate that Covid measures taken to reduce movement between wards affected flow and capacity, and additional cleaning impacted on delays

- Delayed discharge was also identified as a factor in length of stay, reflected by wider system pressures detailed in Section 1 above.

Workforce and staffing: Sickness absence rates for Q3 are 4.7% against a regional median of 5.19%. Safe staffing hours (CHPPD) were met across Q3 and this is overseen at the Nursing, Midwifery and Allied Healthcare Professional (AHP) Committee.

The top theme reported within staffing incidents is failure to provide enhanced patient observation – however it was also noted that patient fall rates at the Trust are now below the national average due to additional work taking place. The Trust actively engage with external partners and workstreams to promote professional development and training pipelines for specialised areas including maternity and AHPs.

Quality insight visits: Visits scheduled during Q3 were delayed supporting level 4 response to the Omicron wave.

QUARTER 4 (2021/2022) SFH FOCUS

FEBQP11a: (SFH)	Focus on HCAI prevention, implementing actions above and learning from investigations and IPC system work
FEBQP11a: (SFH)	Update on Q3 and Q4 position re cardiac arrests
FEBQP11a: (SFH)	Reschedule quality insight visits including maternity as part of perinatal surveillance.

CITYCARE



CQC Inspection March 2017

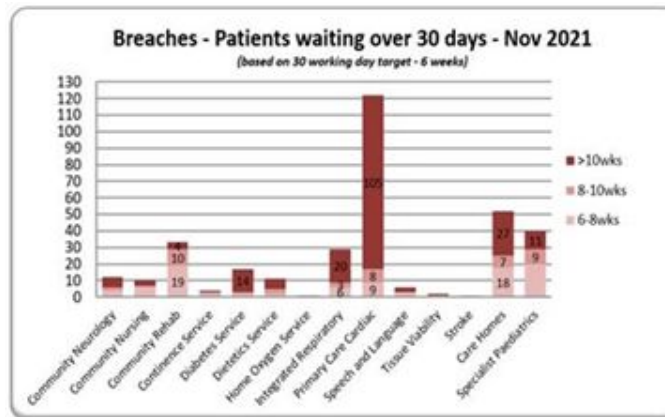


Emerging concerns – workforce and staffing: Regular quality and governance meetings have recently recommenced with CityCare after a long hiatus and emerging concerns have been identified for further scrutiny. There are high vacancy, turnover, and temporary staffing levels across the organisation. Sickness absence rates are rising with stress and anxiety a major factor.

The services provided by CityCare rely on small, specialised teams, and this results in a disproportionate impact of vacancies and absence.

There are high waiting lists in several services (see below) with work underway to identify the impact on patient outcomes and experience. Immediate actions undertaken include prioritisation of urgent assessments, recovery plans focusing on services with highest number of waits; MOSAIC, Primary

Care Cardiac and Paediatric Continence with plans to be in place across all affected services by the end of Q4.



Some services (including community nursing) are operating in business continuity. The situation is anticipated to improve during Q4 as staff return from deployment.

QUARTER 4 (2021/2022) CITYCARE FOCUS

FEBQP12a: (CC)	Quality Insight visit planned for Q4 – update at Q4 report
FEBQP12b: (CC)	Evaluate the community response to the derogation’s framework published in January 2022, including service changes, EQIA and harms review.

EAST MIDLANDS AMBULANCE SERVICE (EMAS)



CQC Inspection July 2019



Delayed response and patient harm (see section 1a): Delayed responses are now the most common serious incident reported by EMAS across both Nottinghamshire and the wider Trust, with falls the most frequent reason for calling an ambulance in this cohort of patients.

EMAS reported 8 SI’s across the Nottinghamshire Division in Q3, 7 of these were harm due to delayed responses.



In December 2021 EMAS held an extraordinary meeting to examine the issue of delayed response more closely, and three factors were identified as significant causes of delayed response:

- Increased activity/calls
- Hours lost due to delayed handovers at hospital
- Resource shortages

Serious incident review and completed investigations did not identify new learning in most cases; however, escalation guidelines for Category 3 calls are now being reviewed, particularly where other action is being taken because of operational pressures.

QUARTER 4 (2021/2022) EMAS FOCUS

FEBQP13: (EMAS)	Gain assurance around support for staff involved in patient harms (including death) because of delayed response
-----------------	---

10. PRIMARY CARE QUALITY HIGHLIGHTS

To be read in conjunction with CCG Primary Care Commissioning Committee Papers

Bilborough Medical Centre (City): Underwent routine CQC inspection in November 2021 – Report now published: Good overall, Good in all domains.

Broad Oak (City): Underwent routine CQC inspection in December 2021 – Report now published: Good overall, Good in all domains, with exception of ‘Effective’ which is rated Requires Improvement. There are no breaches of regulations, or ‘musts’ but the provider ‘should’:

- Strengthen processes for managing people with long term conditions and take action concerning patients with a potential missed diagnosis and those with long term conditions that may be overdue for monitoring
- Continue their work to improve uptake of childhood immunisations and cancer screening
- Improve identification of carers on their practice list
- Continue to recruit relevant staff to support access to care and treatment in a timely way
- Establish a patient participation group to enhance engagement with patients

Highcroft (South Notts): Early 2021, concerns raised to CCG regarding medicines management, administration, lack of support to practice staff, care homes and community staff. CCG meeting undertaken with Highcroft partners in April 2021 and CQC inspection undertaken June 2021. Overall rating of ‘Good’, with ‘Good’ in each of the Key Line of Enquiry domains.

CQC undertook further, unannounced inspection in August 2021 with a specific focus on a potential backlog of administrative tasks. No breaches of regulations or a requirement for any immediate or urgent action. Significant backlog in correspondence identified which required action or completion. The practice was noted to be taking steps to address this.

Further meeting with partners and CCG took place at end of November 2021. Progress noted, particularly in relation to the new phone system which was put in place at the beginning of November and continues to have a positive impact on patient experience.

QUARTER 4 (2021/2022) PRIMARY CARE FOCUS

FEBQP14 (PC)	The primary care team will link with the practice to offer support in developing an action plan.
--------------	--

PART THREE: CCG STATUTORY RESPONSIBILITY

11. CONTINUING HEALTHCARE (CHC) AND CHILDREN CONTINUING CARE HIGHLIGHTS

For Q3 the number of new CHC referrals completed within 28 days was 86% (target 80%). A decline in performance is forecast for the Q4 report due to Covid related impacts on staffing and recruitment.

There is a backlog of 41 new s117 referrals awaiting allocation to a Mental Health (MH) or Learning Disability (LD) Nurse Assessor in Mid Nottinghamshire. This does not affect patient care as the Local Authorities are responsible for arranging and commissioning s117 after-care. The CCG's funding contribution can be agreed retrospectively. However, it does mean that the Local Authority does not always benefit from the clinical advice of a Nurse Assessor prior to placement.

There is a backlog of reviews for CHC, Funded Nursing Care (FNC), Joint Packages of Care (JPOC), s117 after-care and Children's cases. Across the 2 CHC delivery and assessment teams there are 2,009 overdue reviews split as follows:

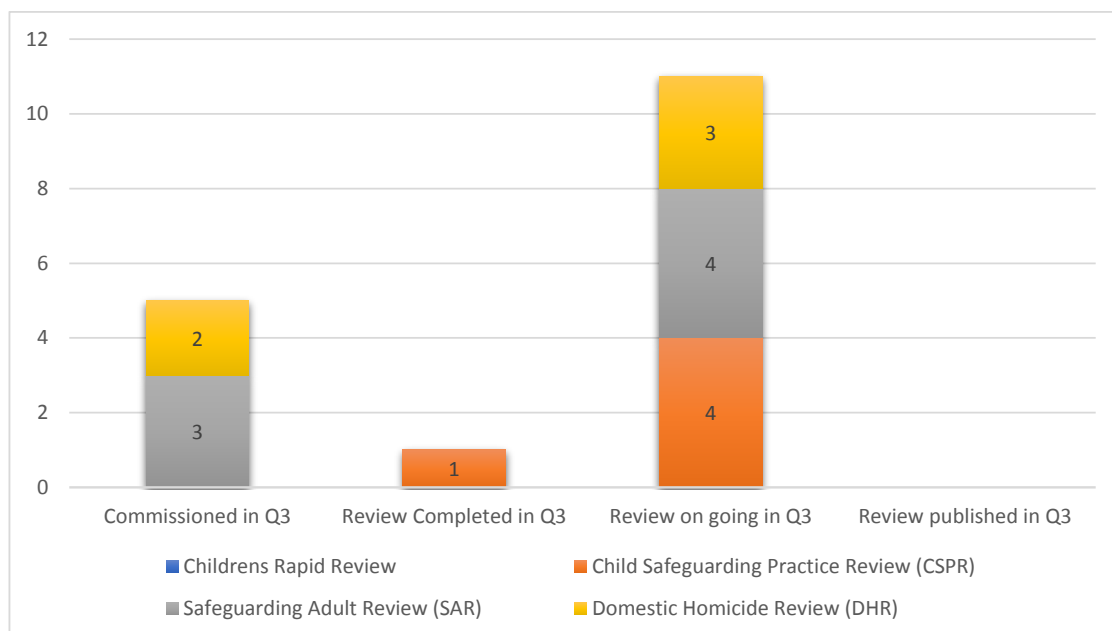
Type of Review	Citycare CHC service	Mid Notts CHC service	Total overdue reviews	Total No. of funded cases ¹¹
CHC	250	135	385	714
Fast track over 12 weeks	9	0	9	273
FNC	279	235	514	1,079
JPOC	333	262	595	811
S117	247	235	482	960
Children	24		24	84
Total	1,142	867	2,009	3,921

¹¹ As of 31 December 2021

QUARTER 4 (2021/2022) CHC/CYP CONTINUING CARE FOCUS

FEBQP15a (CHC)	Aim to accelerate completion of overdue CHC and FNC reviews using a dashboard developed by the CityCare CHC team and shared with Mid Notts colleagues
FEBQP15b (CHC)	Continue to prioritise reviews in accordance with changing needs which are identified through case management, e.g., deteriorating conditions and higher cost packages of care
FEBQP15c (CHC)	Continue to provide training and raising awareness amongst medical colleagues regarding the criteria for fast-track referrals, in order to improve the service provided to people at the end of their lives
FEBQP15d (CHC)	Complete demand and capacity mapping in the Mid Notts CHC team to support business case for service development

12. SAFEGUARDING STATUTORY REVIEWS



13. ADULT SAFEGUARDING – LIBERTY PROTECTION SAFEGUARDS (LPS)

The new Code of Practice for LPS has now been published for consultation. The implementation of the LPS requires adequate time for preparation and consultation. Given the impact of the pandemic on the sectors and professionals who will be called upon to implement these important reforms, along with the unforeseen delay to launching consultation the anticipated launch in April 2022 is no longer being worked towards.

The CCG Adult Safeguarding Team has delivered training aimed at a basic understanding of the Mental Capacity Act, Assessing Capacity, Undertaking Best interest Decisions and Dols (including introduction to the new LPS), this has now been rolled to 108 internal and external staff from CHC, commissioning, primary care, and wider quality team.

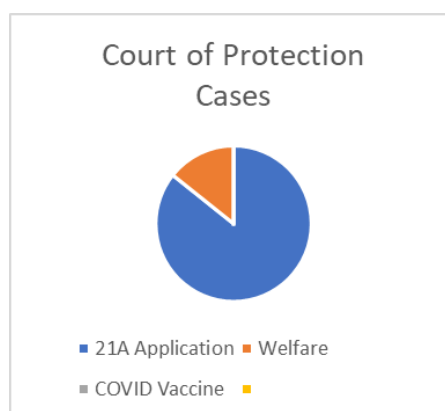
QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16a (SFG)	To continue to facilitate and contribute to the LPS Steering Group.
FEBQP16b (SFG)	Safeguarding team will use the opportunity provided by the delay in implementation to further deliver mental capacity act training
FEBQP16c (SFG)	Engage with wider system partners to contribute to and progress the LPS implementation plan.

14. ADULT SAFEGUARDING – COURT OF PROTECTION (CoP)

In Quarter 3 the CCG continues to have 7 live applications in proceedings in the Court of Protection (CoP). 6 of these are s21a applications. In all these 6 cases the applications have a risen from challenges to the type of care setting and restrictions placed on the individual. 1 case is a welfare application.

The CCG during Quarter 3 the CCG has concluded 2 applications in the COP relating to the administration of the COVID vaccination both people with a learning disability who are unable to consent, and where family members disagreed that it was in the individual’s best interest. In both cases the Court of Protection concluded that it was in the best interest of the non-consenting individual to have the vaccination.



The CCG is working with Primary care colleagues on 3 more cases where there is a dispute between health professionals and family members as to what is in the individuals best interest relating to the covid-19 vaccine, but these have yet to move into formal proceedings.

The CCG has shared its proactive approach and learning from supporting primary care with vaccination disputes with regional colleagues from LDA networks to help address the inequalities and variance in the number of people with LDA who continue to be unvaccinated.

QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16d (SFG)	Extract the learning from managing complex CoP cases and share across the wider quality team by the end Q4
----------------	--

15. ADULT SAFEGUARDING – ASYLUM SEEKERS AND AFGHAN RESETTLEMENT

As identified in Q2 the 4 hotels (3 city and 1 county) continue to operate as accommodation following the temporary amendment to the asylum dispersal programme. In addition, the high-rise

accommodation for Asylum seeking families and single people on a more permanent basis within the city continues to operate.

The identified Primary Care Services delivered by three local GP practices continue to work with the Asylum Seeker LES (Local Enhanced Service). Health assessments have been conducted with additional services established to facilitate care and any risks continue to be identified. As services established the need for multi-agency meetings reduced, but the CCG Primary Care & Safeguarding teams continue to work closely with system partners. Health partners continue to meet monthly to discuss any issues that may have or arise from ongoing assessments or presentations from this group of citizens.

The risk raised in the Q2 Report about access to appropriate and safe equipment for new-borns has resolved through access to equipment via the multi-agency teams, voluntary and charitable organisations becoming more accessible as services have returned to a pre-Covid service.

QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16e (SFG)	To continue to support partners including primary care, refugee forum and relevant, transformation programmes by identifying any gaps and risks and ensuring they are escalated appropriately through the system
----------------	--

16. UNACCOMPANIED ASYLUM-SEEKING CHILDREN (UASC)

The monitoring of unaccompanied asylum-seeking children and young people including those accepted on the National Transfer scheme continues. The health needs of this cohort of children and young people are being considered within the City Looked after Children CAMHS review and the Children In Care nursing team service review.

QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16f (SFG)	To ensure there is ongoing monitoring of young people being accepted onto the scheme. Activity is being monitored with the support of Commissioners to understand the impact on medical providers through contracting measures. Update to committee in 22/23 Quarter 1
FEBQP16g (SFG)	To continue to identify UASC as a minority group for consideration when reviewing any commissioning of services/ or in health needs assessments. Update to committee in 22/23 Quarter 1
FEBQP16h (SFG)	To await any key recommendations from the UK Asylum Seeker Health Steering Group in relation to UASC Update to committee in 22/23 Quarter 1

17. LOOKED AFTER CHILDREN – INITIAL HEALTH ASSESSMENT (IHA) AND REVIEW HEALTH ASSESSMENTS (RHA) PERFORMANCE

IHA performance: CIC medical teams are unable to consistently meet the 20-day statutory timeframe for Initial health assessments. The situation remains challenging with Paediatric vacancies in NUH team (a national concern) and Covid19 continuing to impact. In addition, concerns have been raised about children and young people not being brought to appointments across both CIC medical teams

and the impact this is having on appointment times. Ways to resolve this are currently under discussion with both local authorities.

The CIC nursing team (NHCT) at the time of writing this report are now reporting challenges in achieving timeframes for review statutory review health assessments with delays of up to 8 weeks for some children/young people. Reasons include increasing numbers of looked after children, vacancies, and non-recruitment to posts within the team plus late referrals from the local authorities – further discussion is required.

The IHA/RHA timeline is in place and both local authorities and health providers aware of their roles and responsibilities. Further discussion is being had around how to monitor the effectiveness of the timeline.

At the time of writing this report the CCG/Public Health commissioners are waiting for latest Q1 & 2 2021 data from the 2 specialist CIC health providers (NUH & SFHFT) and CIC nursing team (NHCT). This data will be reviewed in March 2022. To note the IHA data will be from before the timeline was implemented in September 2021. The next set of data should start to see the impact the timeline has made.

QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16i (SFG)	Designated CIC Professionals to have continued oversight and for data to be shared with the County Local Safeguarding Children’s Partnership and both corporate local Parenting Boards.
----------------	---

18. NOTTINGHAM CITY SPECIAL EDUCATIONAL NEEDS & DISABILITY (SEND) LOCAL AREA INSPECTION

A local area SEND inspection was undertaken in November 2021 and the report was published in January 2022¹²

The HMI Ofsted and CQC inspection report) sought to form a judgement on how effective the local area is, in identifying, assessing, and meeting the needs and improving the outcomes for CYP with SEND. It is important to reinforce that the SEND agenda cover those aged 0-25 years and therefore spans children’s and adult services.

The published report provides a narrative judgement about how well the local area has implemented the SEND agenda, since the reforms were implemented, for CYP with SEND and their families. If significant weaknesses are identified during an inspection a Written Statement of Action (WSOA) is issued. This is a formal requirement for improvement with HMI Ofsted and CQC oversight.

The Nottingham City inspection did not identify any significant weaknesses in the local area, SEND provision, that would require them to issue a WSOA. The report identified strengths and areas for development. This was a positive outcome to receive, when comparing ourselves nationally to regions with similar demographics.

The poorest areas of England are “most likely” to have “significant weaknesses” in their special educational needs and disabilities provision (Ofsted). Following inspection, two thirds of areas in the

¹²<https://files.ofsted.gov.uk/v1/file/50175127>

“most deprived quintile” were required to produce and submit a WSoA, compared to half of areas in the “least deprived quintile”. 80% of local area SEND inspections during 2021 received a WSoA. 50% of Nottingham’s statistical neighbours received a WSoA.

There were no specific recommendations for Nottingham and Nottinghamshire CCG raised by the inspectors. However, the areas for development identified will require a system wide approach from all partnerships to drive future SEND provision arrangements forward.

Recommendations made for areas of improvement will be considered in line with the anticipated publication of the national SEND Review (Green Paper) and the new SEND inspection framework, expected April 2022, prompting a system-wide review of our local area SEND strategy and improvement action plan. Triangulation of these pending legislation requirements, along with the inspection feedback, will enable us to continue our collaborative work to improve outcomes for our children and young people with SEND (0-25).

In response to the findings and the impending national SEND legislative changes, we are seeking to further strengthen the health contribution to local system arrangements. A SEND Health Improvement Steering Group is to be formed as a key strand of the wider Children and Young People’s Transformation Programme and our NHS provider colleagues will be key members of this group. Commitment to continue support in championing, prioritising, and driving forward the SEND agenda will be the focus of this group. Providing accountability for the health element of SEND improvement actions plan. A recommendation to health provider partners will be made, to identify a senior director to be the accountability SEND lead within their organisation to ensure the agenda is reflected within the Local Quality Requirements as part of the collaborative approach to Quality Schedules.

Local area SEND leaders have agree initial next steps which include:

- Identified areas for development along with the refreshed joint strategic needs assessment (JSNA) SEND Chapter will inform and update the current self-evaluation framework and improvement action plan.
- Review SEND governance and strategic oversight arrangements
- Review and refresh the current SEND strategy & priorities via co-production with all stakeholders including CYP with SEND (0-25) and their families
- Develop a local area communication strategy to improve co-production and engagement and ensure CYP with SEND (0-25) and their families have access to clear, up to date and relevant information (consideration of EAL and digital poverty)
- Develop a joint commissioning strategy and alignment of local area priorities as part of the ICS developments
- Improve the data and analysis infrastructure and resources to measure the impact of interventions on outcomes for CYP with SEND (0-25)
- Implement a collaborative Quality Assurance process of EHC plans including quality of social care and health reports

QUARTER 4 (2021/2022) SFG FOCUS

FEBQP16j (SFG)	To work collaboratively with partners, respond to the outputs of the SEND review
FEBQP16k (SFG)	To work with the ICS SAIU and NHSE to develop options to ensure SEND activity and outcomes are monitored and reported on

PART FOUR: QUALITY AND TRANSFORMATION

19. LOCAL MATERNITY AND NEONATAL SYSTEM (LMNS) – KEY HIGHLIGHTS

To support level 4 response, key transformation work has been reprioritised to support partner capacity, including the pausing of some areas of work. System workforce capacity is significantly impacted by vacancy, sickness and isolation, and the numbers of pregnant women on the covid virtual wards. This is impacting staffing attendance/input at key meetings, particularly Serious Incident (SI) shared governance group. All non-priority meetings have been stood down to support system capacity.

Key priorities that have continued throughout level 4 include:

- Safety work including Serious Incidents, Perinatal Quality Surveillance Group
- Covid vaccines in pregnant women
- Embedding of Ockenden recommendations

The national team are supportive of this pause of work and are aware that Q4 deadlines in relation to Continuity of Carer plans and the Equity Strategy will be missed.

Alongside priority areas, work has continued digital developments (in line with the recent successful bid) and dashboard reporting.

Covid Vaccination: As of 01.02.22 take up in pregnant women is at 68% first dose, 61% 2nd dose and 32% booster.

It was agreed by the Local Maternity and Neonatal Executive Partnership Board in September 2021 that vaccinators would be available in antenatal clinics at both Trusts as part of the approach to increasing Covid vaccination uptake. Whilst this offer was established, it has not been maintained due to staff shortages and maternity leave of the site vaccinator.

Key issues in relation to a lack of antenatal clinic vaccinators (which has previously been agreed as local model) are being discussed with the vaccination programme with a view to resolution, and an evidence base to support prioritisation has been developed.

A further public Q&A session about vaccinations in pregnancy was held over Zoom on 20th Jan 22 to support uptake during the level 4 incident.

Ockenden Oversight: Trusts have been requested to complete a return by the 15th April 2022 to show their current position for Ockenden and Kirkup. Ockenden performance reporting will now be led locally, rather than regionally. The PMO have been developing a new System Operating Procedure with providers that contains an agreed system level approach to assessment of Ockenden evidence and an agreed process for developing, sharing, and supporting action planning.

During Quarter 2 2021/2022, a deep dive of 40 cases of 'delay in management of care' identified that Induction of Labour (IOL) was a recurrent theme. In response IOL was identified as a regional quality improvement (QI) project with a focus on 'Prioritisation, Patient Flow, and Patient Experience'. To begin this QI project, a survey has been developed to scope a baseline of the processes, challenges

and QI work planned, in development or progressing across each Trust. Both Trusts have been asked to submit responses to the survey by 21st February 2022.

Digital: The LMNS were successful in securing circa £1.7M in funding (split between capital and revenue) from the NHSX Universal Tech Fund (UTF) to develop a single digital maternity system for the ICS including SFH and NUH. The funding allocation was confirmed on 24 December 2021. The funding must be spent by the end of this financial year which places substantial pressure to the procurement processes.

Planning work across both partner trusts was undertaken whilst we waited for the bid outcome confirmation. This was both to ensure that the programme structure was mobilised and in place to move swiftly into delivery and to ensure that procurement processes could be initiated whilst funding was being confirmed.

The procurement reviews of the replacement maternity information systems tenders are underway with an expectation that a preferred supplier will be announced. The Maternity Information System – Replacement (MIS-R) programme has been initiated as a multi partner system programme. Governance alignment has been reviewed to ensure that there is internal provider trust visibility and governance (Up to provider Trust Board) and LMNS oversight to the LMNS Executive Partnership.




The request for funding to commission a single LMNS Maternity webpage was rejected by NHSX from the UTF bid. The value to our women and families of having a single source of information, providing signposting to service offers as well as providing consistent aligned information by provider Trusts means that we will look to use Transformational funding to procure this.

The webpage will be co-produced with service users to ensure that it becomes a valuable, interactive, and informative page to women and families. We will also look to see where we might be able to support the work of our Maternity Voices Partnership through engagement/consultation. Focus will be given to languages other than English, cultural engagement and understanding how we more effectively engage our ‘seldom heard from’ groups.

Nottingham and Nottinghamshire LMNS Perinatal Surveillance Dashboard: Development commenced during March 2021. To date, 25 indicators have been built bringing together both local and national level data, these will continue to be developed and updated and further 15 indicators are currently under development. Key Performance Indicators within the dashboard allow for system oversight and scrutiny and support with planning and responding to issues as they emerge. The below information is being used to review progress and respond to key issues.

Current KPI information includes:

Smoking at The Time of Delivery (SaToD)

12.7%	of N&N women reported being smokers at the time of their deliveries in the 12 months to the end of Nov 2021
<i>That is a significantly higher proportion than the national average over the same period and the national target (by end 2022)</i>	
Status	N&N:  NUH:  SFH: 

Continuity of Carer (CoC)

14.0%	of (in-area) women were reported to have been booked onto Continuity of Carer pathways in the 3 months to the end of Aug 2021
--------------	---

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total - Adult	Current Inpatients	53	52	50	50	52	52	52	53	53	55	51	50
	Target	48	48	48	44	44	44	40	50	50	47	46	43
	Difference against Target	+5	+4	+2	+6	+8	+8	+12	+3	+3	+8	+5	+7
CCG - Adult	Current Inpatients	21	21	19	18	20	19	18	18	18	19	16	16
	Target	17	17	17	16	16	16	16	16	16	14	14	12
	Difference against Target	+4	+4	+2	+2	+4	+3	+2	+2	+2	+5	+2	+4
NHSE - Adult	Current Inpatients	32	31	31	32	32	34	34	35	35	36	35	34
	Target	31	31	31	28	28	28	34	34	34	33	32	31
	Difference against Target	+1	0	0	+4	+4	+6	0	+1	+1	+3	+3	+3
NHSE - CYP	Current Inpatients	5	5	5	4	4	3	3	3	3	2	2	3
	Target	4	4	4	4	4	4	3	3	3	3	3	3
	Difference against Target	+1	+1	+1	0	0	1	0	0	0	-1	-1	0

Forecasts indicate there will be a further 5 inpatient discharges by end of March (which takes the figure down to 50) but this means the trajectory will be missed by 7. This is due to 4 admissions between Nov – Jan 2022.

1 of the CCG admissions had been in discussion for 3 months and had admission prevention strategies in place but eventually required an admission. The 2nd admission was recalled into hospital by the Ministry of Justice. Of the 2 adult secure admissions, 1 had been planned since October 2021 and had been awaiting availability of a bed, and the 2nd was a transfer from an acute to a secure bed with a clarification re diagnosis. Our total admissions in year to 30th of November is 19.

Good News: 12 inpatients have been discharged between April 21 – December 2021, on average 1 discharge per month. 10 of the discharges were from a CCG bed and 2 from NHSE secure bed. To facilitate discharges the system secured funding from NHSE to undertake 22 life plans, this work will inform the system about what needs to be commissioned in the community to provide sufficient support. An Extraordinary LDA Executive has been established to provide robust oversight and scrutiny in relation to our inpatient numbers and unblock discharge challenges and continues to meet monthly.

In addition to this work the system has also secured funding to support with the development of 21 Life Planning Plans. The aim will be to provide an independent view on those patients where there is a lack of agreement between health and social care over discharge pathway and discharge dates. This work is due to commence beginning of March 2022.

NHSEI have been kept informed on our trajectory figures through the following mechanisms:

- Weekly updates via email on any admissions and discharges

- A monthly update on the tracker
- A summary of the Sitrep report on a monthly basis
- At monthly inpatient/discharge meetings
- Quarterly reporting to the regional oversight meeting

NHSE are supportive of the actions we are taking to address the issue of discharges especially within our NHSE secure & IMPACT settings.

Children and Young People Inpatient: The system is on track to achieve the end of year target (3) for the number of children and young people in an inpatient setting. Currently we are ahead of our target by +1. The forecast is that we will achieve the target of 3 by 31st of March 2022.

QUARTER 4 (2021/2022) LDA FOCUS

FEBQP18a (LDA)	Commencement of the Life Planning work overseen by the Transformation Team. Review the learning from the Safe and Well Checks, Life Plans and Senior Intervenor recommendations. LeDeR review findings to be analysed and be embedded into case management and transformational work over the next 6 months.
----------------	--

Annual Health Checks (AHC): As of 31st of January 2022 we have completed 2582 AHC's, our percentage performance has fallen by 3% (43% vs 46%). NHSEI Midlands have acknowledged the current challenges faced by Primary Care and the impact to achieving the 75% target by the end of March 2022. Subsequently the expectation from NHSEI is that systems will, at a minimum, achieve the same position in March as last year. For Nottingham and Nottinghamshire that equates to a minimum target of 67% by the end of March 2022. The forecast based on current performance indicates that we will not achieve this target by quarter 4. The ICS LDA Oversight Board are providing enhanced scrutiny of AHC performance and progress as a matter of priority.

ICP	Performance	LD Register	LD AHCs Completed
Mid Notts	45%	2318	1040
Nottingham City	42%	1906	800
South Notts	42%	1751	742
CCG	43%	5975	2582
2021/2022 Target	67%		

Currently there is no Autism register, but GPs continue to record an autism diagnosis when informed which pulls through to E-Healthscope; there are approx. 15,295 people with a confirmed diagnosis of autism, of which 1,880 have a dual diagnosis of LD and Autism and are therefore eligible for the LD AHCs. There are conversations at a national level around AHC's that include adults and CYP with autism only. There are no confirmed timescales as to when this will happen beyond a commitment within the NHS Long Term Plan for 2023/24

QUARTER 4 (2021/2022) LDA FOCUS

FEBQP18b (LDA)	In response, work is currently taking place with GP leads and PCN managers to quickly understand if additional funding will help primary care to increase capacity and the uptake of health checks during February and March 2022. If additional funding will help to get us back on track then we will work with NHSE Midlands regional leads to draw down central additional funding to increase existing capacity.
FEBQP18c (LDA)	Communications to primary care continue to reinforce the Prioritisation of the AHCs and support the system to work towards meeting our performance target.
FEBQP18d (LDA)	In line with NHSE's focus on improving the quality of health checks this year, a quality AHC audit will be performed by the PCLNs with a sample of practices across the ICS. The audit will be based on the traffic light tool developed by Public Health England. We are closely monitoring the numbers of AHC's completed.

Learning Disability Mortality Reviews (LeDeR): 33 reviews were completed during Q3. 17 reviews missed the 6 months deadline. Some of the delays were due to other statutory reviews or processes such as coroners' inquests needing to be taken place before the LeDeR review could be concluded.

	Nov 21	Dec 21	Jan 22
Completed Reviews -No	8	13	6
Notifications Allocated within 3 months - % - PLAN	10(100%)	7(100%)	2 (100)
Notifications Allocated within 3 months - % - ACTUALS	10 (100%)	7 (100%)	2 (100)
Reviews Completed within 6 months - % - PLAN	6 (100%)	3 (100%)	7 (100%)
Reviews Completed within 6 months - % - ACTUALS	8 (133%)	13 (433%)	6 (86%)

Due to the pressures with primary & secondary care there were also delays in obtaining access to GP records and structure judgement reviews along with technical difficulties outside of our control with the new NHSE platform 7 of our cases had to be submitted late.

No learning has been extracted yet from the reviews submitted in Q3 as they have yet to be concluded

QUARTER 4 (2021/2022) FOCUS

FEBQP18e (LDA)	System work is underway to develop a LeDeR review team in line with LeDeR strategy. The LeDeR admin will be in post by 21 st of February 2022. LeDeR review team to be in place June 2022
FEBQP18f (LDA)	Identify the Actions & Learning from Q3 reports and feed this into the wider LeDeR Steering Group & wider LDA transformation programme.
FEBQP18g (LDA)	The new LeDeR strategy will be reviewed to ensure alignment between Nottingham & Nottinghamshire and Bassetlaw CCG following the planned

	ICS governance changes. Work-stream meetings are ensuring alignment with GP annual health checks and meds management to ensure that primary care systems are targeting prevalent morbidities.
--	---

Learning Disability and Autism (Safe & Wellbeing Reviews): As part of the NHS response to the Norfolk Safeguarding Adults Review (SAR) concerning the deaths of three patients at Cawston Park Hospital, NHSE have set a national priority that all children and young people and adults with a learning disability and/or who are autistic, who are currently in an NHS or independent mental health, learning disability or autism inpatient setting (including those on section 17 leave) must undergo a thorough review of their care & support needs by the end of March 2022. Due to the impact of Covid limiting the ability of case managers to conduct face to face meetings which must be done as part of the safe and well check reviews the system will not be able to meet the deadline of March 2022. Our scheduling of the ICS Scrutiny and Review Panels have highlighted that the system will not complete the reviews until the end of April 2022.

The system has completed 39 reviews between November to 7th of February 2022. Key themes coming out of the reviews are:

- Supporting providers with the usage of agency staff
- Timely access to dentistry
- Occupational Therapist (OT) shortage and OTs trained to undertake sensory assessments
- Physical Health access to AHC
- Physical Health oversight inpatient MDT (BMI, Weight, Healthy eating, Blood tests etc)
- Access to advocacy and how this is framed/introduced
- Lack of community provision delays discharge planning etc.
- Supporting contact and clear principles to support contact with families. Explore where this can be financially supported, and a consistent approach is taken
- Appropriateness of MH settings and reasonable adaptation

The transformational funding and work are supporting the development of key projects that will help the system tackle some of these themes that are being highlighted. For example:

- Workforce is a key enabler throughout the programme. New lead within Quality department will work closely with the LDA transformational team to enable the system to tackle workforce issues within the system. Shortage of occupational therapy had been picked up by the system as well as speech and language therapists. Work will be undertaken with partners to understand the full scale of workforce issues within health, social care, and community provider market. Transformational funding has been allocated to support the delivery around workforce.
- Improving the quality of AHC's is a key priority of the system. A quality AHC audit will be performed by the Primary Care Liaison Nurses (PCLN) with a sample of practices across the ICS. Transformational funds have been attached to improve both accessibility and the quality of AHC's (The LD AHC BAME Nurse started in post on 4 January 22 and has begun to make contact with practices to identify the patient lists and challenges they face with engagement. Meetings with My Life Choices and local BAME community groups are also being set up to co-produce supporting easy read materials, understand barriers faced and inform the development of the service offer).
- Community Provision: the two LA specialist commissioners are in post and have started to develop a local accommodation strategy to facilitate the discharges. This will be supported by the development of the life plans which will set out the needs of individuals highlighting what the gaps

are within the community. There is a recognition that we need further investment in developing forensic community specialisms. A bid has been developed and submitted to NHSEI to open a service in the South of the County (a new forensic service is opening in Mansfield this year). As part of the life planning work, we will need to understand the inpatient work that needs to be done to support patients to become discharge ready.

- The other themes that have been identified will be picked up as part of the transformational work but also be part of informing our commissioning models.

QUARTER 4 (2021/2022) FOCUS

FEBQP18h (LDA)	Complete all reviews, analyse findings, and pull report together ensuring key actions are incorporated as part of case management, commissioning, and transformational work.
----------------	--

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022	
Paper Title:	Integrated Performance Report	Paper Reference:	GB 22 017	
Sponsor:	Stuart Poynor, Chief Finance Officer	Attachments/ Appendices:	-	
Presenter:	Stuart Poynor, Chief Finance Officer			
Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>	Receive/Note for: <input checked="" type="checkbox"/>
				<ul style="list-style-type: none"> Assurance Information

Executive Summary

This report sets out the performance against key standards and targets for the NHS Nottingham and Nottinghamshire CCG with supplementary information showing, where appropriate, the equivalent performance for individual provider organisations. The report is broken down into sections for Planned Care, Urgent Care, Mental Health and Quality 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?

There are 17 key measures which are areas of concern due to variation from the H2 Plan or due to ongoing non-achievement of performance requirements. These are outlined in the CCG Indicator summary table on page 4 of the report. This Executive Summary focuses on the areas of significant concern due to the scale and complexity of difficulties facing the sectors. Mitigating actions and assurances for all areas are provided in the relevant sections of the Integrated Performance Report.

This month’s highlights

In this month’s report, members’ attention is drawn to the following areas:

Planned Care – (Page 11 – 12) The Covid surge December 2021 through to January 2022, significantly increased demand into the acute sector and as such has had a significant impact on the volume of planned activity able to be undertaken during this time. During February and March activity, the pressure seen over December and early January reduced, which has enabled the Harvey 1 ward at City Hospital to be utilised as an elective ward, rather than as additional capacity for non-elective patients.

The forecast of patients waiting 104 weeks or more at Nottingham University Hospitals Trust (NUH) by the end of March was revised from 203 to 308 due to insourcing issues within Ear nose and Throat and other specialties. However, this remains a challenging forecast to achieve and relies upon services achieving their individual specialty level trajectories. In early March, the volume of patients waiting over 104 weeks began to reduce towards the system level forecast of 312 patients (308 at NUH, 4 at Sherwood Forest Hospitals Foundation Trust (SFH)). Each patient is routinely assessed and contacted, and none are considered to be

clinically urgent. Both providers remain committed to achieving the national ambition of zero patients waiting 104 weeks or more by the end of quarter 1 (except where patients choose to wait beyond this date). Progress against plans is tracked daily by providers and reviewed with NHS England/Improvement (NHSE/I) via weekly system level meetings.

Cancer – Patients waiting over 62 & 104 Days (Pages 18-20) – The volume of 2 week wait referrals has continued to remain high at over 120% of pre-covid levels during quarter 3 and 4. The high level of demand is causing pressure in some services, such as Breast, which is leading to patients being seen beyond the day 14 target. However, increased levels of diagnostic activity are being undertaken which means that some patients are unfortunately waiting longer than 14 days for their initial consultation but are receiving a timely diagnosis within 28 days.

At a system level, patients waiting over 62 days have continued to reduce through February and into March. The latest combined position at week ending 13th March is 385 patients waiting 62 days or more against an end of March trajectory of 391 patients. A plan has been submitted to NHSE/I that shows that this volume will reduce to pre-pandemic levels (268 patients) by March 2023.

System Capacity & Flow (pages 25-26)

A key driver in the deteriorating performance of electives, cancer and patients waiting over 12 hours in A&E, relates to acute capacity constraints arising from pressures across the wider system in the ability to discharge patients from the acute episode of care into alternative appropriate settings and the effects of increased Covid infections on capacity and demand. Health and Local Authorities have commissioned additional P1 interim beds for patients awaiting packages of care, however staffing and covid infections remain key factors in being able to fully benefit from the system mitigations introduced. Challenges in sourcing homecare packages and social worker pressures continue to impact upon the ability to move patients onwards to placements and out of hospital. A significant volume of patients are discharged direct to home (90% of discharges), therefore a focused review of internal discharge processes to enable any reductions in time to discharge within the trusts, would enable further support to flow within the system, in addition to the steps being taken to stabilise the home care sector.

A specific section outlining the current position and planned mitigations for Medically Safe for Transfer (MSFT) is include in pages 25-26. The key risk factor to the progress of the remaining system mitigations remains in relation to addressing staffing shortfalls, and difficulties to recruitment to posts, including Discharge to Assess posts, as well as the continued impact of Covid on bed status and staff availability. A system Bed Tracker, daily system calls and a system Programme Management Office overview of mitigating actions being undertaken are all in place.

It should be noted however, that it is extremely difficult to profile forward MSFT levels due to the breadth and scale of the full suite of mitigations being enacted, as included in the report. There is a strong likelihood that, despite all the measures being taken across all parts of the system, minimal material change will be in evidence for a number of months.

Mental Health (pages 27-42)

High levels of sickness across mental health teams continues, and therefore redeployment of staff between services continues. This continues to provide difficulties for services recovery, including Early Intervention in Psychosis (EIP), Children and Young People with an Eating Disorder (CYP ED) and Improving Access to Psychological Therapies (IAPT). Staff absences have started to increase again during March.

Across CYP ED increased levels of demand have been sustained therefore a revised staffing proposal has been submitted by the provider for CYP ED to the CCG for consideration. Out of Area placements have

started to improve during Quarter 3, with January 2022 having only 9 occupied bed days. There is some risk to delivery against the zero requirement for the March 2022 reported position with the continued impact from COVID infection, prevention and control requirements affecting bed availability.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	<input checked="" type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input type="checkbox"/>
Financial Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input type="checkbox"/>
Performance Management	<input checked="" type="checkbox"/>	Procurement and/or Contract Management	<input checked="" type="checkbox"/>
Strategic Planning	<input type="checkbox"/>		

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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not applicable to this item
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not applicable to this item

Risk(s):

Stated in the report

Confidentiality:

No

Yes (please indicate why it is confidential by ticking the relevant box below)

Recommendation(s):

- NOTE** the report and its content.
- NOTE** 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?

NHS Nottingham & Nottinghamshire CCG

Performance Report

April 2022

Table of Contents	
Page 1	Introduction
Page 3-4	Indicator Summary
Page 5-20	Planned Care
Page 21-26	Urgent Care
Page 27-42	Mental Health
Page 43-52	H2 Activity Plan Monitoring
Page 53-58	Quality
Page 59	Glossary

This report sets out the performance against key standards and targets for the NHS Nottingham and Nottinghamshire CCG with supplementary information showing, where appropriate, the equivalent performance for individual provider organisations.

The report is broken down into sections for Planned Care, Urgent Care, Mental Health and Quality 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 assurance?

In this months report, Members attention is drawn to the following areas:

Planned Care

The elective care RTT incomplete performance in January deteriorated for the CCG, NUH and SFH from the December position, which was included in the previous performance report.

Overall, the number of CCG-registered patients on the waiting list is 96,437, which is an increase of 1,147 patients since the December position was reported. Members are asked to note the figures relate to all pathways (admitted and non-admitted) whereas those data quoted in respect to the Elective Recovery Fund relate only to patients on the admitted PTL.

A focus on patients waiting 104 weeks or more can be seen on page 11-12. The ongoing challenges around staff shortages, elective orthopaedic ward capacity and critical care capacity impact upon the level of activity that can be undertaken, particularly in complex patients that have lower clinical priority. ENT remains the speciality with the most 104+ waiters at NUH.

Daily tracking and review is in place to ensure 104+ waiting patients are dated as soon as possible. NUH have forecast that there will be 308 patients waiting 104 days or more by the end of March. SFH have forecast 4 patients waiting 104 weeks by end of March of which 1 is patient choice. All other patients will be dated at SFH and NUH to achieve the zero national ambition by end of June, noting that some patients may still choose to wait beyond this date.

Diagnostic services show a deterioration in performance against the December position with respect to the number of patients waiting against the 6-week national standard.

Cancer services overall continue to show relatively good levels of performance compared to similar populations across the country. The continued high volume of 2ww referrals is a significant challenge for the services to manage. Referral volumes continue to at 20-30% higher than the equivalent pre-COVID period. The performance level for 2ww services reported is significantly below the national standard (79.57% against the 93% standard), this is primarily linked 2ww Breast performance at NUH where performance is 0%. The service was unable to date patients within the 14 day period due to a combination of referral increases and capacity pressures. Performance against 28 day FDS standard at NUH was achieved, which means that despite waiting beyond 14 days for an initial consultation, patients continue to receive a cancer diagnosis within 28 days.

Urgent Care

Sourcing homecare packages remains a challenge particularly for pathway 1 patients. MSFT lists at both acute providers, community bedded and non-bedded services as well as local authority internal reablement services continue to be high and far above required levels to support system flow.

Daily ED average attendance rates at both acute hospitals remained relatively static in the month of January whilst ED presentations to admission rates also remained relatively steady across both NUH and SFH sites. Same day emergency care (SDEC) slightly increased by 1.3% at SFH with NUH decreasing by 0.6%. In January, NUH recorded a significant increase (42%) in 12-hour breaches with SFH recording a decrease (28.6%) from the month of December. NUH Emergency LOS remained relatively static for a second month whilst SFH recorded a sharp increase (40.2% - related to increased MSFT at the trust) with both Trusts not achieving set targets.

Both pre and post Ambulance handover performances continue to be below target at both Trusts. Average daily ambulance activity increased (4.7%) at NUH whilst it remained static at SFH.

Mental Health

The number of people entering treatment for IAPT has decreased since the last report, this decrease was anticipated in line with usual season trends, however remains lower than the required standard for individual months. The service continues to achieve and exceed waiting time standards. The Recovery Rate standard of 50% was not achieved for December 2021, this is the second consecutive month it has not been achieved and reflects trends seen in other areas.

Despite some small improvements in performance, perinatal mental health services continue to be below the standard for 2021/22. Performance in December 2021 has increased to 6.7%, reflecting improvements for a fourth consecutive month, but remains below the standard of 8.6%. Local data for January shows further improvement at 6.75%. National reporting guidance specifies that only face-to-face and video conferencing contacts contribute to access performance. This resulted in a decline in reportable performance from July 2020, in line with other areas regionally and nationally, though performance has stabilised and showing signs of improvement. However, analysis of local data including telephone support demonstrates that more women are accessing support than is reportable nationally. With the inclusion of telephone calls, the service would be achieving a 7.32% access rate.

The proportion of patients with severe mental illness who received primary care health check continues to improve although remains below the national standard at 39.9% in February 2022. Some variation is seen between the ICP-defined areas.

The number of occupied bed days for acute mental health patients placed Out of Area shows a further reduction in Q3 with 218 reported compared to a revised trajectory of 460. The revised trajectory is challenging and aims to reduce the number of bed days to zero by the end of Q4. Monthly data highlights that the number of OBDs reported in January 2022 has decreased to 9, from 56 in December 2021.

Access to eating disorder services for children and younger people improved for urgent and routine patients with 66.67% of patients being seen within 1 week (Q3) and 81.82% within 4-weeks (Q3). Both indicators are performing below the standard. The East Midlands Clinical Network have advised areas to plan for sustained referral rates. Investment plans for 2022/23 have been developed in response to this increasing demand; this proposal is approved in principle and awaiting final sign off, following which a recruitment plan will be developed.

Activity

Progress against H1 plans is shown on pages 43 – 52. Activity within secondary care continues to increase, with elective care services, in most cases, above those levels planned for January.

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	Jan-22	=> 92%	66.87%	5-6
		Incomplete Waiting List Size		N/A	96,437	7-9
		Incomplete number of 52 week waiters		= 0	4,632	10-12
	Diagnostics	Percentage of Patients Waiting Longer Than 6 Weeks	Jan-22	<= 1%	40.23%	13-14
	Cancer	2 Week Wait	Jan-22	=> 93%	76.57%	15
		2 Week Wait - Breast Symptoms		=> 93%	37.04%	15
		28 Day Faster Diagnosis Standard		=> 70%	70.54%	16
31 Day Decision to Treat to First Treatment		=> 96%		83.05%	17	
	62 Day GP Urgent Referral to Treatment		=> 85%	57.89%	17-20	
Urgent Care	A&E	4 Hour Standard	Jan-22	=> 95%	67.86%	21-26
	Ambulance - Nottinghamshire Division (including Bassetlaw)	Category 1 – Life-threatening illnesses or injuries - Average	Jan-22	<= 00:07:00	00:07:34	
		Category 2 – Emergency calls - Average		<= 00:18:00	00:29:56	
		Category 1 – Life-threatening illnesses or injuries - 90th centile		<= 00:15:00	00:13:12	
		Category 2 – Emergency calls - 90th centile		<= 00:40:00	01:01:22	
		Category 3 – Urgent calls - 90th centile		<= 02:00:00	04:48:05	
Category 4 – Less urgent calls - 90th centile	<= 03:00:00	04:04:39				
Mental Health	Improving Access to Psychological Therapies	Entering Treatment - Rolling Three Months	Dec-21	=> 7675	6880	27-28
		Recovery Rate - Rolling Three Months		=> 50%	48.95%	27-28
		Waiting Times - First Treatment within 6 Weeks		=> 75%	91.19%	27-28
		Waiting Times - First Treatment within 18 Weeks		=> 95%	100.00%	27-28
	Dementia	Diagnosis Rate	Jan-21	=> 66.7%	68.61%	29-30
	Perinatal MH	% of Population Birthrate	Dec-21	=> 8.6%	6.7%	31
	SMI	Physical Health Checks for People With an SMI	Feb-22	=> 67%	39.9%	32-33
	OAP	Inappropriate Out of Area Bed Days	Q3 2021-22	< 364	274	34-35
	EIP	Started Treatment in Two Weeks - Rolling Three Months	Dec-21	=> 60%	85.0%	36-37
CYP Eating Disorders	Routine Cases <4 Weeks - Rolling Twelve Months	Q3 2021-22	=> 95%	81.80%	40	
	Urgent Case <1 Week - Rolling Twelve Months		=> 95%	66.70%	40	

Provider Indicator Summary

Theme	Indicator 1	Indicator 2	Period	Standard	Performance		Page Number
					NUH	SFH	
Planned Care	RTT	Percentage of Incomplete Patients Waiting Less Than 18 Weeks	Jan-22	=> 92%	62.96%	71.92%	5-6
		Incomplete Waiting List Size		N/A	61,357	38,991	7-9
		Incomplete number of 52 week waiters		= 0	3,683	678	10-12
	Diagnostics	Percentage of Patients Waiting Longer Than 6 Weeks	Jan-22	<= 1%	49.46%	33.10%	13-14
	Cancer	2 Week Wait	Jan-22	=> 93%	71.15%	87.05%	15
		2 Week Wait - Breast Symptoms		=> 93%	0.00%	85.19%	15
		28 Day FD		=> 70%	72.02%	69.73%	16
31 Day Decision to Treat to First Treatment		=> 96%		81.72%	84.21%	17	
	62 Day GP Urgent Referral to Treatment		=> 85%	58.40%	52.69%	17-20	
Urgent Care	A&E	4 Hour Standard	Jan-22	=> 95%		86.19%	21-26
		12hr trolley waits		= 0	514	41	

H2 Plans Monitoring

The following charts show the progress against the H2 21/22 Activity plans

NHS Nottingham & Nottinghamshire CCG H2 Plan Summary	Jan-22 Actual	Jan-22 Plan	% Difference to Plan	Comparison against 2019/20	Direction of Travel
Total outpatient attendances - Face to face (All TFC)	73,629	73,066	0.8%	-35.4%	
Total outpatient attendances - Telephone/virtual (All TFC)	23,951	25,844	-7.3%	414.7%	
Total outpatient attendances (All TFC)	97,580	98,910	-1.3%	-17.7%	
Consultant-led first outpatient attendances (Spec acute)	17,106	21,722	-21.3%	-25.5%	
Consultant-led follow-up outpatient attendances (Spec acute)	43,062	43,903	-1.9%	-12.3%	
Specific Acute elective day case spells in the period	9,424	11,002	-14.3%	-15.9%	
Specific Acute elective ordinary spells in the period	1,077	898	19.9%	-25.3%	
Specific Acute elective spells in the period	10,501	11,900	-13.3%	-17.0%	
Specific Acute elective day case spells in the period under 18 years of age	238	274	-13.1%	-23.0%	
Specific Acute elective ordinary spells in the period under 18 years of age	79	48	64.6%	-21.8%	
Specific Acute non-elective spells in the period with a LOS of zero days	3,247	3,877	-16.2%	5.0%	
Specific Acute non-elective spells in the period with a LOS of 1 or more days (COVID)	470	266	76.7%	23400.0%	
Specific Acute non-elective spells in the period with a LOS of 1 or more days (Non-COVID)	5,531	6,500	-14.9%	-18.3%	
Specific Acute non-elective spells in the period with a LOS of 1 or more days	6,001	6,766	-11.3%	-11.3%	
Specific Acute non-elective spells in the period	9,248	10,643	-13.1%	-6.2%	
Attendances at Type 1 and Type 2 A&E departments, exc planned follow-up attendances	21,900	23,401	-6.4%	-9.2%	
Attendances at Type 3 and Type 4 A&E departments, exc planned follow-up attendances	6,391	7,664	-16.6%	-18.3%	
Attendances at all A&E departments, excluding planned follow-up attendances	28,291	31,065	-8.9%	-11.4%	
Diagnostic Tests - Magnetic Resonance Imaging	5,435	5,385	0.9%	-7.1%	
Diagnostic Tests - Computed Tomography	10,047	10,229	-1.8%	10.2%	
Diagnostic Tests - Non-Obstetric Ultrasound	9,101	10,115	-10.0%	-13.3%	
Diagnostic Tests - Colonoscopy	922	1,251	-26.3%	-24.3%	
Diagnostic Tests - Flexi Sigmoidoscopy	295	532	-44.5%	-49.0%	
Diagnostic Tests - Gastroscopy	1,114	2,900	-61.6%	-24.2%	
Diagnostic Tests - Cardiology - Echocardiography	1,914	2,900	-34.0%	-42.6%	

Mental Health Indicator Summary - March 2022 Update

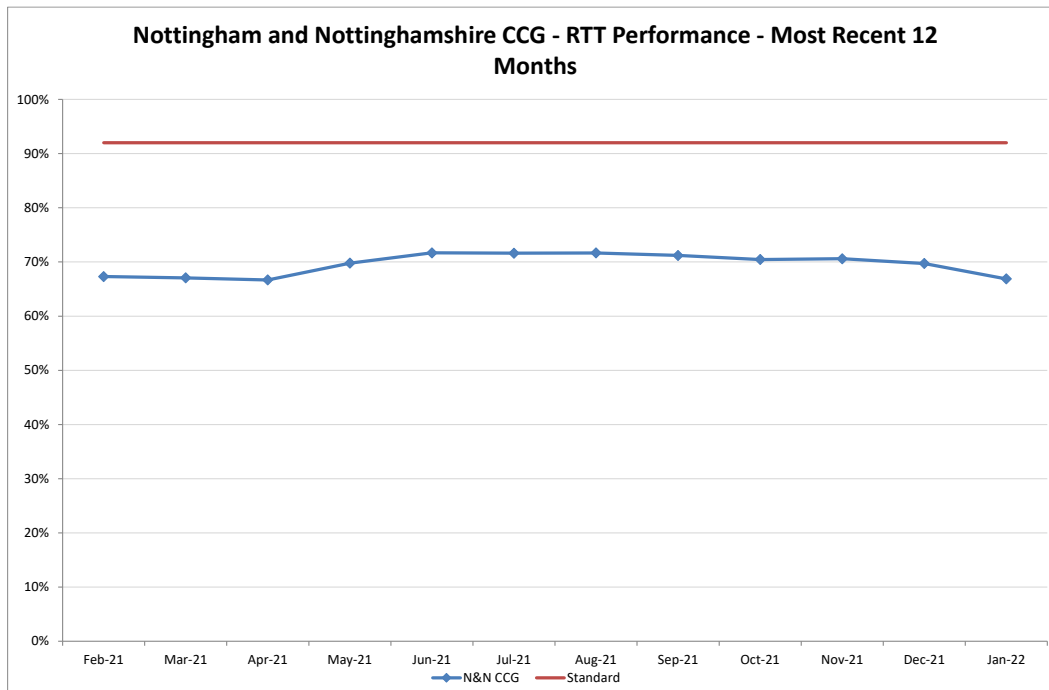
NHS Nottingham & Nottinghamshire CCG

	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
IAPT Access (Rolling 3 Month)	7675 Q3	5.48%	6405	7070	7225	6990	6550	6470	6525	7090	6880		
IAPT Recovery Rate	50.0%	53.3%	53.4%	52.9%	52.8%	52.4%	51.6%	51.1%	50.1%	49.5%	49.0%		
IAPT Waiting times 6 weeks	75.0%	96.7%	96.8%	96.9%	95.1%	95.1%	94.1%	93.1%	94.0%	93.0%	91.2%		
IAPT waiting times 18 weeks	95.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	99.7%	100.0%		
IAPT waits >90 days between 1st & 2nd Treatment	<10%	9.9%	8.8%	7.7%	13.1%	9.6%	9.1%	7.9%	7.4%	4.3%	1.7%		
Dementia diagnosis rate - 12mth Rolling	66.7%	68.7%	68.5%	68.4%	68.7%	69.1%	69.1%	69.1%	69.0%	69.1%	69.0%	68.6%	
Perinatal Access (Local data) - 12mth Rolling	1008	680	700	725	720	725	730	725	735	760	785		
Perinatal Access Rate - 12mth Rolling	8.60%	5.81%	5.98%	6.19%	6.15%	6.19%	6.23%	6.19%	6.28%	6.49%	6.70%		
SMI % achievement - 12mth Rolling	67.0%	20.5%	22.5%	24.4%	25.7%	26.1%	28.3%	28.7%	31.0%	35.2%	36.1%	38.1%	39.9%
SMI achievement - 12mth Rolling	4881	1479	1624	1766	1868	1903	2054	2091	2280	2605	2666	2813	2958
Out of Area Placement bed days (Local) - 3mth	0	505	516	554	466	399	389	441	453	403	274	158	
Out of Area Placement bed days (MHSDS) - 3mth	0	510	535	545	455	440	430	475	450	440	360		
EIP Waiting times - MHSDS - 3mth Rolling	60.0%	85.0%	84.0%	83.0%	84.0%	83.0%	82.0%	80.0%	79.0%	82.0%	85.0%		
CYP Access Rate - 12mth Rolling (2 Contacts) 20/21	35.0%	40.9%	44.3%	48.7%	52.3%	54.9%	56.4%	57.8%	57.5%	56.0%	54.9%		
CYP Access Rate - 12mth Rolling (1+ Contact) 21/22	11709	12955	13010	13470	13690	13890	13925	13985	13690	13440	14040		
CYP Eating Disorder WT - Urgent (4 QTR)	95.0%	72.2%			62.5%			59.1%		66.7%			
CYP Eating Disorder WR - Routine (4 QTR)	95.0%	86.6%			85.4%			83.9%		81.8%			
Individual Placement Support (IPS)	608		159	191	222	264	287	336	396	439	473	523	

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)	Lisa Durant	CCG Acute Providers

Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	
N&N CCG	Greater than or equal to 92%	88.80%	86.97%	80.76%	73.66%	64.35%	57.75%	62.44%	68.04%	70.42%	71.49%	69.58%	68.08%	↓
NUH		89.56%	86.52%	78.85%	69.85%	58.64%	50.61%	56.75%	64.26%	67.92%	70.83%	70.21%	69.47%	
SFH		86.18%	85.39%	82.15%	77.35%	70.83%	66.03%	67.74%	70.56%	71.01%	69.78%	66.17%	62.96%	

Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 92%	67.31%	67.07%	66.68%	69.78%	71.68%	71.63%	71.66%	71.20%	70.46%	70.59%	69.73%	66.87%	↓
NUH		68.19%	66.75%	65.39%	68.47%	70.31%	70.03%	68.51%	66.60%	65.57%	66.29%	63.75%	62.96%	↓
SFH		62.12%	63.58%	63.92%	66.20%	68.91%	69.63%	70.34%	72.06%	71.55%	72.65%	72.44%	71.92%	↓



RTT Specialty - January 2022	N&N CCG			NUH			SFH		
	Patients	Breaches	>18Wks	Patients	Breaches	>18Wks	Patients	Breaches	>18Wks
General Surgery	4603	1813	60.61%	850	449	47.18%	3780	1292	65.82%
Urology	4834	1627	66.34%	2931	1120	61.79%	1855	398	78.54%
Trauma & Orthopaedics	10520	4848	53.92%	6542	3366	48.55%	3671	1135	69.08%
Ear, Nose & Throat (ENT)	7684	2627	65.81%	5239	2091	60.09%	3755	931	75.21%
Ophthalmology	11297	4049	64.16%	7278	3093	57.50%	4049	906	77.62%
Oral Surgery	2	0	100.00%	2958	1653	44.12%	705	308	56.31%
Neurosurgery	266	96	63.91%	598	194	67.56%	0	0	
Plastic Surgery	858	340	60.37%	1077	460	57.29%	169	57	66.27%
Cardiothoracic Surgery	221	101	54.30%	383	155	59.53%	0	0	
General Medicine	24	7	70.83%	2	1	50.00%	0	0	
Gastroenterology	8083	3242	59.89%	4704	2253	52.10%	3991	1124	71.84%
Cardiology	3195	1134	64.51%	1421	318	77.62%	2192	968	55.84%
Dermatology	4942	1017	79.42%	3758	641	82.94%	2040	519	74.56%
Thoracic Medicine	2609	808	69.03%	1141	314	72.48%	2015	627	68.88%
Neurology	907	78	91.40%	950	57	94.00%	0	0	
Rheumatology	2901	943	67.49%	1061	349	67.11%	2206	732	66.82%
Geriatric Medicine	289	34	88.24%	130	2	98.46%	196	35	82.14%
Gynaecology	6944	2765	60.18%	2828	873	69.13%	1843	476	74.17%
Other – Medical Services	10772	2094	80.56%	6755	1705	74.76%	2698	783	70.98%
Other – Mental Health Services	10	2	80.00%	2	0	100.00%	0	0	
Other - Paediatric Services	6207	1114	82.05%	3433	700	79.61%	3698	655	82.29%
Other - Surgical Services	5625	2499	55.57%	6346	2913	54.10%	128	2	98.44%
Other – Other Services	3644	710	80.52%	970	21	97.84%	0	0	
Other (Total)	26258	6419	75.55%	17506	5339	69.50%	6524	1440	77.93%
Total	96437	31948	66.87%	61357	22728	62.96%	38991	10948	71.92%

Root Cause

The position for Nottingham and Nottinghamshire CCG is 66.87% for January 2022 against the national standard of 92%. This is a small deterioration of the December 2021 position of 69.73%. NUH and SFH failed to meet the national standard with performance of 62.96% and 71.92% respectively.

The specialties with the highest number of patients waiting beyond 18 weeks for the Nottingham and Nottinghamshire CCG were 'Other', Trauma and Orthopaedics, Gastroenterology, and Ophthalmology. 'Other' specialty is nationally defined and includes a wide range of specialties including colorectal surgery, Allergy and Upper GI.

Harvey 1 ward at NUH was converted back to Orthopaedics on 23rd February. Clinical teams across medicine and surgery are working together with an aim of returning the second orthopaedic ward back to elective during April, but this will be dependent on non-elective pressures.

Mitigating Actions

- Waiting list management is overseen at system level through the Elective Hub, which includes NHS and Independent Sector providers
- The ICS Diagnostic Programme has been successful in receiving national funding to increase diagnostic capacity at both NUH and SFH as part of system wide plans to implement Community Diagnostic Hubs
- System transformation projects are addressing short term tactical solutions as well as longer term transformation. Specifically:
 - Eye Health – supporting ophthalmology pathways and capacity
 - MSK – to address capacity in Elective orthopaedics, conservative treatment options and control of demand
 - System wide work to control demand utilising community-based options – non disease specific
 - ENT– work to consider community-based options to control demand in ENT. IS capacity at Ramsey Woodthorpe has been confirmed. Mutual aid via NUH and SFH is taking place at present
- Further work will be undertaken to implement the wider suite of pathways described in the ICS Community Clinical Services Strategy (CCSS)
- Pathway redesign is aligned with national best practice including GIRFT recommendations
- Work to embed the existing outpatient transformation with increased virtual appointments where appropriate, and Patient Initiated Follow up continues

Assurances

Performance is underpinned by whole system transformation with excellent system engagement from a managerial and clinical perspective. An ICS Planned Care Transformation Board is in place to oversee all Cancer, Diagnostics, Elective and Outpatient Transformation which responds to operational pressures in addition to wider transformational opportunities.

Gaps in Assurance

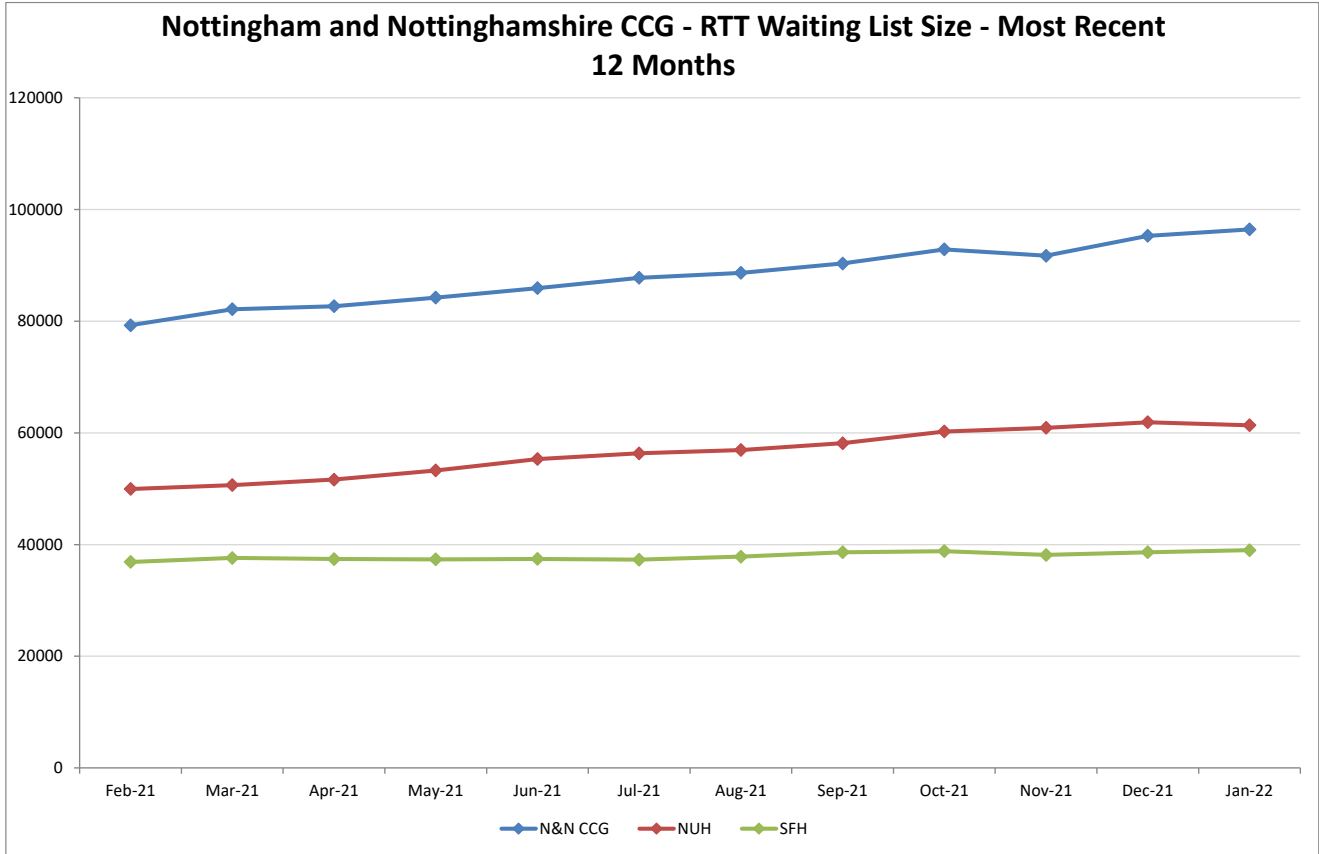
None identified

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	Lisa Durant	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
		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	
N&N CCG	Reduction in patients waiting	65033	62670	59969	59505	60240	63228	67690	70824	71656	74311	76232	77400	
NUH		44452	42326	39684	38773	39805	40491	42847	43327	43101	45964	47394	48153	
SFH		25812	25059	26690	27763	28535	30302	32612	34695	35531	35379	36329	36680	

Organsation	Standard	Most Recent 12 Months Waiting List												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Reduction in patients waiting	79271	82141	82687	84229	85921	87768	88651	90322	92863	91724	95290	96437	↓
NUH		49964	50645	51634	53279	55307	56334	56933	58153	60247	60906	61913	61357	↑
SFH		36895	37603	37408	37358	37433	37304	37834	38626	38825	38140	38617	38991	↓



N&N CCG Waiting List Trend	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
General Surgery	3850	4027	4246	4370	4291	4274	4326	4657	4681	4553	4497	4603
Urology	4142	4432	4490	4673	4678	4688	5122	5164	5117	4856	4956	4834
Trauma & Orthopaedics	9032	8844	8786	8908	9234	9306	9033	9186	9604	9618	9893	10520
Ear, Nose & Throat (ENT)	8344	8241	8286	8211	7818	8029	7895	7486	7446	7460	7519	7684
Ophthalmology	14742	14606	13673	13339	13591	13367	12593	12418	12288	11836	11860	11297
Oral Surgery	0	0	779	13	10	10	13	14	7	3	3	2
Neurosurgery	227	246	226	223	234	257	249	273	290	257	270	266
Plastic Surgery	555	625	649	642	628	686	680	722	777	769	794	858
Cardiothoracic Surgery	151	149	186	180	195	213	211	223	225	215	232	221
General Medicine	25	17	75	27	27	24	34	37	36	34	61	24
Gastroenterology	5458	5922	6515	6320	6294	6707	6824	7051	7380	7551	7833	8083
Cardiology	3120	2916	2915	3203	3410	3503	3493	3437	3451	3395	3406	3195
Dermatology	3094	3077	3193	3504	3953	4371	4689	4806	4913	5007	4934	4942
Thoracic Medicine	2206	2237	2390	2608	2714	2696	2762	2716	2685	2549	2607	2609
Neurology	555	420	523	568	759	908	1017	984	1065	969	977	907
Rheumatology	2056	2250	2223	2246	2272	2196	2229	2534	2716	2920	2935	2901
Geriatric Medicine	477	1804	509	629	712	801	554	359	359	442	395	289
Gynaecology	5235	5447	5658	5817	6000	6042	6152	6087	6237	6286	6755	6944
Other – Medical Services	0	0	5674	6367	6766	6718	7572	8063	8662	7918	9897	10772
Other – Mental Health Services	0	0	10	12	14	377	21	9	5	7	13	10
Other - Paediatric Services	0	0	3540	3856	4069	4167	4444	4957	5577	5842	6170	6207
Other - Surgical Services	0	0	4505	4649	4756	4828	4678	5126	5418	5367	5496	5625
Other – Other Services	0	0	3636	3864	3496	3600	4060	4013	3924	3870	3787	3644
Other (Total)	16002	16881	17365	18748	19101	19690	20775	22168	23586	23004	25363	26258
Total	79271	82141	82687	84229	85921	87768	88651	90322	92863	91724	95290	96437

Root Cause

The size of the waiting list (PTL) is driven by:

- Volume of clock starts (new referrals and overdue reviews)
- 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 January 2022 was 96,437, which is an increase of 1,147 patients from the December position.

'Other' has the largest waiting list at specialty level, although Trauma & Orthopaedics, Gastroenterology and Ophthalmology also have large waiting lists. Note: 'Other' specialty includes a wide range of specialties including colorectal surgery, Allergy and Upper GI.

At the end of January both Acute Trusts had a number of long waiting patients:

- Over 52 weeks: NUH had 3,683 and SFH had 678 patients waiting
- Over 78 weeks: NUH had 1,072 and SFH had 105 patients waiting
- Over 104 weeks: NUH had 351 and SFH had 9 patients waiting

Most of Nottinghamshire patients are waiting for treatment at NUH and SFH and their respective total trust level waiting lists are bulleted below:

- NUH – 61,357 patients (includes Nottingham Treatment Centre)
- SFH – 38, 991 patients

Elective capacity was constrained during late December and in January due to the impact of the Omicron on staffing, beds and theatre capacity.

Mitigating Actions

- CCG closely monitors patients waiting at all providers by time band, with focus on patients waiting 52, 78 and 104 weeks.
- Trust waiting lists are discussed in detail within each organisation, with appropriate clinical prioritisation in place in line with national guidance
- The weekly system Elective Hub, chaired by the ICS lead continues to have oversight of all waiting lists to ensure that capacity is used at a system level and that 104 week waits are dated appropriately
- All available IS capacity is utilised. IS providers are routinely monitored and managed against the activity plan that forms the basis of the IS contract.
- Mutual aid between organisations is considered where clinically appropriate. To date, 575 patients have been treated via mutual aid between NUH and SFH this financial year
- An Insourcing company has been employed at NUH providing weekend ENT lists from 22nd January 2022
- The overall elective position is reported weekly to the Health and Social Care Economy Tactical Coordinating Group (HSCETCG). This is triangulated with urgent care pressures and mitigating action by all health and social care partners. Decisions to reduce elective capacity for a short period of time are made as a system via the HSCETCG informed by an ICS decision making framework
- Additional IS activity has been sought under a national contract agreement as a direct response of the impact of the Omicron variant. To date an additional 278 patients have been treated in the IS

Assurances

Key points:

- Performance is underpinned by whole system transformation. An ICS Planned Care Transformation Board is in place to oversee all Cancer, Diagnostics, Elective and Outpatient Transformation which responds to operational pressures and wider transformational opportunities.
- Collaborative working with CCG, IS and NHS providers to maximise all available capacity in the system and to align capacity with predicted future demand is in place
- Royal College of Surgeons guidance in relation to clinical prioritisation of patients waiting for elective care has been implemented by NHS Providers. Weekly monitoring of patients at NUH and SFH is undertaken at specialty level.
- Clinical Executive Group has oversight of this process and considers the level of risk associated with long waits.
- Assurances have been sought from IS provides in regard to long waits and appropriate clinical prioritisation

Performance is underpinned by whole system transformation. An ICS Planned Care, Cancer and Diagnostics Board has been established to oversee all transformation and ensure operational delivery.

Gaps in Assurance

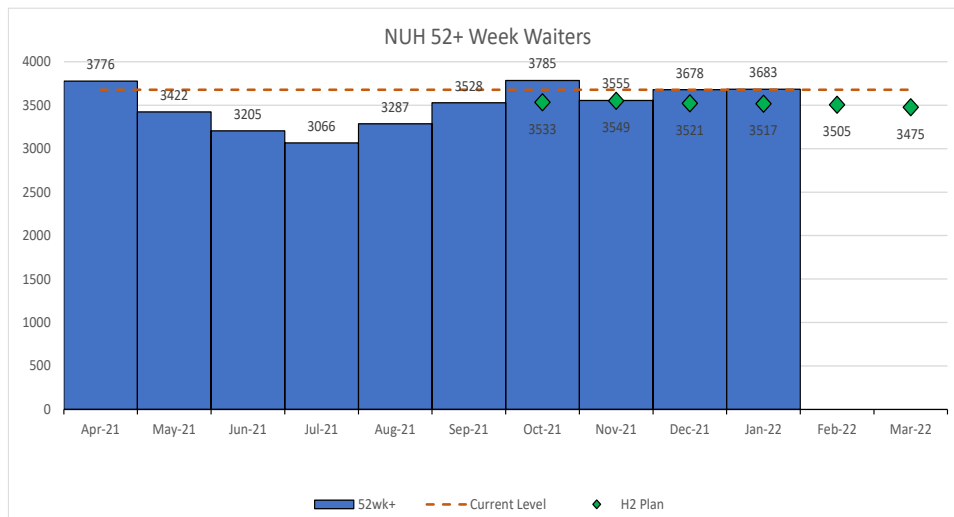
Waiting times will not significantly reduce in all specialties until trusts are able to fully utilise all elective wards which have been re-purposed to increase emergency capacity.

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

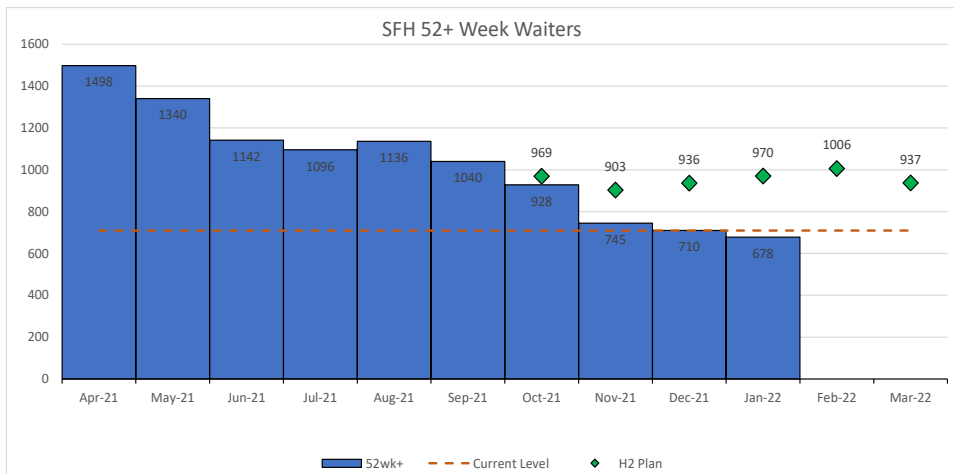
The number of incomplete pathways exceeding 52 weeks at the end of the month

Organisation	Standard	Most Recent 12 Months 52 Week Waiters											
		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
N&N CCG	No patients waiting over 52 Weeks	2	9	39	117	249	483	716	959	1175	1528	2065	3076
NUH		0	0	15	61	138	272	404	553	806	1222	1725	2516
SFH		0	0	15	47	125	217	316	417	418	465	598	990

Organisation	Standard	Most Recent 12 Months 52 Week Waiters												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	No patients waiting over 52 Weeks	4259	4960	4656	4153	3764	3864	3881	3931	4128	3823	3963	4632	↓
NUH		3484	3990	3776	3422	3205	3066	3287	3528	3785	3555	3678	3683	↓
SFH		1385	1618	1498	1340	1142	1096	1136	1040	928	745	710	678	↑



NUH 52+ Week Waiters	
Trauma & Orthopaedics	969
Other - Surgical Services	661
Ear, Nose & Throat (ENT)	650
Ophthalmology	269
Urology	262
Oral Surgery	203
Other - Paediatric Services	130
General Surgery	120
Gastroenterology	95
Plastic Surgery	90
Gynaecology	90
Neurosurgery	56
Cardiothoracic Surgery	51
Other – Medical Services	18
Thoracic Medicine	10
Cardiology	8
Rheumatology	1
Total	3683



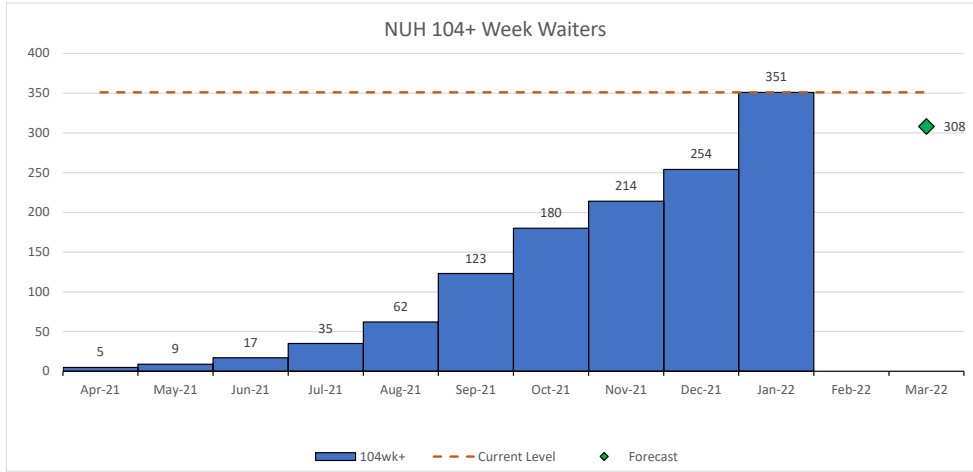
SFH 52+ Week Waiters	
Trauma & Orthopaedics	152
General Surgery	146
Ear, Nose & Throat (ENT)	110
Cardiology	67
Ophthalmology	60
Urology	38
Rheumatology	30
Gynaecology	30
Oral Surgery	19
Thoracic Medicine	9
Gastroenterology	8
Other - Paediatric Services	5
Other – Medical Services	4
Total	678

The charts above show the number of 52 week waiters against the H2 plan at NUH and SFH with a breakdown by specialty shown in the tables on the right hand side.

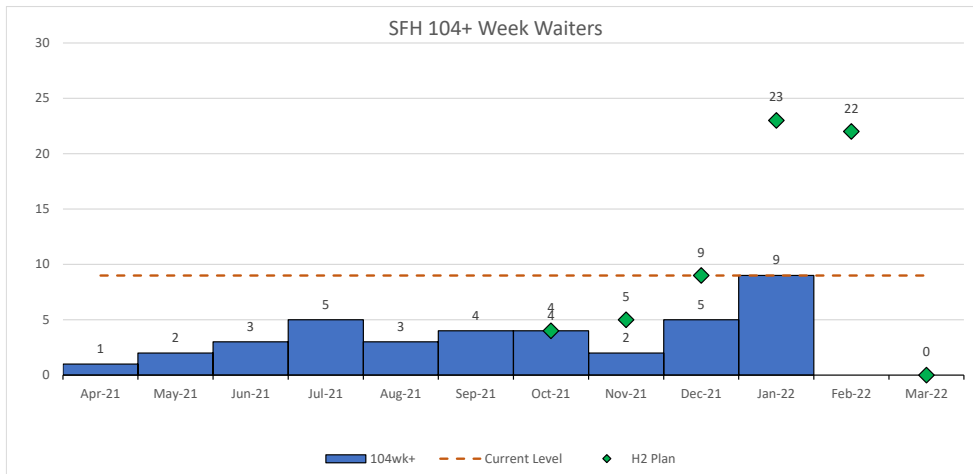
At the end of January 2022 NUH were above the H2 plan of 3,517 with 3,683 patients waiting longer than 52 weeks. SFH had 678 patients waiting over 52 weeks, which is below the H2 plan of 970.

104 Week Waiters

The charts below illustrate the volume of patients waiting 104 weeks or more at NUH or SFH at the end of January 2022. Note that this is shown alongside the H2 trajectory for SFH and the forecast for NUH. Key actions are described overleaf.



Ear Nose and Throat Service	134
Trauma and Orthopaedic Service	55
Other - Surgical Services	41
Oral Surgery Service	25
Other - Paediatric Services	23
General Surgery Service	22
Ophthalmology Service	18
Urology Service	12
Gynaecology Service	9
Cardiothoracic Surgery Service	7
Neurosurgical Service	3
Plastic Surgery Service	1
Other – Medical Services	1
Total	351



General Surgery Service	4
Trauma and Orthopaedic Service	4
Urology Service	1
Total	9

Root Cause

As a result of the COVID 19 pandemic there has been a substantial increase in the number of long wait patients awaiting routine surgery locally and nationally.

The volume of long waiting patients is due to:

- National instruction at the beginning of the Covid 19 pandemic
- The level of non-elective acute demand due to Covid 19 and most recently the Omicron variant which has impacted upon: beds, theatre capacity, staffing and discharge delays.
- Elective capacity was significantly constrained in particular at NUH for these reasons during late December and January.
- Reduced productivity due to IPC requirements and social distancing
- Prioritisation of cancer and urgent categories of patients waiting before patients waiting over 52 weeks

These factors mean that waiting times for patients with a lower clinical priority have increased and therefore, unfortunately some patients have waited 104 weeks or more.

Please note: local Independent Sector (IS) providers also have patients waiting in excess of 52 week waits. This is due to prioritisation of clinically urgent patients from NHS providers and the transfer of long waiting patients to the IS via inter provider transfers.

All patients, whether from NHS or IS providers are reviewed and prioritised through the system Elective Hub.

Mitigating Actions

The ongoing challenges around staff shortages, elective orthopaedic ward capacity and critical care capacity impact the level of activity that can be undertaken, particularly in complex patients that have lower clinical priority. NUH will continue to prioritise urgent and cancer cases above priority 4 patients which make up a significant proportion of the existing volume of patients waiting 104 weeks or more.

The volume of patients waiting 104 weeks or more for treatment position has deteriorated from a previous forecast of 203 to 308 patients waiting for treatment by the end of March 2022.

The forecast of 308 has been redeveloped by each service to acknowledge the individual challenges that exist at specialty level.

Key recovery actions being taken are bulleted below:

- Daily tracking is in place to ensure the Trust remains on track to achieve the March and June targets
- Speciality level trajectories are being developed to deliver zero 104 week waiters by end of June 2022 other than where patients choose to wait beyond this date
- Additional insourcing is taking place around ENT during the week and at weekends, which has led to a reduction in the cancelled theatre lists due to staffing issues
- Harvey 1 ward at City Hospital was converted back to an elective ward on 23rd February, which has enabled a higher volume of complex Orthopaedics surgery to be undertaken
- There is an aim of returning the second orthopaedic ward to elective patients during April, but this will be dependent on urgent care pressures
- The increase in availability of HDU capacity has enabled an increased number of long waiting spinal patients to be treated
- Waiting list validation is being undertaken, which is focusing on the longest waiting patients. The trust is validating down to 52 weeks wait and beyond in some specialties.

SFH have forecast that there will be 4 patients waiting 104 weeks or more by end of March. One of these patients has chosen to be treated beyond the end of March. All other patients will be dated to achieve the national target of zero patients waiting more than 104 weeks or more by the end of June 2022.

Assurances

Key points:

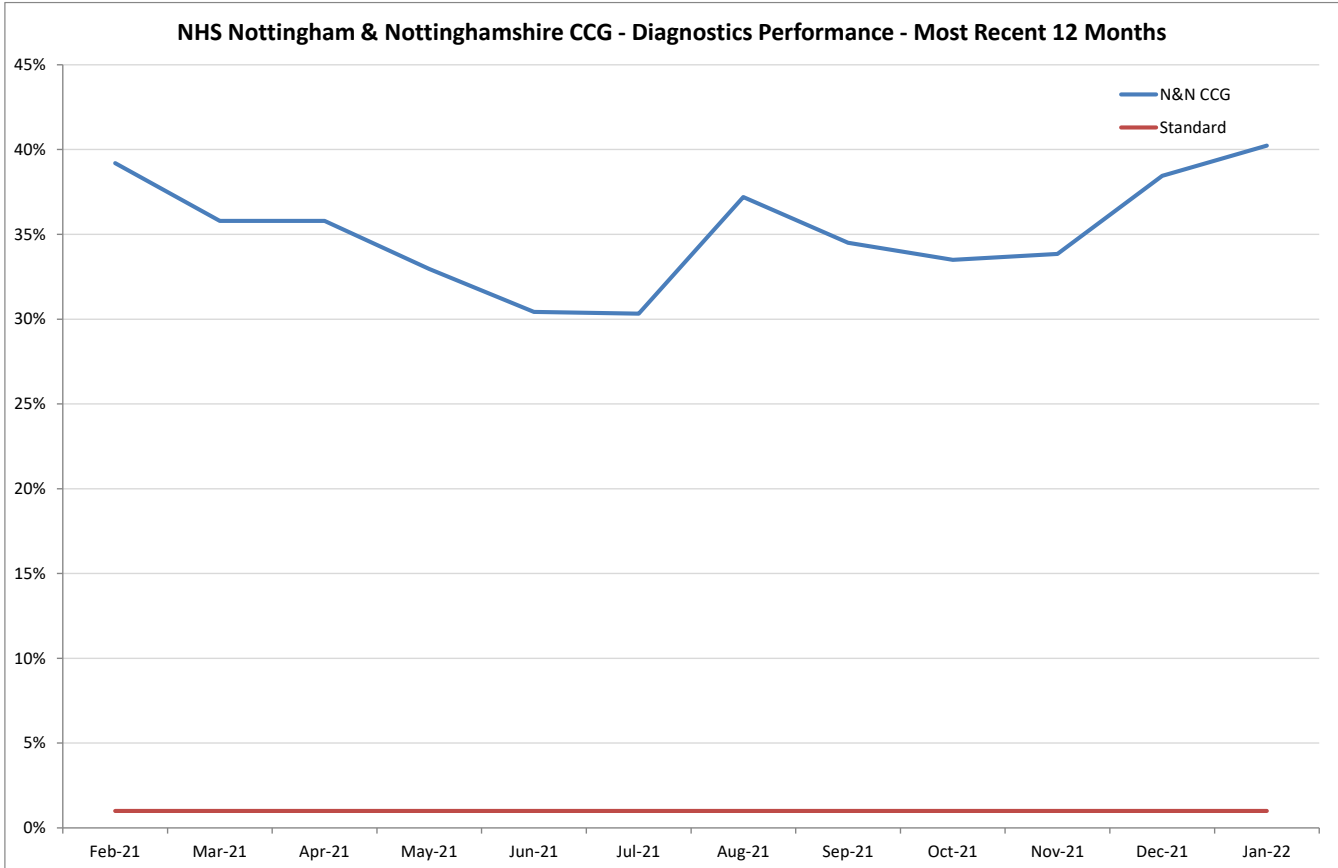
- All patients are regularly reviewed and their priority is escalated if their condition has deteriorated
- Performance is underpinned by whole system transformation. An ICS Planned Care Transformation Board is in place to oversee all Cancer, Diagnostics, Elective and Outpatient Transformation which responds to operational pressures and wider transformational opportunities.
- Collaborative working with CCG, IS and NHS providers to maximise all available capacity in the system and to align capacity with predicted future demand is in place
- Royal College of Surgeons guidance in relation to clinical prioritisation of patients waiting for elective care has been implemented by NHS Providers. Weekly monitoring of patients at NUH and SFH is undertaken at specialty level.
- The definition of harm is being confirmed at a system level in order to define and identify harm consistently, which will inform consistent system wide action
- Clinical Executive Group (CEG) has oversight of this process and considers the level of risk associated with long waits.
- As noted above the Health and Social Care Economy Tactical Coordination Group (HSCETCG) take material decisions as a system, this is underpinned by an ICS decision making framework which is supported by CEG.
- Long waiting patients consist largely of routine surgical patients assessed as safe to wait for their procedure. Trusts are providing treatment to patients in order of clinical priority (rather than wait time)

Gaps in Assurance

- Waiting times will not reduce until system pressures related to workforce, emergency demand and physical capacity pressures subside and Trusts are able to fully restore all elective services
- The increased length of stays expected because of the deconditioning of some patients will require careful management

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	Lisa Durant	CCG Acute Providers

Organisation	Standard	Most Recent 12 Months Performance												Performance Direction
		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	
N&N CCG	Less than or equal to 1%	0.99%	9.97%	54.73%	59.68%	53.26%	46.80%	46.06%	41.60%	43.36%	42.22%	41.01%	43.19%	↓
NUH		1.01%	12.42%	57.23%	61.63%	57.74%	52.00%	49.95%	47.28%	48.91%	48.89%	48.00%	50.57%	
SFH		1.43%	6.19%	53.00%	57.58%	50.01%	40.39%	38.63%	32.61%	35.05%	31.91%	31.24%	34.00%	
Organisation	Standard	Most Recent 12 Months Performance												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Less than or equal to 1%	39.20%	35.79%	35.79%	32.95%	30.43%	30.33%	37.20%	34.50%	33.50%	33.84%	38.45%	40.23%	↓
NUH		47.60%	43.46%	44.23%	40.63%	39.17%	38.54%	44.38%	44.65%	43.81%	43.75%	49.63%	49.46%	↑
SFH		29.75%	27.35%	25.36%	23.05%	20.08%	21.75%	25.13%	20.02%	19.71%	20.02%	25.26%	33.10%	↓



Tests Below Standard - January 2022	N&N CCG			NUH			SFH		
	Patients	Breaches	<6Wks	Patients	Breaches	<6Wks	Patients	Breaches	<6Wks
MRI	6910	4035	58.39%	6601	4587	69.49%	1309	66	5.04%
Computed Tomography	2761	591	21.41%	2263	470	20.77%	942	201	21.34%
Non-obstetric ultrasound	8651	2136	24.69%	2310	408	17.66%	4853	1832	37.75%
Barium Enema	0	0		0	0		0	0	
DEXA Scan	1403	671	47.83%	1069	643	60.15%	819	104	12.70%
Audiology	847	99	11.69%	577	104	18.02%	0	0	
Echocardiography	4538	2488	54.83%	3074	1627	52.93%	2027	1180	58.21%
Cardiology - Electrophysiology	1	1	100.00%	0	0		0	0	
Neurophysiology	172	6	3.49%	180	2	1.11%	0	0	
Sleep studies	490	228	46.53%	400	198	49.50%	376	142	37.77%
Urodynamics	98	24	24.49%	38	11	28.95%	72	18	25.00%
Colonoscopy	949	367	38.67%	702	375	53.42%	302	25	8.28%
Flexi sigmoidoscopy	319	160	50.16%	272	162	59.56%	64	9	14.06%
Cystoscopy	447	154	34.45%	170	17	10.00%	323	151	46.75%
Gastroscopy	1233	635	51.50%	1051	648	61.66%	253	25	9.88%
Total	28819	11595	40.23%	18707	9252	49.46%	11340	3753	33.10%

Root Cause

At NUH, Performance had been gradually improving as restoration of services occurred, however the impact of COVID over the winter period has led to an increase in staff isolating. When combined with existing staff vacancies and sickness it resulted in an increase in the volume of breaches during Dec-21 and Jan-22.

At NUH, the most significant backlogs are in MRI, Echocardiography, CT and Non-Obstetric ultrasound. Echocardiography experienced a rise in the number of breaches in Sep-21 which has continued due to a range of staffing challenges; this position continues to be challenging

There are similar issues at SFH around the impact of COVID and staff absences, but they are of a lower magnitude. Within Non-Obstetric Ultrasound at SFH staffing challenges exist due to sickness, vacancies and maternity leave, which is expected to continue in the short term. There are longer term plans around increasing the number of training places available. The highest number of breaches are in non-obstetric ultrasound and echocardiography. NUH are providing mutual support in ultrasound.

Mitigating Actions

- Insourcing of nursing staff, recruitment and “grow your own” training measures.
- Patients will be prioritised by clinical urgency and then longest waits
- The system is a Community Diagnostic Centre early adopter and MRI, CT and endoscopy unit capacity will continue in 2022/23
- NUH will continue to use the increased utilisation tool within radiology and expand into other modalities
- MRI Recruitment to staff the two replacement scanners at NUH is ongoing; however given the national shortage of radiologists this is expected to be challenging
- There is the intention to maintain the CT mobile unit at NUH beyond Mar-22 to sustain current performance, which is progressing through internal approval processes
- In Gastroscopy, activity remains high and additional capacity has been secured in the Independent Sector
- Echocardiography at NUH secured locum staff and are working weekends to meet demand
- Vacancies are being filled in the DEXA service at NUH as well as additional sessions planned to increase capacity.

Assurances

- Trusts have strong action plans in place.
- In the longer term (2023/24), Community Diagnostic Centres will provide significant additional diagnostic capacity.

Gaps in Assurance

- Staffing challenges and recruitment delays will affect ability to increase capacity across all areas.
- Capital enabling works extend beyond 2022/23.

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

Organisation	Standard	Most Recent 12 Months Performance - Two Week Wait												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 93%	95.84%	96.44%	86.25%	89.67%	88.45%	91.59%	90.55%	89.74%	89.22%	79.84%	79.76%	76.57%	↓
NUH		95.38%	96.65%	82.56%	87.31%	87.70%	92.30%	90.64%	89.66%	88.58%	73.62%	75.09%	71.15%	↓
SFH		96.76%	96.44%	95.17%	95.20%	89.92%	90.69%	90.43%	90.31%	91.19%	90.43%	88.04%	87.05%	↓

Organisation	Standard	Most Recent 12 Months Performance - Two Week Wait - Breast Symptoms												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 93%	96.94%	96.15%	63.11%	74.42%	75.00%	89.43%	95.31%	92.31%	95.51%	69.23%	72.41%	37.04%	↓
NUH		98.63%	96.81%	45.71%	68.49%	71.95%	90.63%	96.67%	94.81%	93.59%	10.53%	23.08%	0.00%	↓
SFH		97.50%	100%	100%	100%	77.27%	92.86%	100%	92.59%	94.12%	94.44%	92.45%	85.19%	↓

Root Cause

NUH

- January performance fell to 71.2%, primarily linked to Breast performance.
- Breast is currently at 10.1% due to the on-going surge in demand and impact of capacity limitations.
- The consultant Breast Radiologist has retired and been replaced with a locum two days a week. NUH continue to work on finding additional locums, although the lack of locums appears to be a national issue. Lack of Radiologist capacity is likely to be an issue for a few months.
- Breast also continues to be impacted by a 'surge and dip' referral pattern
- Breast continues to achieve 28 day FDS target
- All areas continue to see higher demand than pre-covid levels and staffing shortages are affecting capacity / performance across all areas.
- Gynae, H&N, LGI have all seen a dip in performance this month.

SFH

- Performance for January reduced marginally to 87.1% from 88.0% in December.
- The specialties with the highest number of breaches are gynaecology (41), upper GI (32), urology (31) and breast (27)

Mitigating Actions

NUH

Breast are still achieving FDS target, currently 86% by: -

- 80% of patients have initial appointment and leave with an outcome on the day.
- Approx. 20% need biopsy /Histology and are called back for a planned MDT /patient appointment 3-5 days later, where they are given their outcome.

SFH

- Breast:** Insourcing capacity discussions remain ongoing to support triple assessment capacity.
- Skin:** Same key drivers as Breast.
- Gynae:** Combined first Outpatient Appointment, diagnostic hysteroscopy and treatment hysteroscopy, have reduced waits overall which has created additional capacity. Equipment has been purchased which facilitate additional waiting list initiatives throughout March to reduce waits.

Assurances

NUH

- Treatment numbers have remained high even with surgical and HDU capacity issues.

SFH

- The Trust are making good progress with the use of Straight to Test strategies across a number of tumour sites.
- Extra clinical and admin posts being recruited to using Rapid Diagnosis Service funding will accelerate diagnostic pathway

Gaps in Assurance

NUH

- Number of 2ww referrals are consistently above pre-pandemic levels.
- Outpatient capacity is becoming increasingly impacted by 2ww referral increases, as follow-up slots have been utilised in some areas to increase 2ww capacity.

SFH

- Level and duration of increased referral demand is unknown. Referral numbers have remained significantly over 2019/20 levels since March 21.

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

Organisation	Standard	Most Recent 12 Months Performance - Twenty Eight Day FDS												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 70%	83.44%	83.83%	79.25%	79.11%	81.00%	76.79%	78.46%	76.89%	80.12%	77.93%	77.61%	70.54%	↓
NUH				79.67%	79.03%	81.36%	78.72%	81.80%	80.81%	82.29%	80.42%	78.82%	72.02%	↓
SFH				78.25%	80.26%	80.16%	75.89%	74.58%	73.69%	78.24%	75.51%	77.72%	69.73%	↓

Root Cause SFH

- SFH have achieved this target every month from April 2021 until December 2021. In January 2022 Head & Neck, breast and skin were the only specialties achieving 75%.
- Lower GI – constrained clinical capacity struggling to meet demand. Expected to be transient issue whilst backlog is being tackled and has a related effect on FDS.
- Upper GI – high referral numbers and complex diagnostic pathway.
- Urology – Cystoscopy capacity is under pressure and MRI waits need to be improved.

Mitigating Actions

- Good progress being made with recruitment to clinical and administrative roles funded by Rapid Diagnostic Services (RDS) programme.
- Lower GI – One stop colonoscopy and staging CT clinics started.
- Upper GI – Exploration required to see whether tests can be protocolised to reduce delays between them. TACE, EUS, ESD all NUH delivered. EUS capacity sought at SFH - ongoing discussions between providers to agree training plan.
- Urology – Cancer Support Worker now inducted and mid-grade locum started in February.
- Gynaecology – light cables purchased for hysteroscopes creating additional capacity. 6 additional see and treat list per month planned in March.

Assurances

- Trust is engaged with RDS programme and have active projects across a number of pathways.
- Internal metrics being developed to understand pinch points and progress.
- Project manager role has been appointed to.

Gaps in Assurance

- Level and duration of increased referral demand is unknown. Referral numbers have remained significantly over 2019/20 levels since March 2021.
- Staff absence level due to Covid going forward is unknown.

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

Organsation	Standard	Most Recent 12 Months Performance - 31 Day											Performance Direction	
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21		Jan-22
N&N CCG	Greater than or equal to 96%	93.01%	92.66%	91.72%	92.23%	87.19%	90.25%	91.63%	90.34%	89.94%	89.32%	91.14%	83.05%	↓
NUH		91.40%	91.13%	90.09%	90.34%	86.31%	89.90%	89.69%	89.46%	90.27%	88.39%	89.34%	81.72%	↓
SFH		99.00%	96.97%	95.88%	97.73%	91.91%	92.70%	95.76%	91.94%	91.89%	91.49%	91.85%	84.21%	↓

Root Cause

NUH

- Day 31 performance has fallen to 82%.
- The key reasons for breaches are surgical / HDU capacity and clinical priority - particularly impacting Urology, Gynae, and LGI. An increased number of HDU beds are now being offered, so some improvement is expected - although continues to be challenging
- Ongoing increases in referral rates continue to impact on 31-day performance

SFH

- There were 22 breaches for 133 treatments in January.
- Breaches were across skin (13), lower gastrointestinal (5), urology (3) and breast (1).
- High referral levels are the main contributing factor to declining 31 day performance.

Mitigating Actions

NUH

- Surgical prioritisation continues to take place matching available capacity with clinical need across all specialties. 'POCUS' - (prioritisation of cancer and urgent surgery) meets weekly.

SFH

- Cancer treatment activity levels remain protected by the Trust

Assurances

NUH

- Treatment numbers have remained high even with surgical and HDU capacity issues.

SFH

- The Trust has achieved and is maintaining pre-Covid levels of treatment activity

Gaps in Assurance

NUH

- Number of 2ww referrals are consistently above pre-pandemic levels.
- Number of patients waiting over 62 days for treatment continues to grow
- Outpatient capacity is becoming increasingly impacted by 2ww referral increases, as follow-up slots have been utilised in some areas to increase 2ww capacity.

SFH

- Level and duration of increased referral demand is unknown. Referral numbers have remained significantly over 2019/20 levels since March 21.
- Staff absence level due to Covid going forward is unknown.

Root Cause

- Almost all specialties are having significant challenges to achieve the 85% target.
- Tumour sites with the lowest performance are: Gynae 10.0%, LGI 41%, Urology 43.7%, UGI 48.4%, H&N 53.6% and Lung 53.6%.
- Total breaches are 79.5, with the highest numbers in:- Urology 24, LGI 10, Gynae 8.5, and UGI 8.
- Access to beds, theatres and HDU is beginning to improve and having an impact on the number of long waiters.
- Outpatient capacity, particularly for Urology and LGI is also a considerable issue, impacted by higher demand and staffing challenges.
- Histology turnaround times also continue to be an issue.
- Breast performance has fallen to 66%. Increased demand, Radiologist capacity and lack of additional sessions are all an issue.
- Treatment Centre is being used for admissions to bring in cancer patients for elective surgery but will not accommodate all cancer surgery.

Mitigating Actions

- Gynae implemented their RDC pathway during February and have also increased medical capacity through February, March and April with appointment of locums.
- It is expected that an improvement in performance will be seen from Feb onwards
- IS - HDU beds are being utilised at The Park and Spire Hospital – only approx. 25% of the capacity previously had at height of covid.
- Surgical prioritisation continues to take place matching available capacity with clinical need across different specialties. 'POCUS' Group (prioritisation of cancer and urgent surgery) meets weekly.

Assurances

- Treatment numbers have remained high even with surgical and HDU capacity issues.

Gaps in Assurances

- Number of 2ww referrals are consistently above pre-pandemic levels.
- Outpatient capacity is becoming increasingly impacted by 2ww referral increases, as follow-up slots have been utilised in some areas to increase 2ww capacity.
- Staff absence levels due to COVID remain a risk to delivery

Sherwood Forest Hospitals Performance Focus

Root Cause

- Year to date referrals are 14% above the same period in 19/20 average.
- There were 44 breaches for 93 treatments.
- Highest numbers of breaches were seen in urology (19), lower GI (10) and skin (6).
- The 62 day backlog has reduced from 130 in January to 98 at the beginning of March.
- Referral increase impact on diagnostic capacity such as CT colon; compounded by a high volume of DNA/patient cancellations

Mitigating Actions

- **UGI:** waits for OP are currently extended - additional capacity has been agreed and will be in place before April, with closer alignment to the Best Practice Timed pathway. Ongoing discussions around shortening waits for endoscopy. Multiple phased tests continue to extend pathways, as does reliance on NUH capacity for EUS, TACE and staging laps.
- **Skin:** backlog has continued to reduce and is nearly in line with trajectory and re-forecast. The majority of capacity lost in service through planned sickness is now covered with the remainder intended to be managed closely by the division on a patient by patient basis.
- **Gynae:** Reduced backlog from previous week. Average days wait for test reduced from 27.3 to 18.4 days. Further reductions in first seen and FDS waits expected but noting risk around mutual aid and impact on treatment capacity/backlog.
- **Head & neck:** Clinical capacity meeting with NUH on 09/03. Ongoing discussions with team around frequency of tests to establish local best practice.

Assurances

- High cancer treatment levels are being maintained by the Trust.
- Cancer diagnostic and treatment capacity remains protected.

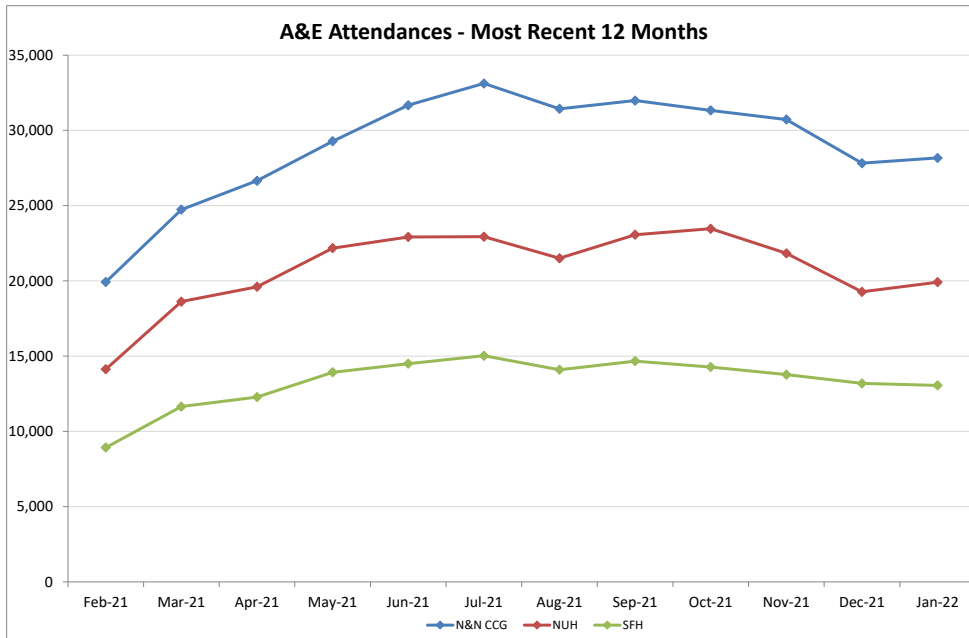
Gaps in Assurances

- Level and duration of increased referral demand is unknown. Referral numbers have remained significantly over 19/20 levels since March 21.
- Staff absence levels due to Covid remain a risk to delivery

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	Acute Providers CCG

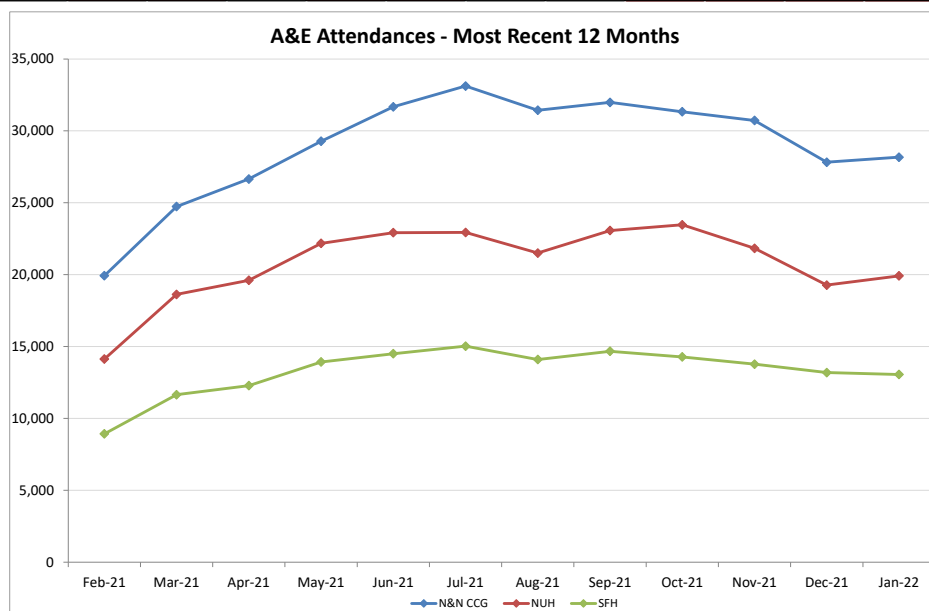
Organsation	Standard	Most Recent 12 Months Performance												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 95%	76.64%	76.04%	76.30%	73.27%	72.23%	70.14%	68.70%	65.41%	63.75%	66.19%	66.55%	67.86%	↑
NUH		Reporting suspended due to trial of new indicators												↔
SFH		92.26%	94.11%	93.77%	91.75%	88.84%	86.34%	86.61%	82.42%	82.74%	84.33%	82.95%	86.19%	↑

Organsation	Standard	Most Recent 12 Months - Attendances												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	N/A	19,930	24,735	26,651	29,282	31,676	33,120	31,436	31,980	31,328	30,726	27,820	28,173	N/A
NUH		14,134	18,627	19,607	22,179	22,924	22,938	21,502	23,070	23,469	21,831	19,277	19,917	N/A
SFH		8,932	11,654	12,284	13,930	14,505	15,029	14,099	14,673	14,279	13,776	13,193	13,060	N/A



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	Acute Providers CCG

Organsation	Standard	Most Recent 12 Months - 12hr												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
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		27	8	0	5	0	74	128	140	108	445	363	514	↓
SFH		2	1	0	1	4	0	0	9	2	23	57	41	↑



Root Cause

Key Bullet Points:

1. Sourcing homecare packages remains a challenge as regards pathway 1 patients coupled with issues linked to pathway 0 patients who required family support to enable discharge; in January there were 22 requests for “Personal Health Budget” funds to help families to support discharged patients at home.
2. MSFT lists at both acute providers, community bedded and non-bedded services as well as local authority internal reablement services continue to be high and far above required levels to support system flow.
3. Daily ED average attendance rates at both acute hospitals remained relatively static in the month of January whilst ED presentations to admission rates also remained relatively steady across both NUH and SFH sites. Same day emergency care (SDEC) slightly increased by 1.3% at SFH with NUH decreasing by 0.6%.
4. In January, NUH recorded a significant increase (42%) in 12-hour breaches with SFH recording a decrease (28.6%) from the month of December.
5. NUH Emergency LOS remained relatively static for a 2nd month whilst SFH recorded a sharp increase (40.2% - related to increased MSFT at the trust) with both Trusts not achieving set targets.
6. Both pre and post Ambulance handover performances continue to be below target at both Trusts. Average daily ambulance activity increased (4.7%) at NUH whilst it remained static at SFH.
7. Accelerated discharge events (ADE) events were expanded into Mid-Notts during the month of January. This involved senior management representation within the ICS.

Headline ED Data:

ED daily average attendances increased slightly by 1.8% in January when compared to December. There was also a reduction (7.6%) in referrals to NEMS Primary Care.

Table 1 – Front Door Performance Indicator (NUH) 6 months up to January 2022

Performance Indicator - Nottingham University Hospital	Performance Metric	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
ED Attendance NUH (Type 1 only)	Daily Average	494	542	534	507	448	456
London Road UTC Attendances	Daily Average	149	175	162	160	127	136
Referrals from NUH to UTC	Month Total	137	149	79	185	86	
Streaming to NEMS Primary Care	Month Total	1365	1910	1930	1989	1746	1614

ED daily average attendances slightly increased by 1.1% in January when compared to December at SFH. Related decreases (3.1%) were recorded in Newark UUC daily average attendances, (3.7%) PC24 AE attendances and a slight (0.8%) decrease in PC24 monthly performance as a % of ED attendances.

Table 2 – Front Door Performance Indicator (SFH) 6 months up to January 2022

Performance Indicator - Kings Mill Hospital	Performance Metric	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
ED Attendance KMH (Type 1 only)	Daily Average	304	318	295	302	280	283
Newark UCC Attendances	Daily Average	68	77	71	72	65	63
PC24 AE Attendances	Daily Average	86	95	93	88	81	78
PC24 as a % of ED attends	Month Performance	22.10%	23%	24.10%	22.60%	22.40%	21.60%

Pre-Hospital & Front Door

Primary Care

Since returning after the New Year, primary care continues to focus on delivering services during core hours as well as providing extended hours access, some of this has been flexed for utilisation to provide additional COVID vaccination capacity where needed.

In addition to core services, general practices have delivered an additional 41,000 appointments in the period to December against Winter Access Fund plans (WAF), The WAF plan aims to deliver circa 200,000 appointments over the period Nov 21 to Mar 22 - approval from NHSE/I for the WAF plan was not received until early December. The support to the vaccine programme also impacted planned delivery during this period, the level of delivery to date shows the commitment from primary care colleagues to support the recovery of services. General practices and PCNs have now rephased the activity over the remaining period to deliver the planned number of appointments.

Staff absence levels due to COVID sickness and isolation, other sickness and other leave which peaked over the two bank holiday weekends has now normalised and appear to be in a more stable position.

Nottingham and Nottinghamshire practices continue to work through the backlog of long-term condition work and reviews. Practices continue to flex routine and urgent appointments to meet patient demand, with extended hours/access being used in a similar manner to respond to patient need. Variation in how this is flexed across practices continues as they focus on meeting the needs of their individual populations. Patient demand continues to be higher than previous.

OPEL reporting for general practice continues to see several practices at OPEL Level 3 each day, with the majority over the month of January being consistently on OPEL Level 2.

Note: Data for primary care remains a month behind.

Table 3 – Primary Care activity for 6 months up to December 2021

Performance Indicator	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
% of Same Day Appointments	46%	42%	39%	41%	44%	
Number of Same Day Appointments Booked	206,755	229,897	223,063	236,250	214,975	
Total Number of Appointments Booked	454,315	548,322	577,747	581,070	486,478	

NHS111

NHS111 dispositions recommended for ED diverted by the Clinical Advisory Service remained relatively static. This has been the trend month on month for the last 6 months. The total direct bookings into primary care from 111 decreased (12.4%) in January.

Table 4 – NHS111 Data over 6 months up to December 2021

Performance Indicator	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Total Direct Bookings into Primary Care from 111	2183	2474	2509	2323	2358	2066
NHS111 dispositions recommended for ED diverted by the Clinical Advisory Service	68%	71%	69%	71%	72%	72%

EMAS

The pre and post-handover performances at both trusts remain below the national target with an increase in average pre handover times at NUH and a decrease at SFH for both pre and post handover. Pre handover times for both trusts continue to perform better than most counterparts in the EMAS geography.

Table 5 – EMAS Performance standard monthly comparison

January 2022							
Workstream	Performance Indicator	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Urgent Care	Average Pre Handover NUH	00:19:16	00:19:51	00:20:53	00:18:39	00:16:53	00:17:26
	Average Post Handover NUH	00:18:37	00:18:55	00:18:51	00:19:56	00:19:55	00:19:21
	Average Pre Handover SFH	00:15:54	00:17:34	00:17:06	00:20:56	00:16:13	00:15:57
	Average Post Handover SFH	00:20:09	00:20:07	00:20:04	00:36:44	00:20:49	00:24:34

Handover Delays > than 30 minutes:

Similar to the last 3 months, Nottinghamshire has failed to achieve the 15-minute national standard pre and post-handover times. Kings Mill Hospital recorded an average pre handover time of 15 minutes and 57 seconds which was an improvement from the 16 minutes and 13 seconds in December whilst the average post-handover remained relatively static at just over 20 minutes. NUH average pre handover times for January declined to 17 minutes and 26 seconds from 16 minutes and 53 seconds in December. The average post-handover times remained relatively static at slightly over 19 minutes.

Conveyance Performance

Conveyance rates slightly increased (1.8%) at NUH with an increase (1.4%) at SFH in the month of January.

Table 6 – EMAS Conveyance Rate to NUH and SFH - 6 monthly comparisons

Performance Indicator	Performance Metric	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
Conveyance Rate to NUH for GN incidents	Monthly %	55.90%	55.20%	56.60%	54.40%	53.00%	54.80%
Conveyance Rate to SFH for MN Incidents	Monthly %	57.50%	58.40%	61.80%	59.70%	61.00%	62.40%

ED ACTIVITY

12-hour breaches remain a challenge. Delays at NUH continue to be linked to high demand for acute medicine beds and some infection related bed closures.

12-hour breaches

NUH

December = 363
 January = 514
 Increase of 42 %

SFH

December = 57
 January = 40
 Decrease of 28.6%

Capacity issues have been the largest factor in the number of 12-hour DTA breaches within the system. RCAs have not been received to further identify details or themes, however significant measures are being taken in the Trusts to reduce harm and maintain patient safety at times of overcrowding in ED.

ACUTE TRUST FLOW

Same day Emergency Care (SDEC) Performance

The SDEC as a percentage of admissions at NUH decreased by 0.6% in January whilst it increased (1.3%) at SFH. The specialties providing pathways for SDEC and the health care professionals that can refer to these pathways are being expanded, to further improve the SDEC offer.

Table 7 – SDEC performance over 6 months up to January 22

Performance Indicator	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
% of admissions classed as SDEC - NUH	30%	35%	37.30%	34.60%	34.70%	32.10%	31.50%
% of admissions classed as SDEC – SFH	30%	39%	41.5	41.1	39.8	40.80%	42.10%

Admissions

Apart from the January care home admission decrease (9%) at SFH, ED Overall attendances and admissions have remained reasonably static over the last 4 months. No NUH care home admissions data was available at the time of writing.

NUH

Table 8 – NUH ED Attendance to Admissions over 6 months up to January 2022

Performance Indicator	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
ED Attendance to Admission	29.70%	27.40%	27.50%	27%	27.60%	27.30%
Admissions from ED	153	153	153	143	129	130
Total Admissions	228	309	292	301	272	270
Care Homes Admissions	237	271	186	213	132	

SFHFT

Table 9 – SFHFT ED Attendance to Admissions over 6 months up to January 2022

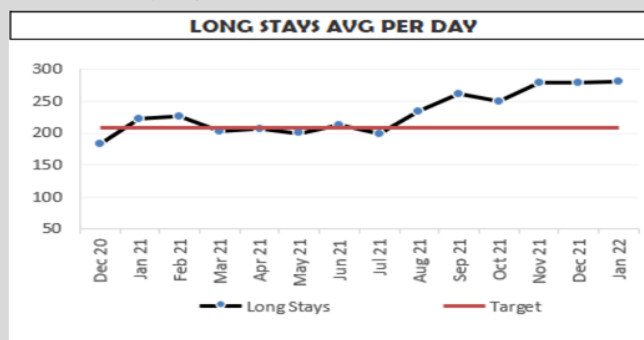
Performance Indicator	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
ED Attendance to Admission	33.90%	33.40%	34.40%	34.30%	36.50%	35.50%
Admissions from ED	77	80	77	76	74	71
Total Admissions	86	88	84	85	81	80
Care Homes Admissions	182	174	166	162	189	172

Discharges and System Flow

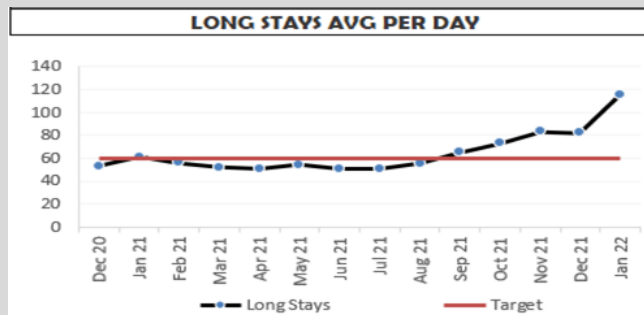
Hospital Length of Stay

Acuity of patients coupled with challenges related to the discharge of pathway 1, 2 and 3 patients has impacted on the long stay monthly averages at both Trusts. Over the last 3 months, both NUH and SFH have failed to achieve the set target. In December, NUH remained static whilst SFH recorded a sharp increase (40.2%).

Graph 1 – NUH Long Stay Monthly Average up to January 2022



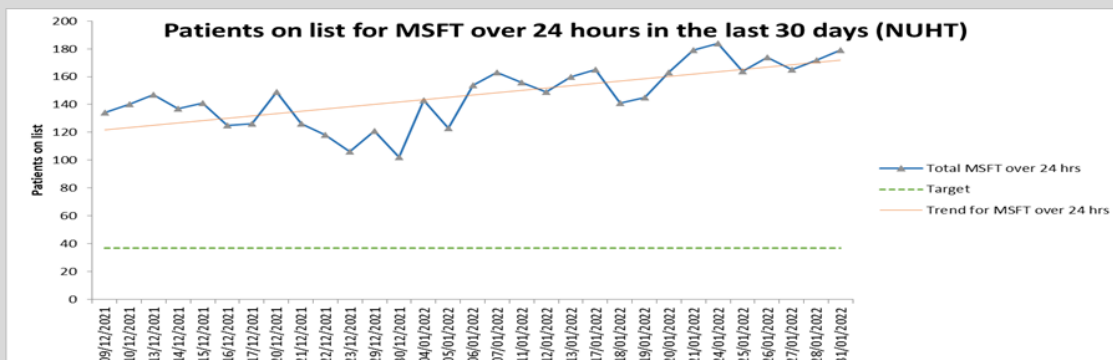
Graph 2 – SFH Long Stay Monthly Average up to January 2022

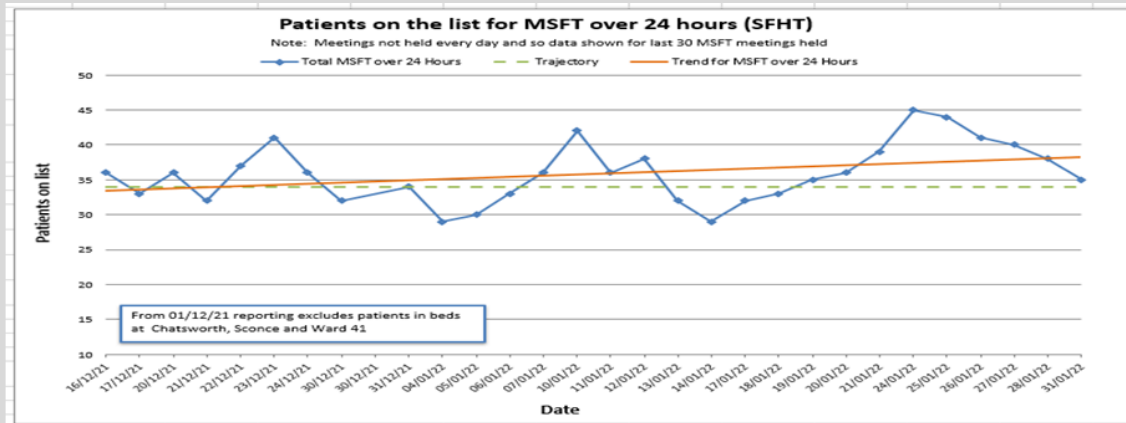


Medically Safe:

MSFT continues to be a significant challenge for both Trusts, despite huge input from system partners to discharge patients medically safe and in an acute bed. The continued issues impacting on the care home market along with capacity challenges being faced by Adult Social Care (ASC) has led to growing MSFT numbers and significant delayed discharges. In January, the system expanded Accelerated Discharge Events (ADE) into the Mid-Notts space.

Graphs dated 31.01.22





Adult Social Care (ASC)

Capacity challenges in both City and County ASC, has led to a continued increase in patients awaiting allocation of package of care in the system. This impacts on the ability to move patients to onward placements and maintaining appropriate flow in the system.

Due to capacity challenges, both City and County ASC are facing issues related to social worker case allocation coupled with timely assessment. A systemwide approach has led to continued support from the community CURT service in providing bridging care where appropriate.

Interim Care Home & Home Care Capacity

Interim Care Home Placements:

Work started at the beginning of winter to identify and secure interim care home placements across the system for patients who are waiting for a package of care and are delayed in any bedded facility is now in place. The interim beds arrangement has been impacted by some infection related care home closures. The system is also in the process of developing a model to be used in an agreement with primary care as regards interim beds GP cover.

System Wide: As of 18/01/2022, the system had a total of 449 beds (core and interim inclusive), of these 323 beds were occupied, 52 empty and 27 infection linked bed closures. Flow is being impacted by home care capacity and staffing shortages.

Home Care

British Red Cross and Turvida continue to further support additional hours and packages of care. British Red Cross has continued to struggle with capacity with recruitment efforts not leading to much success. The CURT service continues to support where possible with packages of care in Mid-Notts with plans in place to establish a CURT service in Greater Notts.

In January, Sciensus maintained its daily capacity at an average of 70 visits per day.

IPC closures.

As of 17/02/2022, there were 51 Covid linked care home closures across the ICS. A further 57 core and interim beds along with 1 home care agency have also been closed due to infection related issues. This impacts on flow, but it is also a recognised national picture. COVID positive isolation has been amended to 10 days isolation and the system is assessing the potential impact of this development.

Transport

ERS have supported additional transport requests to include the interim placements, as well as juggle the demands for outpatients. Challenges being faced by the provider includes working to current National IPC Standards which impact on activity. At the time of writing this report, it had not been determined how the amended Covid guidelines (mid-February) would impact on ERS operations.

Conclusion

The ICS remains in a challenged position. The issues highlighted in this report such as hospital discharges, home care, care home and capacity linked to staffing, remain areas of focus. It is anticipated that some of these challenges will take immediate, medium, and long-term actions to resolve. The A&E Delivery Board is encouraged to continuously support a risk sharing approach in managing and resolving the system challenges.

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

Organsation	Standard	Most Recent 12 Months Performance - Patients Entering Treatment (Rolling Three Months)												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Rolling Three Months Performance	5.45%	5.15%	5.48%	5.84%	6.45%	6.59%	6.38%	5.97%	5.90%	5.95%	6.47%	6.28%	↓
	Standard	6.25%	6.25%	6.25%	7306	7306	7306	7490	7490	7490	7675	7675	7675	N/A
	Patients Entering Treatment	5970	5645	6005	6405	7070	7225	6990	6550	6470	6525	7090	6880	↓
	Additional Patients Required	882	1207	847	901	236	81	500	940	1020	1150	585	795	↑

Organsation	Standard	Most Recent 12 Months Performance - Recovery Rate (Rolling Three Months)												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Greater than or equal to 50%	54.66%	54.25%	53.30%	53.39%	52.86%	52.78%	52.37%	51.64%	51.06%	50.05%	49.54%	48.95%	↓

Organsation	Standard	Most Recent 12 Months Performance - Waiting Times - First Treatment Within 6 Weeks												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Greater than or equal to 75%	98.15%	97.05%	96.68%	96.80%	96.93%	95.07%	95.11%	94.10%	93.08%	93.97%	93.03%	91.19%	↓

Organsation	Standard	Most Recent 12 Months Performance - Waiting Times - First Treatment Within 18 Weeks												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Greater than or equal to 95%	99.63%	99.58%	100%	99.29%	100%	100%	100%	100%	99.71%	100%	99.73%	100%	↑

Organsation	Standard	IAPT waits >90 days between 1st & 2nd treatment												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Less than 10%	4.14%	7.41%	9.89%	8.83%	7.65%	13.12%	9.59%	9.06%	7.85%	7.36%	4.28%	1.69%	↑

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Number of Referrals	2270	2690	2785	3290	2780	3120	3070	2970	2925	3270	3270	4035	2845
Number entering treatment	1860	1945	1840	2220	2345	2505	2375	2110	2065	2295	2165	2630	2085
Rolling 3 month treated	6105	5970	5645	6005	6405	7070	7225	6990	6550	6470	6525	7090	6880

Root Cause
 ICS 3-month rolling access performance decreased in December 2021 to 6,880 patients against the target of 7,675 patients. This decrease was anticipated in line with usual season trends.

The service continues to achieve and exceed waiting time standards. The average wait for an appointment in January 2022 has increased to 24 days, with this reflecting the increase in referrals usually seen following the Christmas period.

The recovery standard has not been achieved in December 2021 but is in line with the national position (48.6%). The downward trend also reflects trends seen in other areas and relates to a reported increase in complexity of presentations. In December 2021, 65% of patients showed reliable improvement upon completing treatment which is in line with the national position. Waiting time and recovery performance for the ICS continues to be above national average in December 2021.

Mitigating Actions

Local data is utilised to identify and address performance issues with providers and agree actions to improve capacity and service delivery, including workforce issues.

Key actions to increase performance over the next quarter include:

- Mid Notts will focus on service promotion, community advertising and engagement and strengthening links with localities and PCNs.
- All services are continuing with service promotion and awareness raising through social media animations, videos and blogs, monthly newsletters, community advertising and attendance at community events.
- Partnership working to develop new pathways.
- A continued focus on inequalities to include the roll out of online offers in different languages and the commencement of community engagement workers, with a primary focus on BAME communities and older adults.
- Expansion of the workforce through recruitment (on-going), use of agency and affiliates (on-going) and new trainee cohort will increase capacity to support delivery of access and waiting times standards.
- Workforce planning with NHS England and Health Education England to agree trainee numbers for 2022/23.
- The wider roll out of NHS Limbic will improve online access, help with ensuring the right step first time and signposting of referrals that are either not meeting caseness or are not appropriate, ensuring that clinical capacity is used most appropriately, thus supporting the access and recovery standards.
- A continued focus on staff wellbeing, supervision and caseload management including training and drop-in support sessions.

Specific actions by providers to improve recovery:

- A Delivered Practice Programme for staff with lower recovery rates
- A review of inclusion/exclusion to ensure only those suitable for IAPT are accepted
- Case Management refresher training for case managers
- Implementation of new risk management procedure
- Reduction in use of agency staffing
- Continued supervision for all staff, including the use of supervision software
- Review of data quality

Assurances

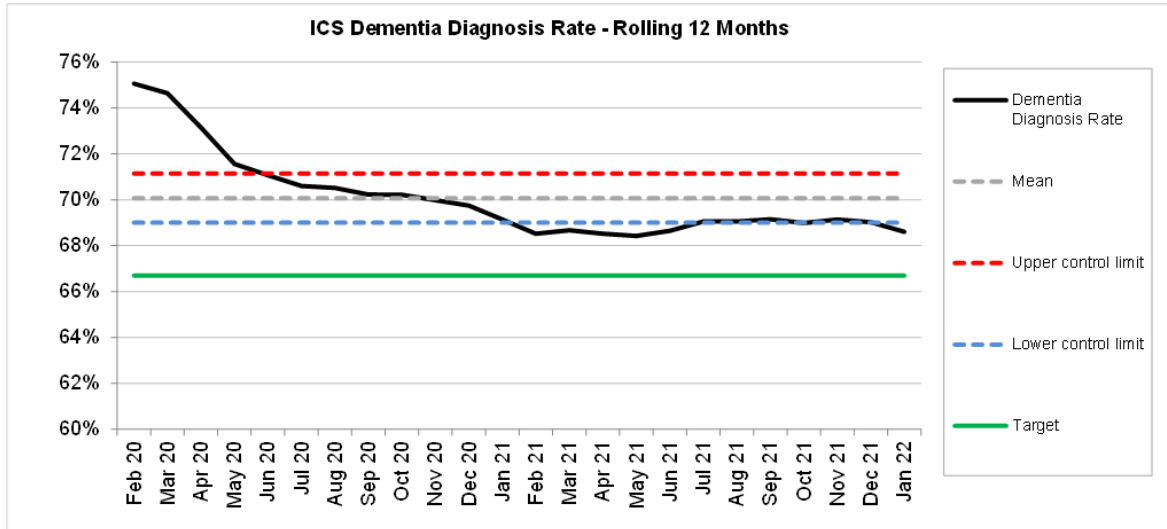
An established monthly steering group with IAPT providers is in place, with focussed monitoring of targeted actions to assess impact of improvement actions and delivery of spending review investments.

Gaps in Assurance

None

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

Organsation	Standard	Most Recent 12 Months Performance - Dementia Diagnosis Rate												Performance Direction
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Greater than or equal to 66.7%	68.52%	68.67%	68.52%	68.42%	68.65%	69.05%	69.05%	69.15%	68.99%	69.14%	69.02%	68.61%	↓



Organsation	Metric	Most Recent 12 Months - Dementia Diagnosis & Prevalence												Monthly Trend
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
N&N CCG	Patients Diagnosed	8217	8247	8245	8263	8309	8367	8385	8412	8400	8426	8425	8377	↓
	Estimated Prevalence	11992	12009	12033	12076	12103	12117	12143	12165	12176	12186	12206	12210	↑

Average waiting time from Referral to Assessment

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
MHSOP MAS - City	10.0	8.6	8.1	6.6	4.4	4.3	4.9	4.7	5.0	4.6	5.7	5.1
MHSOP MAS - Ashfield & Mansfield	10.4	11.3	9.6	3.4	1.5	2.0	2.4	2.6	3.1	1.8	3.1	4.0
MHSOP MAS - Broxtowe	7.4	7.8	7.4	8.5	8.4	6.8	8.1	9.0	9.4	9.2	7.2	6.1
MHSOP MAS - Gedling & Hucknall	3.8	3.5	4.0	5.1	4.5	5.8	5.9	7.0	8.3	8.5	9.9	7.1
MHSOP MAS - Newark & Sherwood	8.5	8.1	6.6	5.6	5.8	5.1	6.4	5.5	5.9	5.4	6.5	6.0
MHSOP MAS - Rushcliffe	3.7	2.0	3.2	4.7	3.8	3.9	3.8	5.0	5.4	4.7	6.6	8.1
N&N CCG	8.7	7.8	6.9	6.0	5.1	5.0	5.6	5.9	6.5	6.0	6.7	6.2

Patients Waiting for Assessment

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
MHSOP MAS - City	210	178	150	114	105	87	95	105	111	119	126	128
MHSOP MAS - Ashfield & Mansfield	74	72	46	25	21	26	38	41	40	35	56	55
MHSOP MAS - Broxtowe	54	65	58	51	62	64	73	70	66	57	56	56
MHSOP MAS - Gedling & Hucknall	40	53	54	53	68	83	97	107	119	108	111	116
MHSOP MAS - Newark & Sherwood	77	75	70	78	73	72	85	82	85	78	71	70
MHSOP MAS - Rushcliffe	19	29	46	37	42	48	51	60	59	61	87	95
N&N CCG	474	472	424	358	371	380	439	465	480	458	507	520

Root Cause

The ICS continues to exceed the dementia diagnosis rate standard.

Historical long waiting times and variations in localities (pre-Covid) for memory assessments have been reducing from their peak in September 2020 (19 weeks) following additional investment in the service and the reinstatement of the Memory Assessment Services (MAS) in September 2020.

Waiting times remain lower than pre-Covid levels (10.3 weeks at March 2020) but have started to increase gradually since September 2021. Average waiting time has improved this month, decreasing from 6.7 weeks in January 2022 to 6.2 weeks in February 2022.

Mitigating Actions

In response to increasing referrals, the MAS has implemented remote consultations / assessments where clinically appropriate to increase efficiency and capacity.

MAS teams continue to flex staffing to meet demand across localities, to ensure equitable waits across the system.

Non-recurrent monies have been agreed to increase capacity to further reduce waiting times during 2022/23.

Assurances

The MAS has reduced waiting times significantly since its reinstatement in September 2020.

A waiting time recovery trajectory was agreed to ensure the historical backlog is cleared and to monitor the 8-week waiting time to diagnosis target; this is monitored, and progress will be reviewed at a new Mental Health Older People's Steering Group.

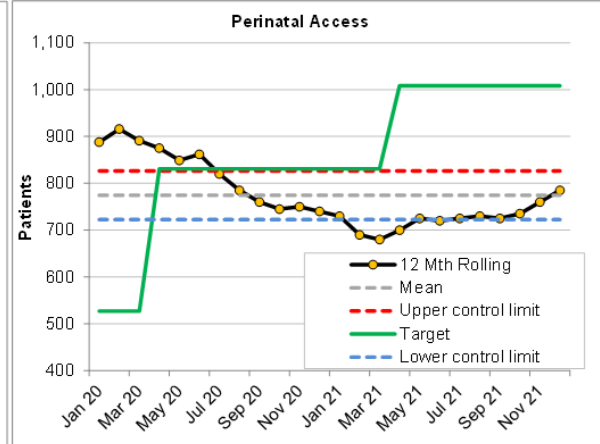
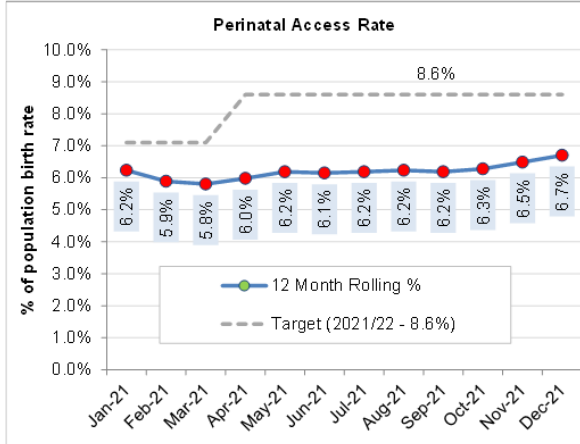
Further modelling has been undertaken as new roles have been embedded into the service, to enable the service to achieve the Memory Services National Accreditation Programme (MSNAP) 6-week wait to diagnosis standard by April 2022.

Gaps in Assurance

The service currently captures referral to assessment, and referral to treatment. Data systems have been reconfigured to accurately record referral to diagnosis and data is currently being reviewed to ensure accuracy.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Perinatal Mental Health Services	% of Population Birth-rate	Maxine Bunn	CCG

Organisation	Measure	Most Recent Rolling 12 Months Performance - Perinatal Mental Health												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	% of Population Birthrate	6.23%	5.89%	5.81%	5.98%	6.19%	6.15%	6.19%	6.23%	6.19%	6.28%	6.49%	6.70%	↑
	Patients	730	690	680	700	725	720	725	730	725	735	760	785	↑
	Standard	7.1%	7.1%	7.1%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	N/A



Organisation	Most Recent Rolling 12 Months Performance - Perinatal Mental Health											
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Mid Notts ICP	5.13%	4.82%	5.13%	5.47%	5.30%	5.50%	5.87%	5.82%	6.07%	6.30%	6.56%	6.59%
Nottingham City ICP	5.66%	5.56%	5.63%	5.77%	5.96%	5.84%	5.89%	6.07%	5.91%	5.93%	6.24%	6.24%
South Notts ICP	6.23%	6.43%	6.41%	6.69%	6.28%	6.35%	6.38%	6.48%	6.61%	7.12%	7.40%	7.38%
ICS	5.72%	5.66%	5.78%	6.02%	5.89%	5.93%	6.07%	6.16%	6.23%	6.46%	6.64%	6.75%

ICP level data is NHFT only (not published by NHSD)

Root Cause

Performance data is now based on nationally reported data published by NHS Digital, rather than locally reported figures.

Performance in December 2021 has increased to 6.7%, reflecting improvements for a fourth consecutive month, but remains below the standard of 8.6%. Local data for January shows further improvement at 6.75%.

National reporting guidance specifies that only face-to-face and video conferencing contacts contribute to access performance. This resulted in a decline in reportable performance from July 2020, in line with other areas regionally and nationally, though performance has stabilised and showing signs of improvement. However, analysis of local data including telephone support demonstrates that more women are accessing support than is reportable nationally. With the inclusion of telephone calls, the service would be achieving a 7.32% access rate.

Mitigating Actions

A 2-year investment plan to meet the increased access standard and deliverables outlined in the Long Term Plan was agreed in April 2021. Recruitment has taken place and has been phased throughout 2021/22; all additional roles for year 1 have been recruited, with the majority of additional roles for year 2 in place. The service transformation, which includes an extended period of care, the provision and support to partners, increased access to psychological therapies and the commencement of the maternal mental health pilot (trauma and bereavement service) in January 2022, will have a positive impact on the access target, with increased numbers expected to access the service.

Due to the impact of the 12-month rolling performance measure and recruitment timescales, the 8.6% target is not expected to be met by quarter 4.

ICS leads are refreshing the performance trajectory to reflect the increasing access target from 8.6% to 10% during 2022/23, with the aim to achieve the revised target by Q4.

Actions to increase the number of women accessing the service include:

- Undertaking promotional activity to increase the number of referrals to the service. This includes a launch of the new trauma and bereavement service on 31 March 2022 and a wider promotion of the expanded service during maternal mental health week in May 2022.
- Analysis of DNAs which are high for new assessments, including exploring the functionality of the text messaging reminder service to ensure that the number of missed appointment slots is reduced

Assurances

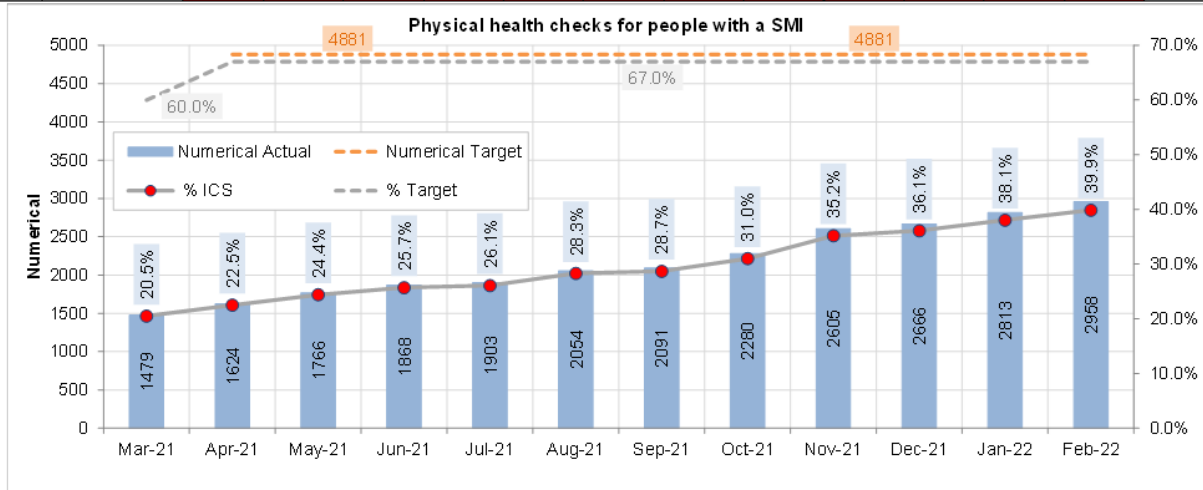
An ICS Perinatal Recovery Action Plan has been developed, including an improvement trajectory outlining when the service is expected to achieve the access target. This is monitored through the Perinatal Mental Health Steering Group.

Gaps in Assurance

None

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

N&N CCG	Standard	Most Recent 12 Months Performance - Physical Health Check for people with a SM												Performance Direction
		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	
% Standard	60% 2020/21 67% 2021/22	20.5%	22.5%	24.4%	25.7%	26.1%	28.3%	28.7%	31.0%	35.2%	36.1%	38.1%	39.9%	↑
Numerical Standard	4881 2020/21 5592 2021/22	1479	1624	1766	1868	1903	2054	2091	2280	2605	2666	2813	2958	



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Mid-Notts ICP	16.7%	17.6%	19.8%	22.1%	23.4%	25.0%	28.7%	29.9%	34.3%	38.6%	40.3%	43.4%	45.8%
Nottm City ICP	16.4%	16.9%	18.9%	21.1%	22.8%	22.4%	24.6%	24.8%	27.2%	31.6%	31.9%	32.5%	33.7%
South Notts ICP	28.0%	29.6%	31.2%	32.3%	32.8%	33.3%	33.8%	33.9%	34.0%	37.8%	38.7%	41.7%	44.0%
ICS	19.7%	20.5%	22.5%	24.4%	25.7%	26.1%	28.3%	28.7%	31.0%	35.2%	36.1%	38.1%	39.9%
Target	60.0%	60.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%

Root Cause

The national Physical Health Check for people with Severe Mental Illness (PHSMI) targets and monitoring has recently changed from percentage to numerical in line with the LTP ambitions tool published in February 2021. The 21/22 target for the ICS is 4,881 physical health checks by March 2022.

There has been continued improvement in February 2022 for the eleventh consecutive month with ICS performance increasing to 39.9% (2,958 checks); this is above the regional (33.3%) and national (34.9%) averages.

The Quality and Outcomes Framework (QOF) for PHSMI has been suspended/income protected for the rest of the year due to re-prioritisation of the COVID vaccination programme. This may impact on primary care capacity and prioritisation to undertake health checks in line with the Q4 trajectory to meet the end of year target. Additional outreach support will continue to be provided for the health checks, flu and COVID vaccinations to help with system pressures and improve access for people with SMI.

Mitigating Actions

An ICS recovery action plan is in place to support improvements in performance. Actions include:

- Performance against the PHSMI LES is monitored monthly, enabling the system to respond in a timely manner and flex support accordingly. This data is shared with the PHSMI Steering Group to agree prioritisation of outreach support from the Health Improvement Workers (HIWs) to primary care. Communications to practices will continue to promote the undertaking of physical health checks.
- Monthly monitoring of practice and PCN level data continues, identifying areas requiring additional focussed support. Performance dashboards are reviewed at Primary Care Network (PCN) and Place Based Partnership (PBP) level.
- The PHSMI LES went live on 1 May 2021, with 98% of practices signed up to the incentive scheme to deliver the 5 additional supporting indicators. This 2-year LES contract will continue into 2022/23.
- Outreach support for those with an SMI continues to be provided by the HIWs, to those individuals who have not yet responded to the COVID vaccination invites from their GP. As of 1 March 2022, 79.7% of people on the SMI register have received their first vaccination dose, 75.7% have received their second vaccination, and 60.9% have received their booster.
- Improvements to the PHSMI communication plan is being developed to raise the profile of the HIW's to support delivery and integration within primary care and to ensure continued focus and prioritisation of the PHSMI health check.
- Scoping is underway to determine the role of the VCSE, with a review of learning from other systems underway and particular emphasis on the peer support element of the PHSMI pathway with implementation planned in Q2 2022/23.

Assurances

Oversight of delivery of the standard has been integrated into the Community Mental Health Transformation Programme within the Primary Care Interface Group. This ensures coordination with all service developments, including the development and expansion of Local Mental Health Teams and introduction of Mental Health Practitioners in PCNs.

The PHSMI LES will progress into its 2nd year of its contract in 2022/23 to support primary care with the health checks and follow ups.

Gaps in Assurance

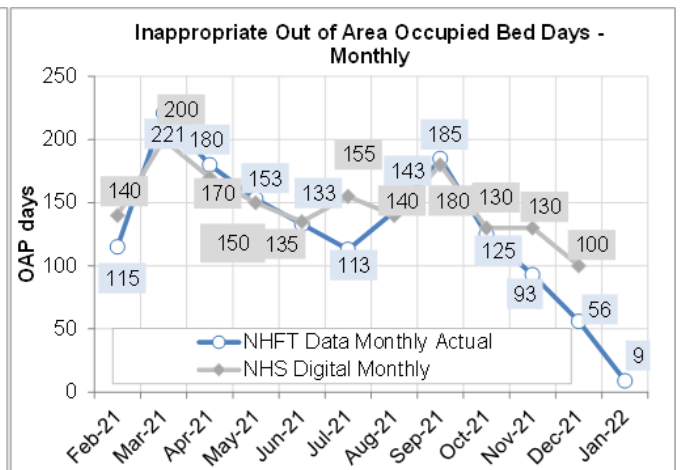
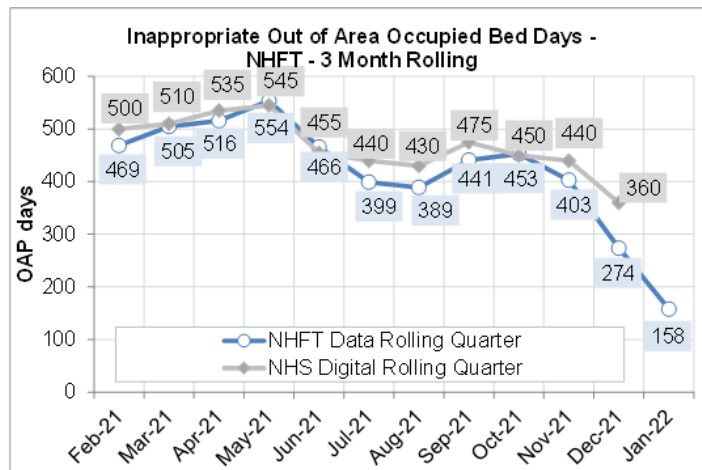
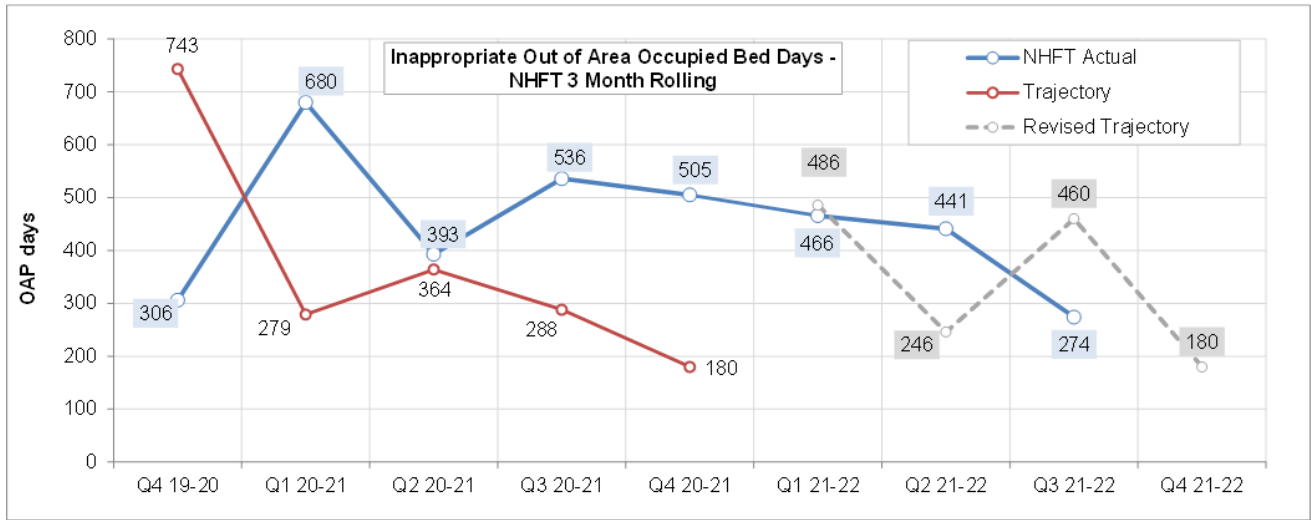
The individual impact of the QOF and LES is not easily quantifiable, though 98% of practices have signed up to the LES. However, NHS England have provided national evidence to suggest that the uptake in performance is attributed to the QOF.

Winter pressures, flu vaccinations and the COVID vaccination / booster programme impact on primary care capacity to undertake health checks in line with the Q4 trajectory to meet the end of year target.

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

Organisation	Measure	Monthly Performance - Inappropriate Out of Area Occupied Bed Days											
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
NHS N&N CCG	NHFT Data	115	221	180	153	133	113	143	185	125	93	56	9
	NHSD Data	140	200	170	150	135	155	140	180	130	130	100	

Organisation	Measure	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		2019-20	2019-20	2019-20	2019-20	2020-21	2020-21	2020-21	2020-21	2021-22	2021-22	2021-22	2021-22
Nottinghamshire Healthcare Trust	NHFT Actual (QTR)	2555	2085	618	306	680	393	536	505	466	441	274	
	Revised Trajectory	3432	2024	1748	743	279	364	288	180	486	246	460	180



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Adult acute long length of stay (60+ days) - rolling quarter (Target 8)	5.5	5.5	6.5	7.1	7.1	6.3	6.1	6	7	6	6	6
Older adult acute long length of stay (90+ days) - rolling quarter (Target 10.75)	8.5	10.6	12.8	13.8	12.2	11.7	10.2	10	11	12	15	11

Root Cause
 In quarter 3 2021/22 there were 218 OBDs, against a local trajectory of 460. The number of OBDs reported in January 2022 has decreased to 9, from 56 in December 2021. Future performance may still be impacted due to COVID-19 guidance that requires isolation beds and ward closures due to COVID. This has previously resulted in patients being admitted to out of area placements.

The refreshed NHSE guidance is to achieve zero inappropriate out of area placements by end of quarter 4 2021/22.

Mitigating Actions

On-going implementation and review of the Crisis and urgent mental health pathway, including:

Crisis/Community Support

- Crisis Resolution and Home Treatment Teams (CRHT) delivering Intensive Home Support and in-reach to wards. CRHT are providing 24/7 home treatment, with staffing commissioned to core fidelity levels (recruitment to some posts remains challenging).
- The 24/7 mental health crisis line and helpline have been combined to deliver an integrated service provided by NHT and Turning Point (VCS). The new telephony system supporting the phone line will be implemented in Q1 2022/23 and will further improve reporting and patient experience.
- Crisis sanctuaries commenced in quarter 4 2020/21. Since the start of the pilot (Feb 2021 to end of January 2022) there have been more than 750 attendances. The pilot is being reviewed and will inform the long-term delivery model, which will be implemented from Q2. A pilot of the daytime Crisis House provision will commence in Q1 2022/23 to provide daytime support alongside the existing overnight stays.
- A working group has been established between EMAS, NHT, CCG and Crisis Sanctuary leads to ensure EMAS have access to local mental health pathways.

Inpatients and discharge

- Long stay patients have been reviewed to identify reasons for discharge delays and inform system actions and utilise discharge funding. ICS mental health accelerated discharge events took place in February & March (the March one focussed specifically on older adult delays). MFFD data is also now being reported through to NHSEI and the system urgent care daily meetings. A regular report detailing reasons for delays has been developed by NHT and is shared with system colleagues.
- A number of actions are underway by local authorities which will support discharge and flow from mental health acute inpatient units.
- Future inpatient demand modelling review for adults and older adults commenced January 2022 and will be completed by May 2022. The review will propose options for inpatient and community services.
- Some discharge schemes that have had the greatest impact on admission prevention and discharge have been continued into 2022/23 and are being aligned to wider transformation plans.
- NHT is scheduled to open a new acute mental health inpatient unit, originally planned to open in November 2021, but delayed until Summer 2022 due to building and fire regulations that require action. The unit will increase the number of acute beds by 14, with plans to reduce the reliance on sub-contracted beds.

Assurances

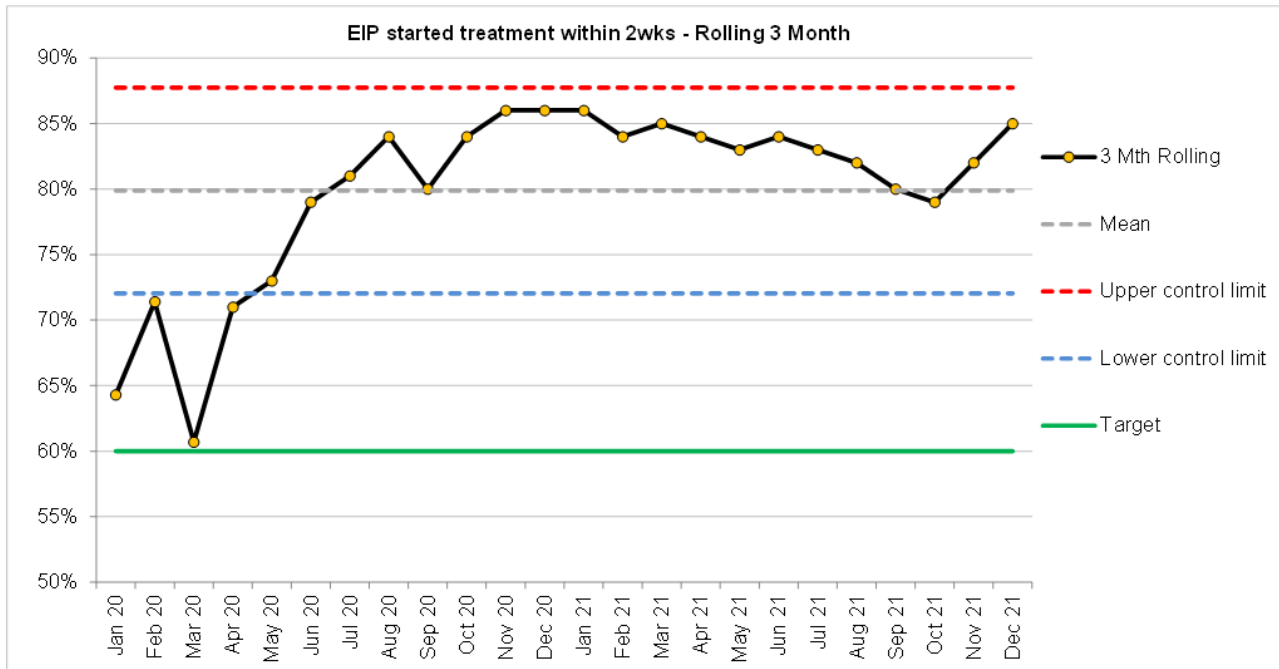
The Mental health Crisis and Urgent Care Steering Group reviews actions on a monthly basis. Partnership meetings are also in place to identify actions that can be taken to alleviate system pressures.

Gaps in Assurance

No gaps identified

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

Organsation	Measure	Most Recent 12 Months Performance - EIP Waiting Times (Rolling Three Months)												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	Started treatment in 2 weeks	86.0%	84.0%	85.0%	84.0%	83.0%	84.0%	83.0%	82.0%	80.0%	79.0%	82.0%	85.0%	↑
	Standard	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	N/A



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Referrals on EIP pathway entering treatment	115	115	130	145	145	140	135	115	100	90	115	110
Referrals on EIP pathway entering treatment within two weeks	100	100	110	120	120	115	115	95	80	75	95	95

In addition to the access standard the service is required to meet NICE standards. The ICS is currently rated as a Level 3 (Performing Well) overall (assessed through local audit/dashboard).

The most recent National Clinical Audit of Psychosis (NCAP) report published in July 2021 rated the ICS as a level 1 (Greatest Need for Improvement) overall. However, the data that informs the audit is taken from caseloads from 2020 which does not reflect developments and transformation that have taken place.

Performance against NICE EIP standards based on local data in January 2022:

NICE standard	Current performance	Rating
Access	Level 4	Top Performer
CBTp	Level 3	Performing Well
Family Interventions	Level 2	Needs Improvement
Supported employment and education	Level 4	Top Performer
Physical Health Checks	Level 3	Performing Well
Carer Focussed education	Level 4	Top Performer
Outcome measures	Level 2	Needs Improvement

Root Cause

The access standard has been consistently exceeded at an ICS level. Level 3 NICE compliance was achieved in September 2021, evidenced through the local EIP dashboard.

Mitigating Actions

The Focus remains on maintaining a level 3 NICE compliant service. An updated service model, which includes testing of an 'At Risk Mental State' (ARMS) pathway, has been developed and built into Community Mental Health Transformation Plans. Following the testing of the ARMS pathway, an options appraisal for meeting the ARMS standards will be reviewed in April for implementation in 22/23.

Assurances

EIP Transformation meetings are in place to review progress against agreed actions.

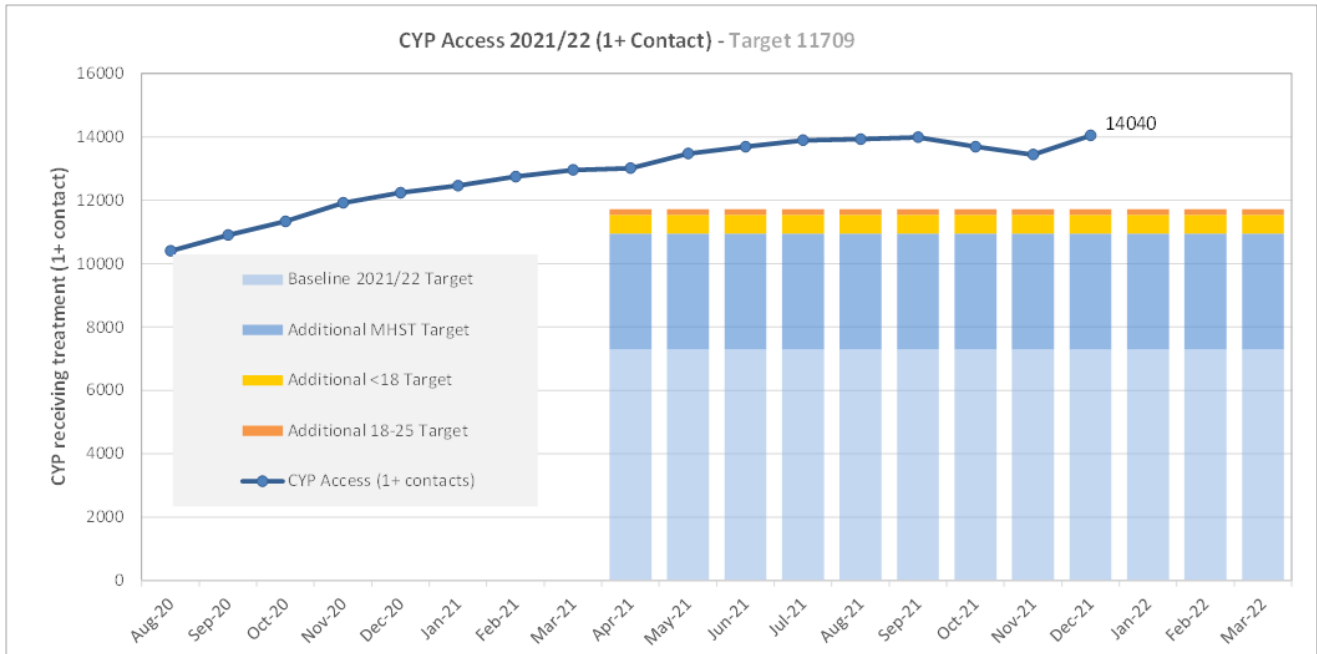
Gaps in Assurance

No gaps identified

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	Children & Young People Increasing Access	Children & Young People Increasing Access	Maxine Bunn	CCG

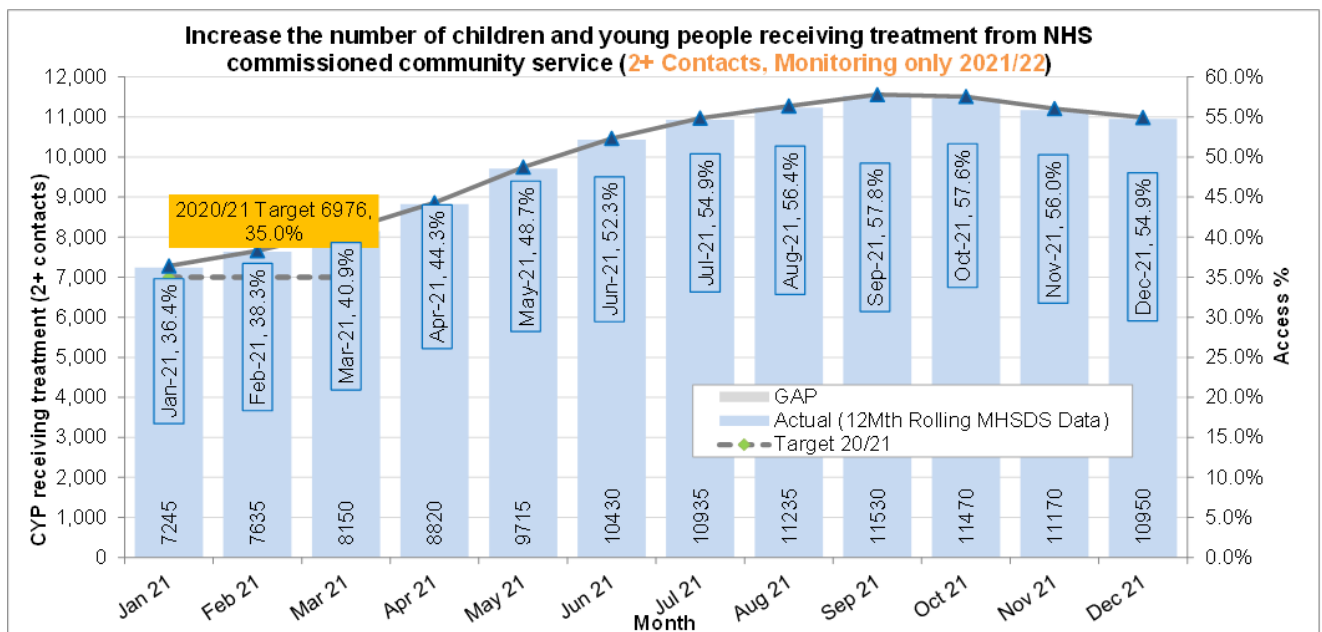
1+ Contact (Target introduced from April 2021)

Organsation	Standard	CYP Access (1+ Contact)												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	2021/22 - 11709	12460	12745	12955	13010	13470	13690	13890	13925	13985	13690	13440	14040	↑



2+ Contacts (Target removed April 2021)

Organsation	Standard	CYP Access (2+ Contacts)												Performance Direction
		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
N&N CCG	2020/21 35%	36.4%	38.3%	40.9%	44.3%	48.7%	52.3%	54.9%	56.4%	57.8%	57.5%	56.0%	54.9%	↓



Root Cause

The ICS is exceeding the new access target of number of children and young people (CYP) receiving support (1-contact); 14040 CYP were recorded as having at least 1 contact in the rolling 12 months ending December 2021, exceeding the annual plan of 11,709 this financial year.

The previous target for the number of CYP receiving support (2-contacts) continues to be reported; performance for the 12 months rolling to December 2021 (54.9%) exceeds the 2020/21 standard.

Mitigating Actions

No action required.

Assurances

Investment has been agreed to deliver the Long Term Plan objectives during 2021/22 and 2022/23 which enable service expansion and transformation across a range of services; schemes are being implemented throughout the current financial year and next. Regular multi-agency transformation meetings are scheduled which support the areas of transformation and ensure partnership working.

Gaps in Assurance

None. Local system remains a high performer for access.

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

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

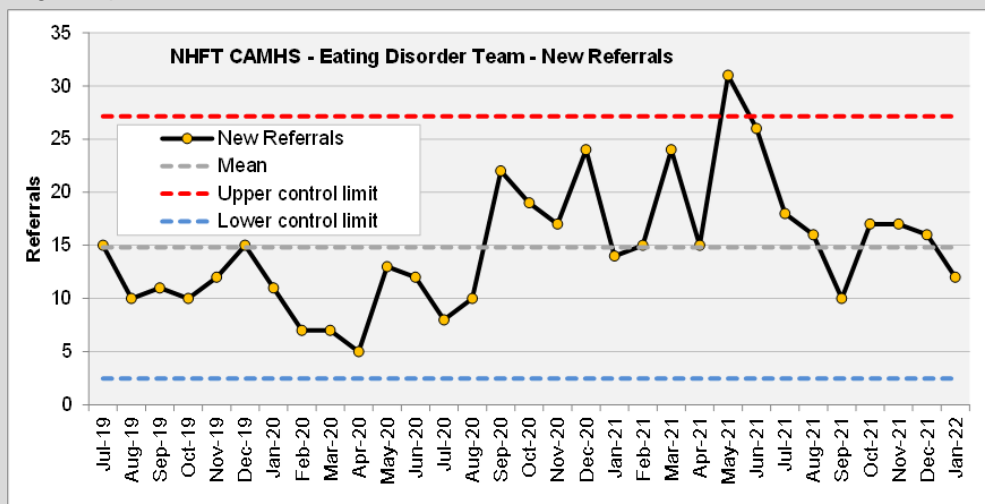
Organsation	Standard	Most Recent - Routine Complete (Rolling 4 Quarters)				Performance Direction
		Q4 2020-21	Q1 2021-22	Q2 2021-22	Q3 2021-22	
N&N CCG	95% Under 4 Weeks	86.60%	85.38%	83.93%	81.82%	↓
		97	130	112	99	N/A
Organsation	Standard	Most Recent - Urgent Complete (Rolling 4 Quarters)				Performance Direction
		Q4 2020-21	Q1 2021-22	Q2 2021-22	Q3 2021-22	
N&N CCG	95% Under 1 Week	72.22%	62.50%	59.09%	66.67%	↑
		18	24	22	18	N/A

Root Cause

Q3 data (2021/22) shows performance at 81.82% (routine) and 66.67% (urgent). Local data shows that during Q3 there were 3 breaches for routine referrals, all attributed to patient choice and 0 breachers for urgent referrals. January 2022 data shows 0 breaches for both routine and urgent referrals. February data is not yet available.

The system benchmarked the workforce against CYP ED guidance during 2021 and identified a staffing capacity gap based on number of referrals received by the service. Investment plans to address this gap were agreed as part of the Mental Health Transformation Programme for 2021/22 in order to ensure achievement of the waiting standards. However, since this time referrals have continued to increase and a recent review of the workforce against referrals (YTD) concluded that despite additional capacity being commissioned, this is not sufficient to address the increase in referrals seen within 2021/22.

From September 2020 onwards, 14 of the previous 16 months report above the mean (see below graph). This reflects the trends reported by regional peers.



The East Midlands Clinical Network have advised areas plan for sustained referral rates. Investment plans for 2022/23 have been developed in response to this increasing demand; this proposal is approved in principle and awaiting final sign off, following which a recruitment plan will be developed.

Based on the proposed increase in workforce to meet demand rate of 150 referrals per year, a recovery trajectory and action plan is being developed to show when the waiting time standard will be met. This will be available for April's assurance report.

Mitigating Actions

Recruitment in line with agreed investment is progressing; 6.2 WTE posts have been recruited, with the Speciality Doctor joining in March 2022. The remaining 1 WTE Psychology post is currently out to advert.

The revised business case to support a further increase in the workforce to meet demand has been agreed in principle with final sign off by the end of March 2022. This represents a further increase of 8.3 WTE to the current workforce (total increase of 16.7 WTE). This would create the longer-term capacity to meet sustained increase in referrals and respond within the timeframe required, enable the service to deliver the wider requirements of the access and waiting time standard.

Recovery trajectory has been set based on 150 referrals per annum. An action is being developed to monitor the monthly trajectory and will be shared as part of April's assurance update.

Assurances

All-age transformation meetings continue, which address any performance issues and agree required remedial action.

Peer review of neighbouring areas referral rates are aligned with locally reported patterns in Nottingham and Nottinghamshire complete.

Exception reporting is received as part of monthly contract reports which is received by the CCG at the end of each month.

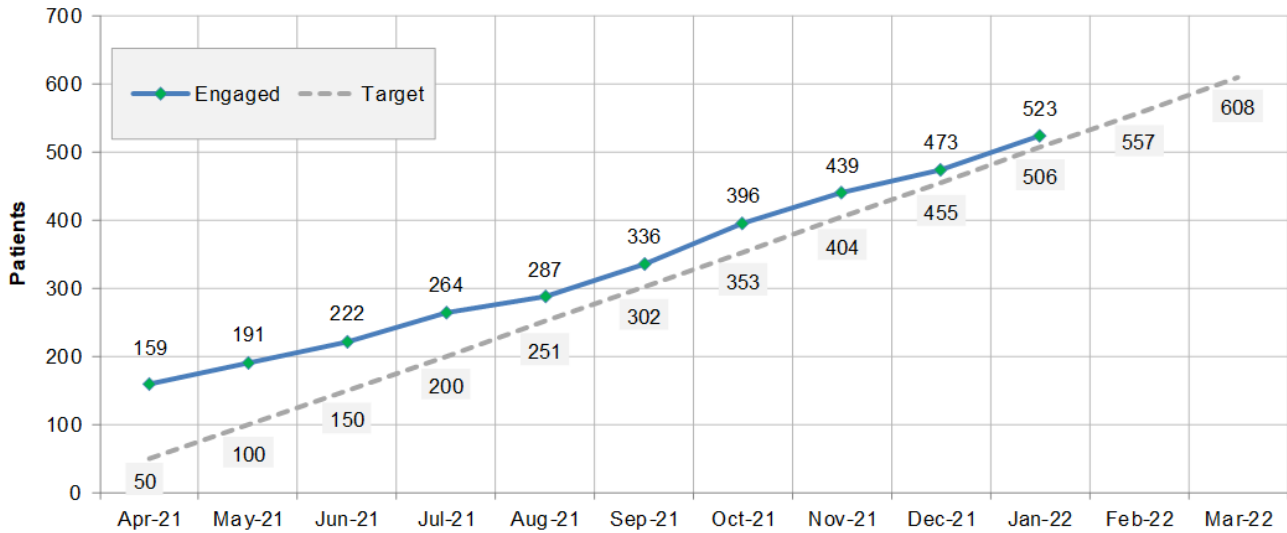
Gaps in Assurance

It not expected that referral levels will plateau. Referral trends have continued largely above the mean and the national team at NHS England advise areas to plan for a sustained response to the current level of referrals.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Mental Health	IPS	Individual Placement Support	Maxine Bunn	CCG

Organsation	Standard	IPS Service Users Engaged 2021/22											Performance Direction	
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		Mar-22
N&N CCG	Engaged	159	191	222	264	287	336	396	439	473	523			↑
	Target	50	100	150	200	251	302	353	404	455	506	557	608	N/A

IPS - Service Users Engaged 2021/22



Root Cause

The ICS continues to meet and exceed the IPS access standard performance trajectory and remains on track to achieve the 2021/22 year-end target.

Mitigating Actions

None required.

Assurances

Additional investment has been agreed in 2021/22 to enable sufficient capacity to; deliver the target (all new roles have been recruited and post holders are fully embedded in Local Mental Health Teams (LMHTs)); align the team across the ICS; and ensure equity of offer across the ICS footprint.

Proposals for further investment in line with the LTP deliverables for 2022/23 are expected to be approved in March 2022.

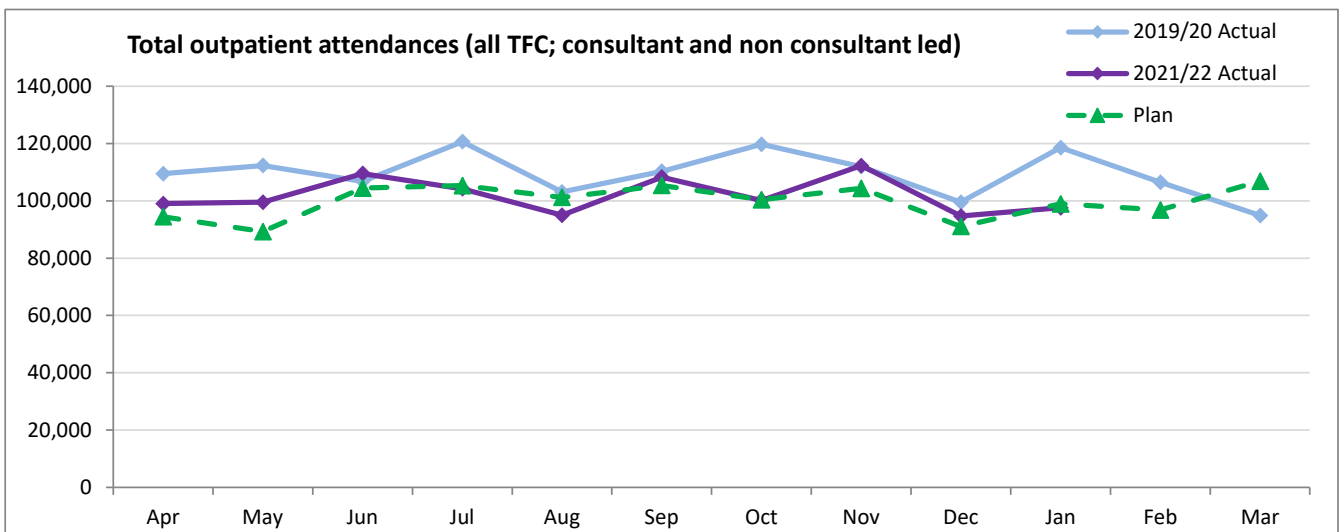
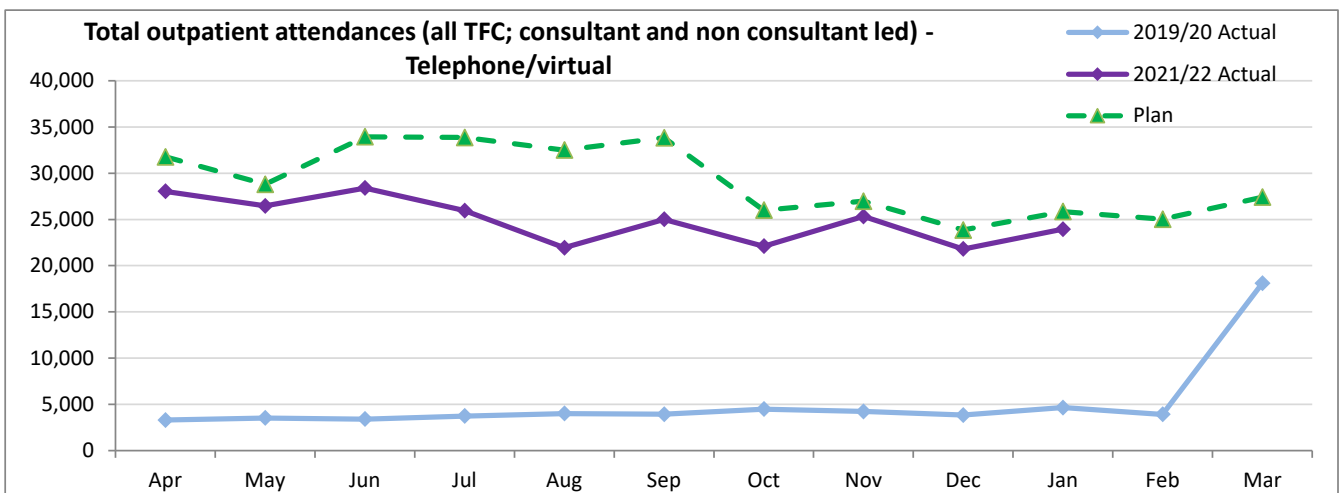
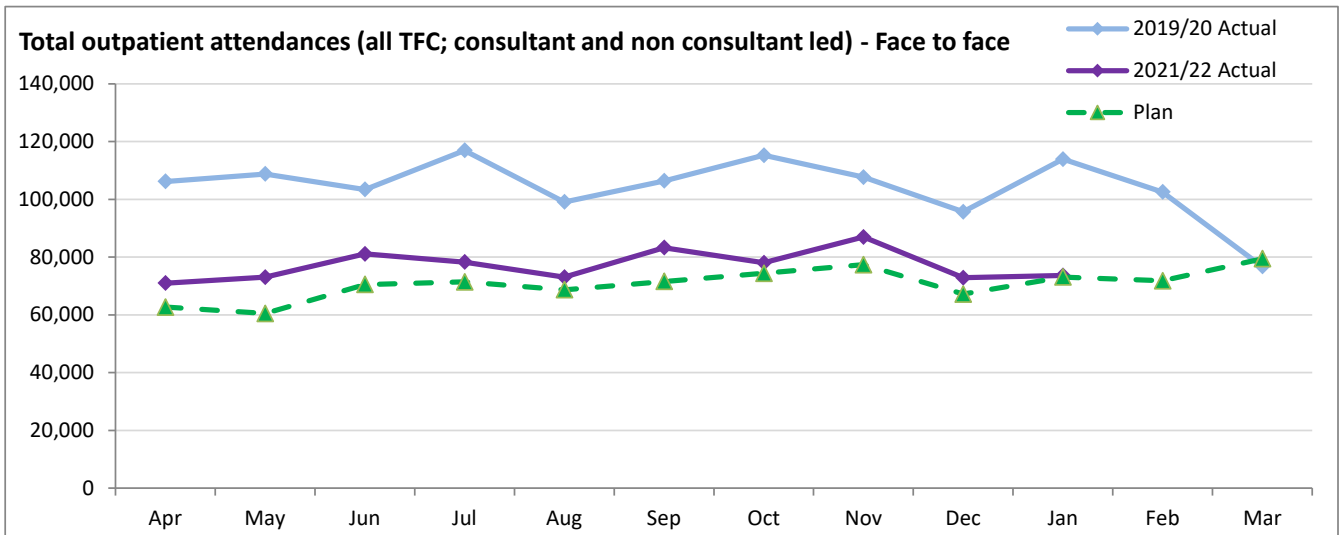
A fidelity review of the Mid Notts element of the service has been undertaken by IPS Grow, with the service being assessed as a Centre of Excellence. The proposed South Notts fidelity review will be scheduled for Q1 2022/23.

The IPS steering group continues to meet bimonthly to monitor and address performance, issues and risks.

Gaps in Assurance

None

Outpatients

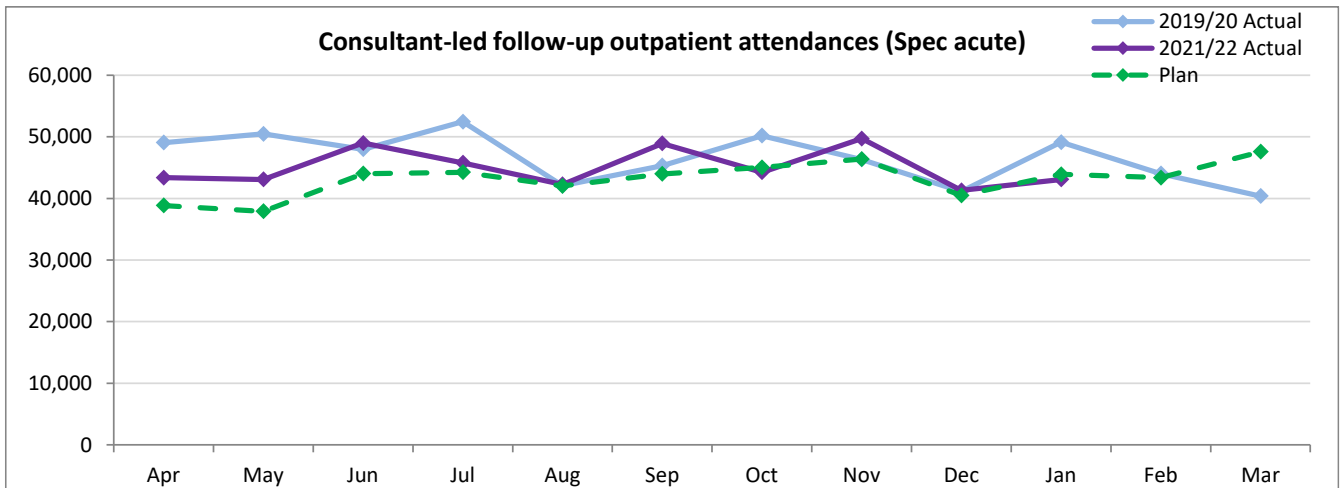
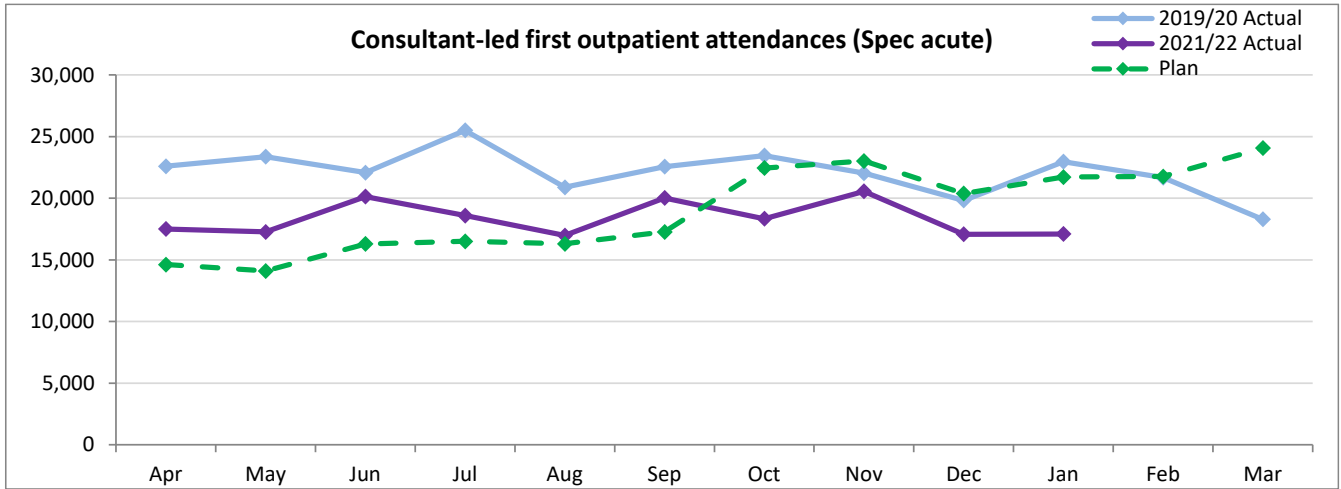


H2 Plans Monitoring (continued)



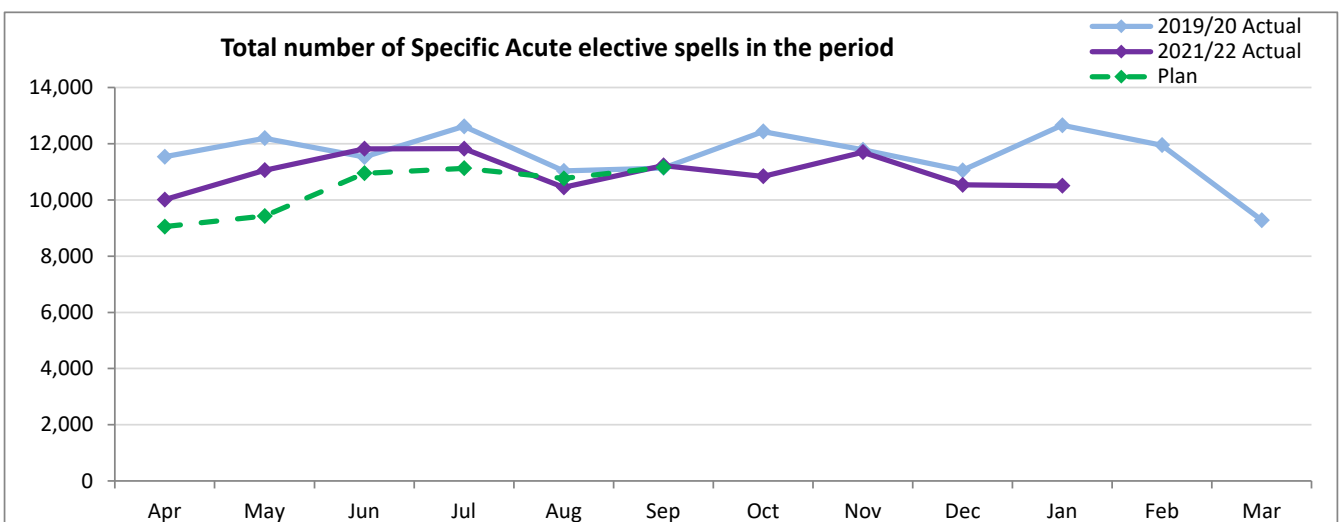
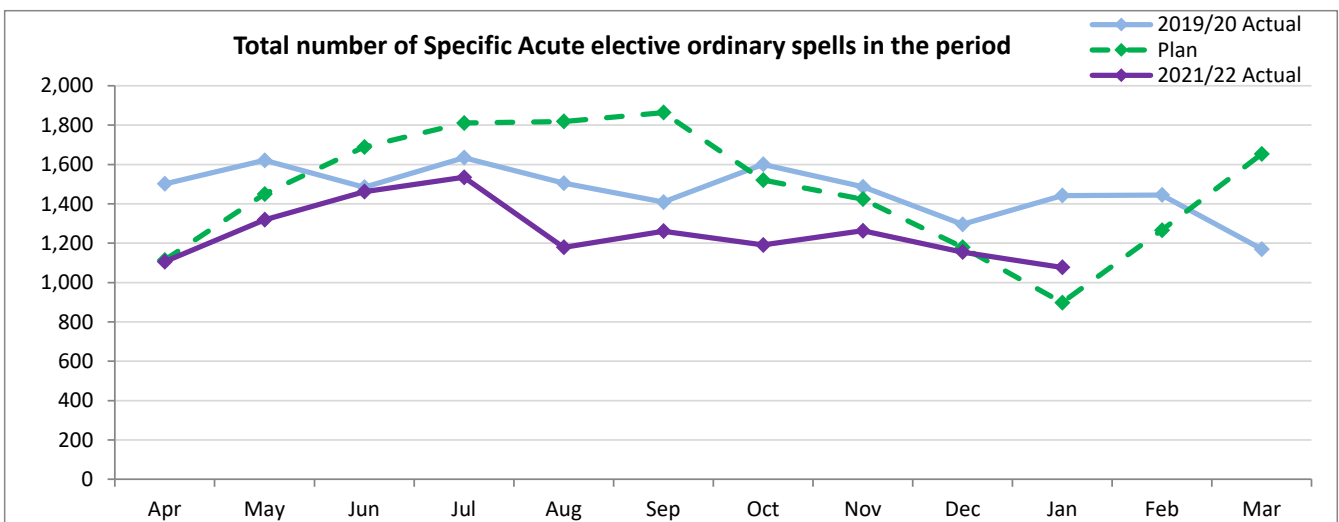
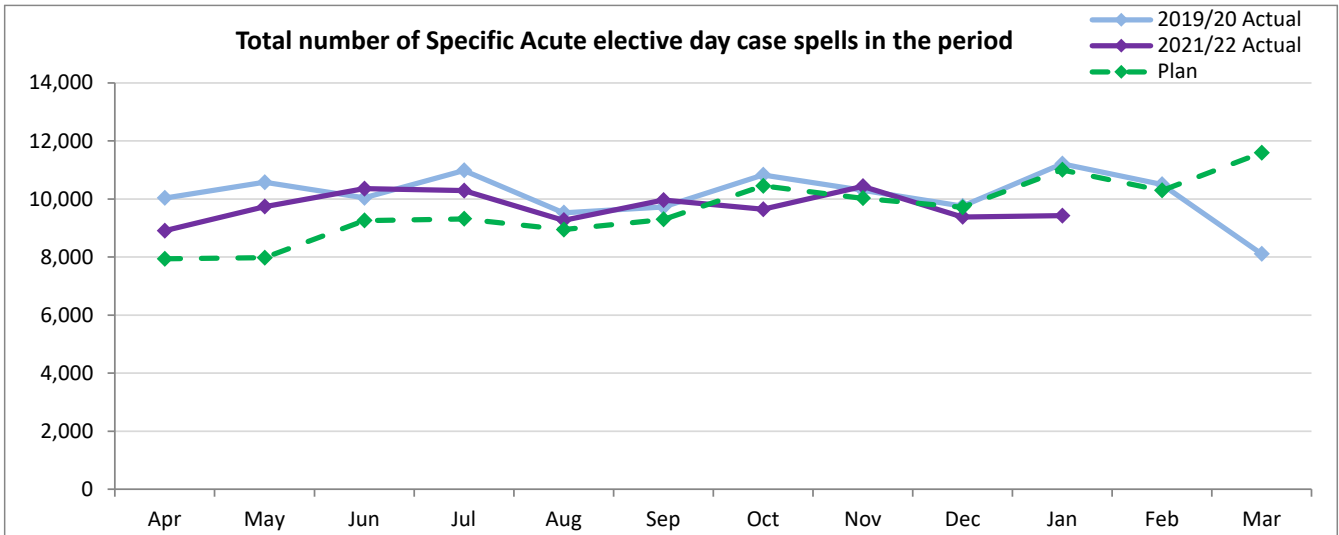
Nottingham and Nottinghamshire
Clinical Commissioning Group

Outpatients (continued)



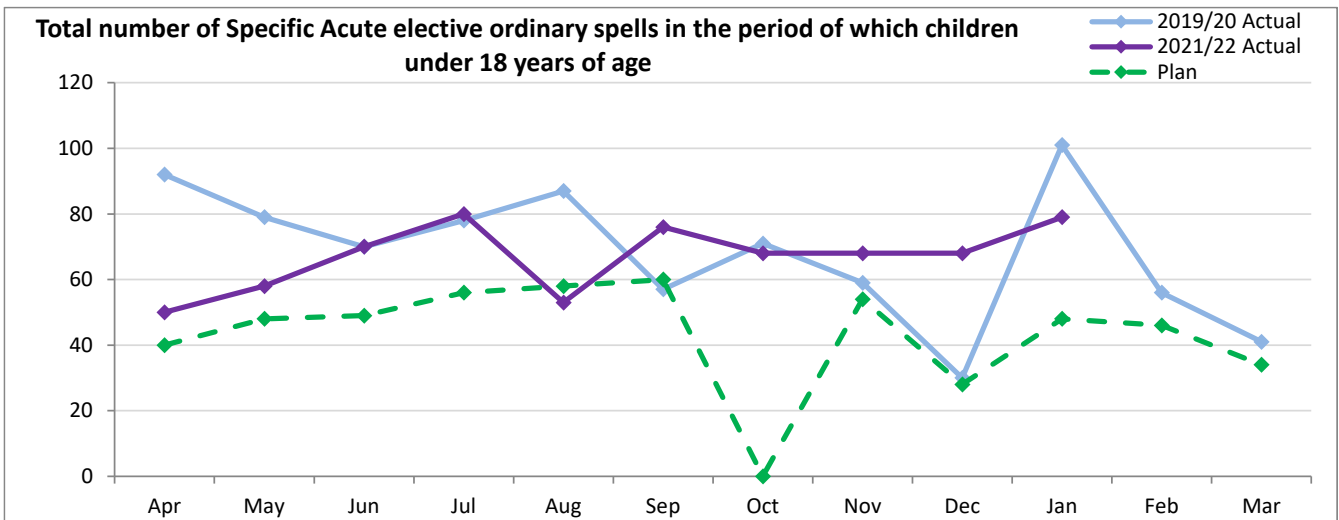
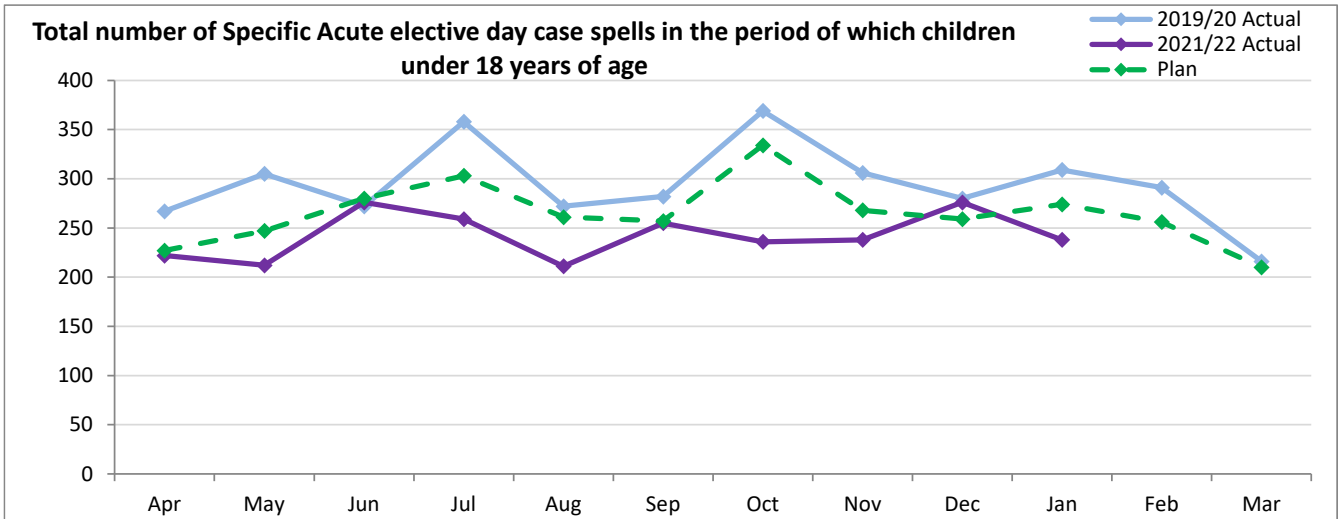
H2 Plans Monitoring (continued)

Elective



H2 Plans Monitoring (continued)

Elective (continued)

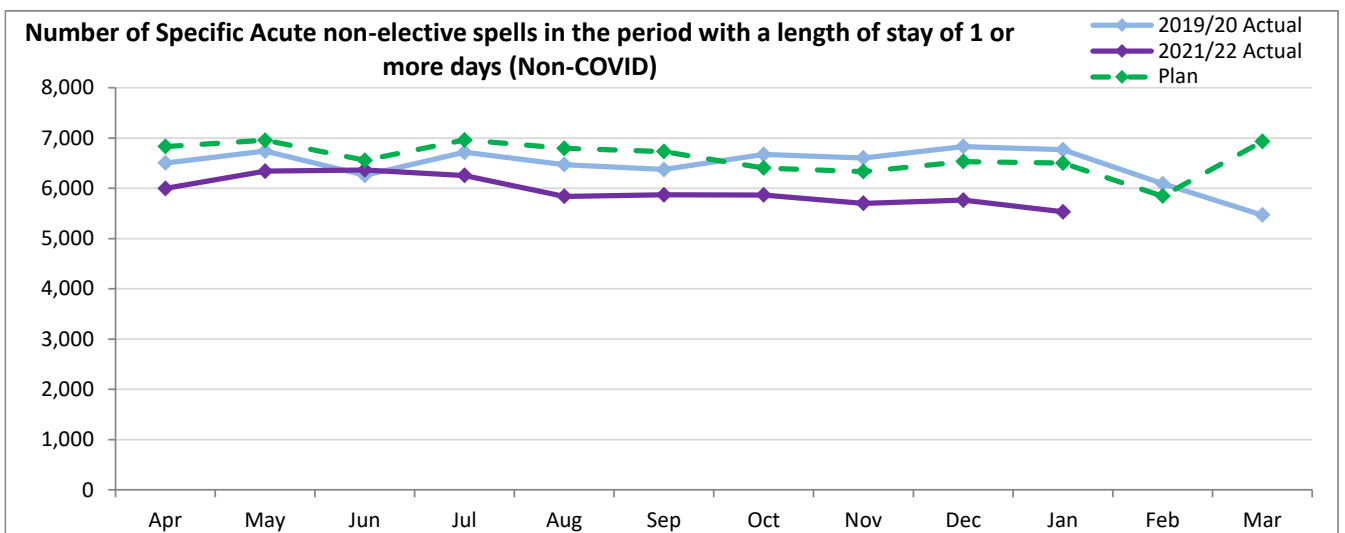
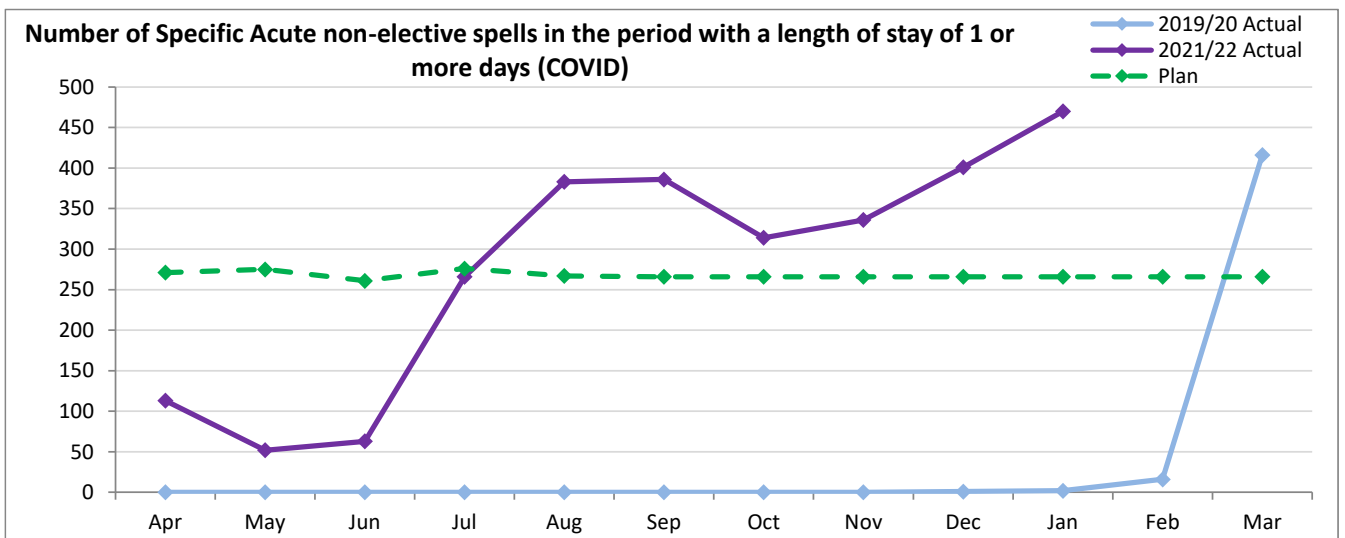
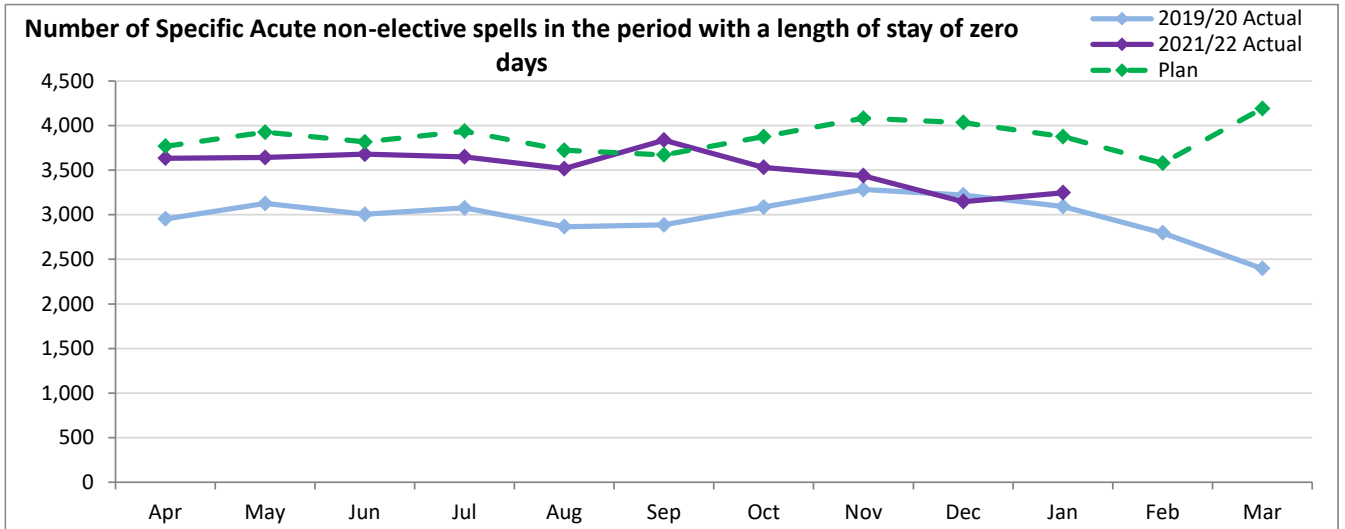


H2 Plans Monitoring (continued)



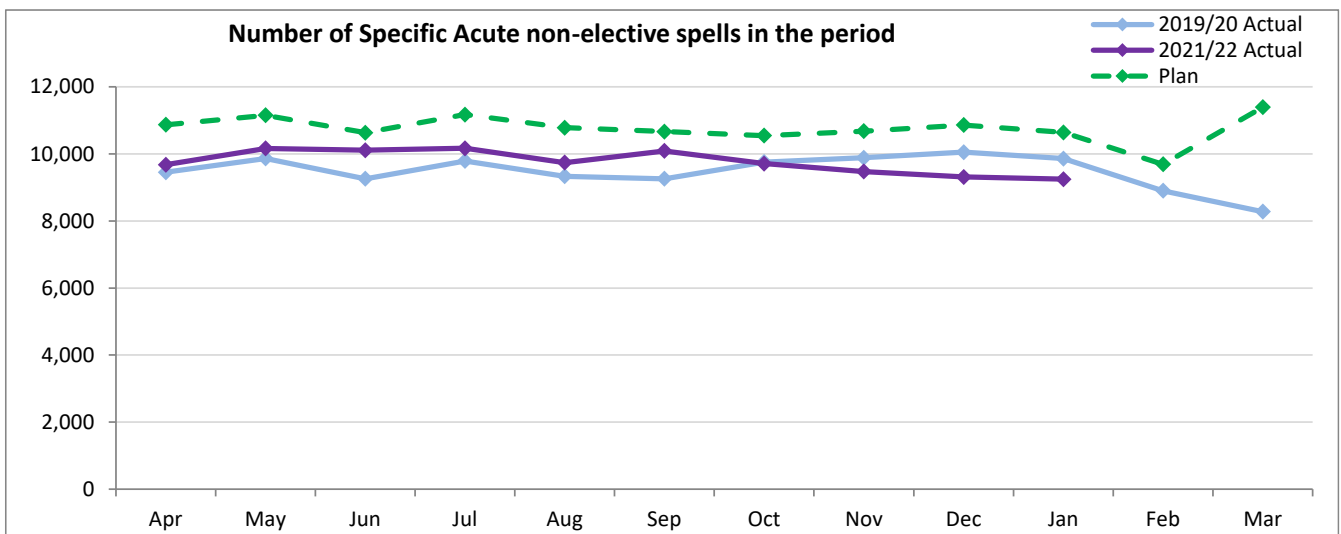
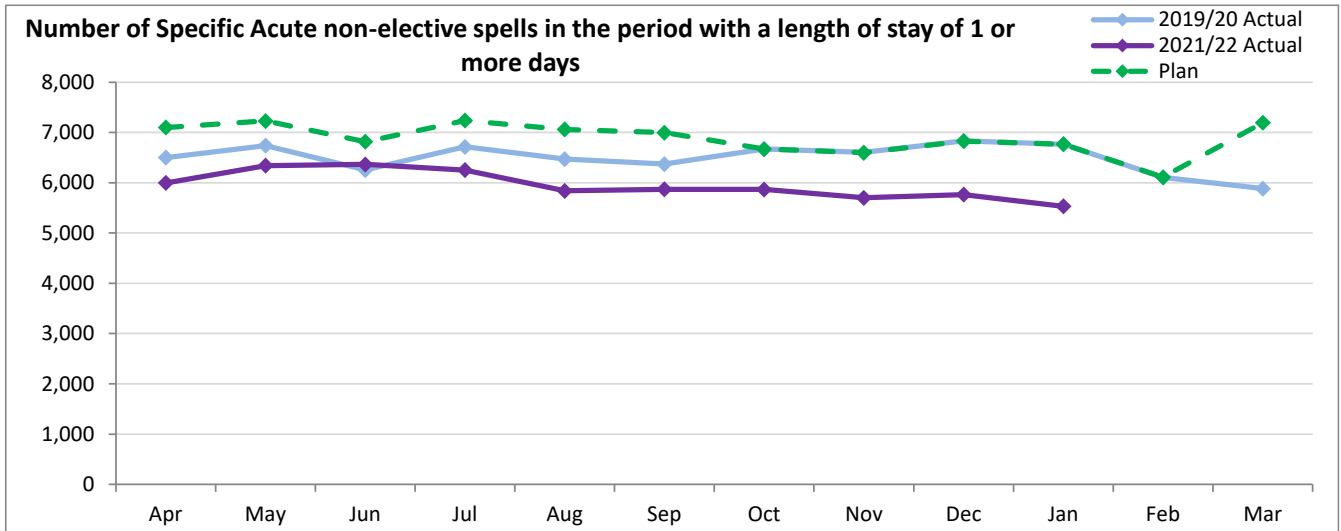
Nottingham and Nottinghamshire
Clinical Commissioning Group

Non-Elective



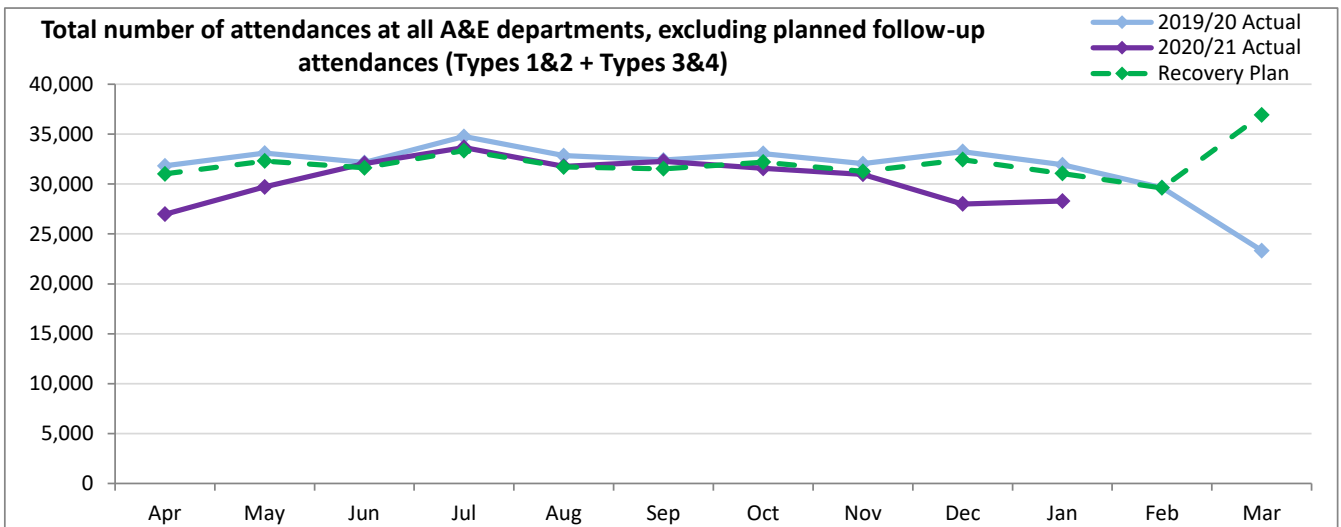
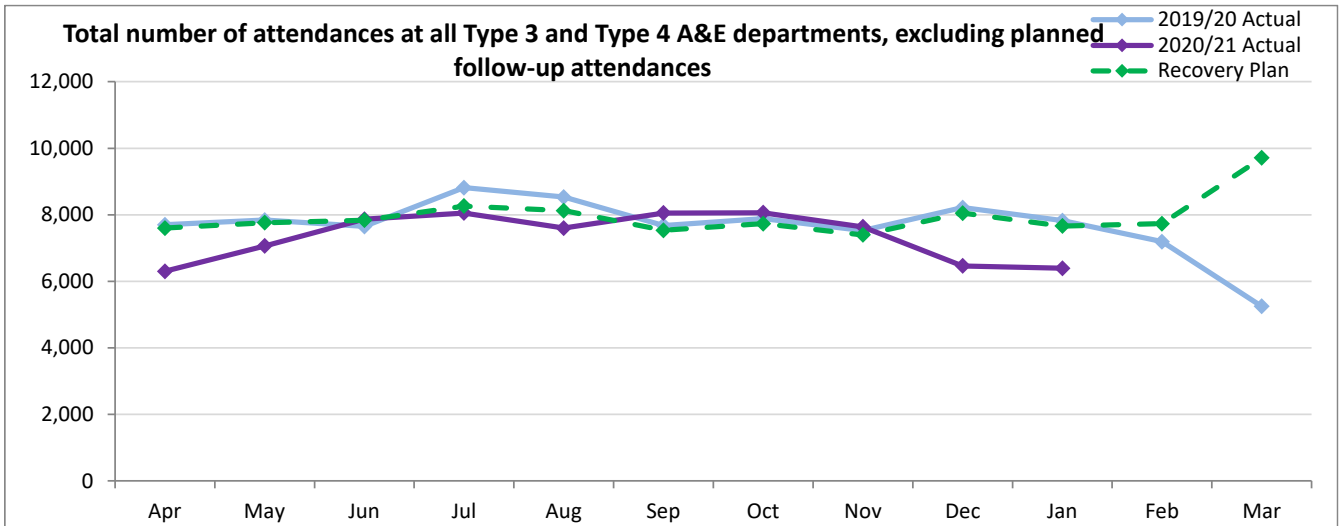
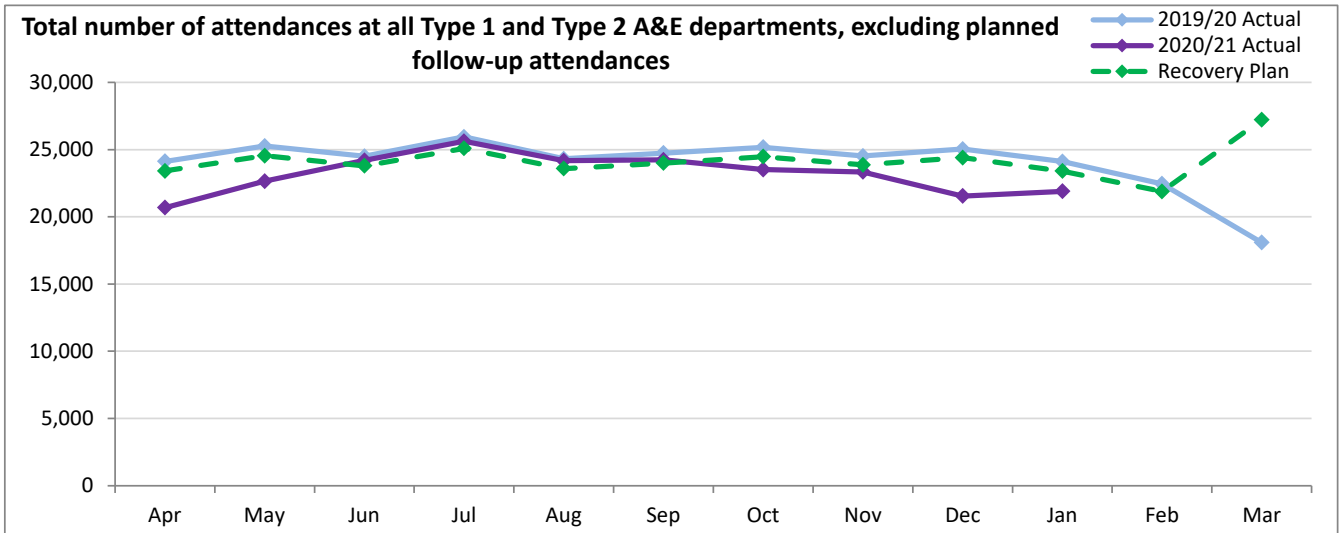
H2 Plans Monitoring (continued)

Non-Elective (continued)



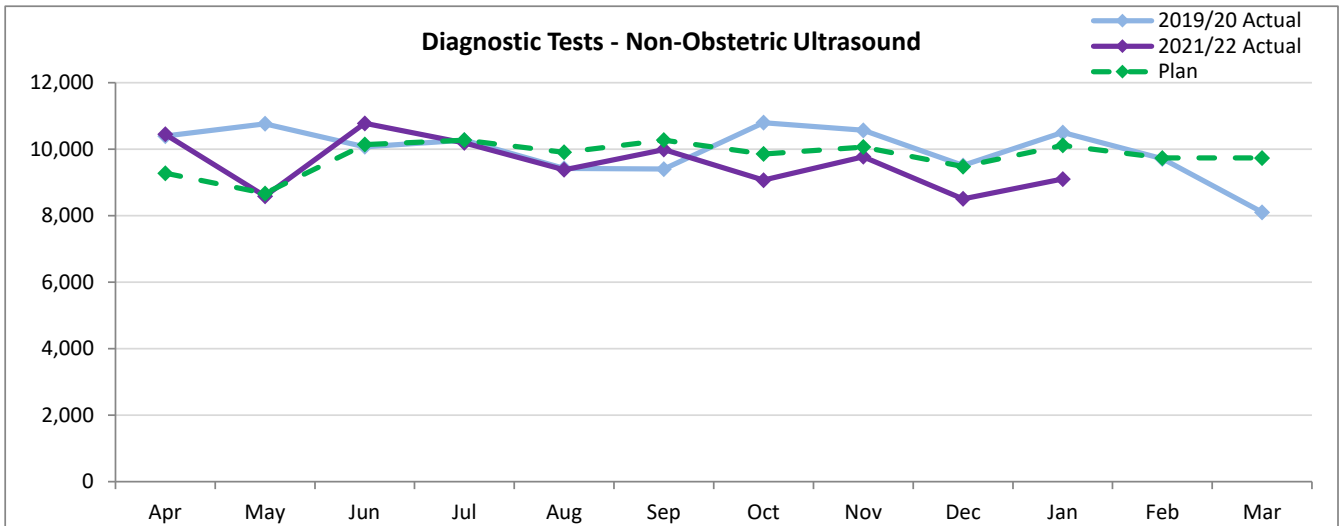
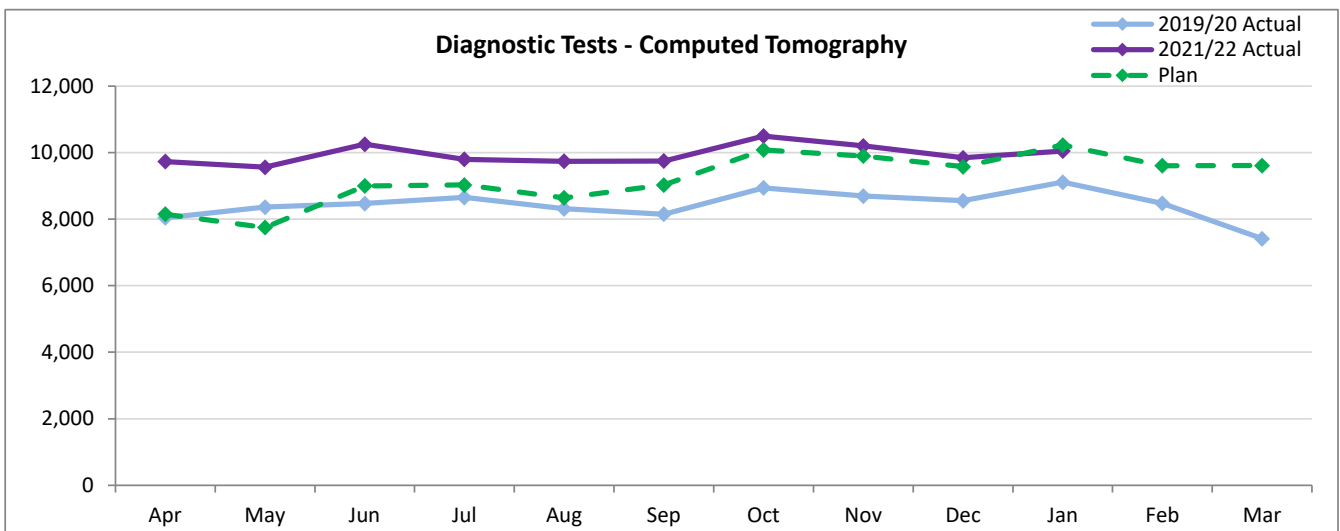
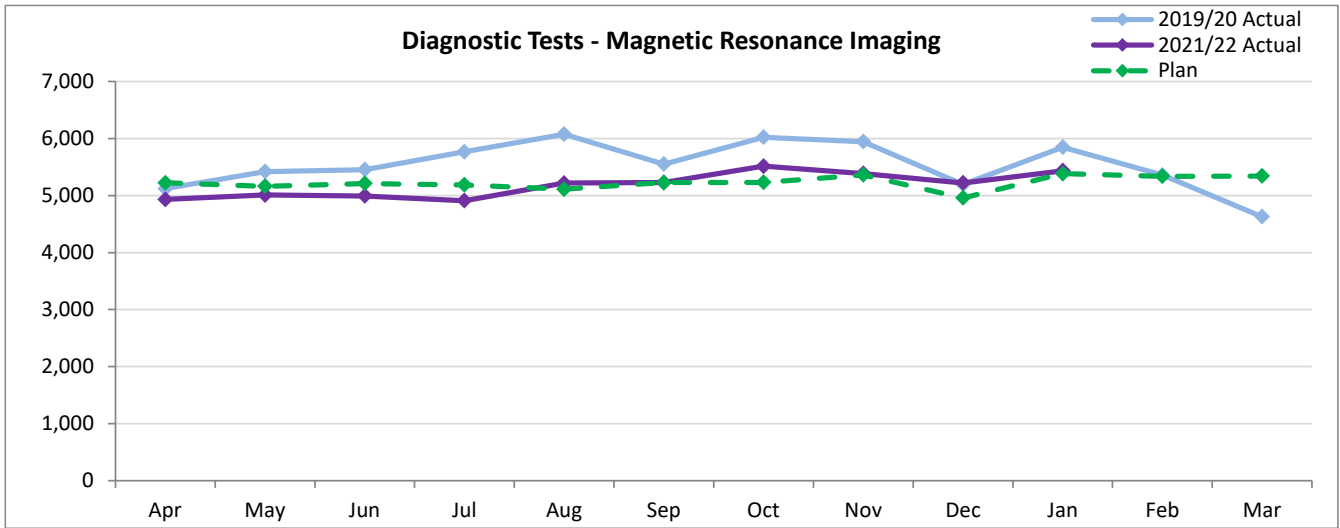
H2 Plans Monitoring (continued)

A&E



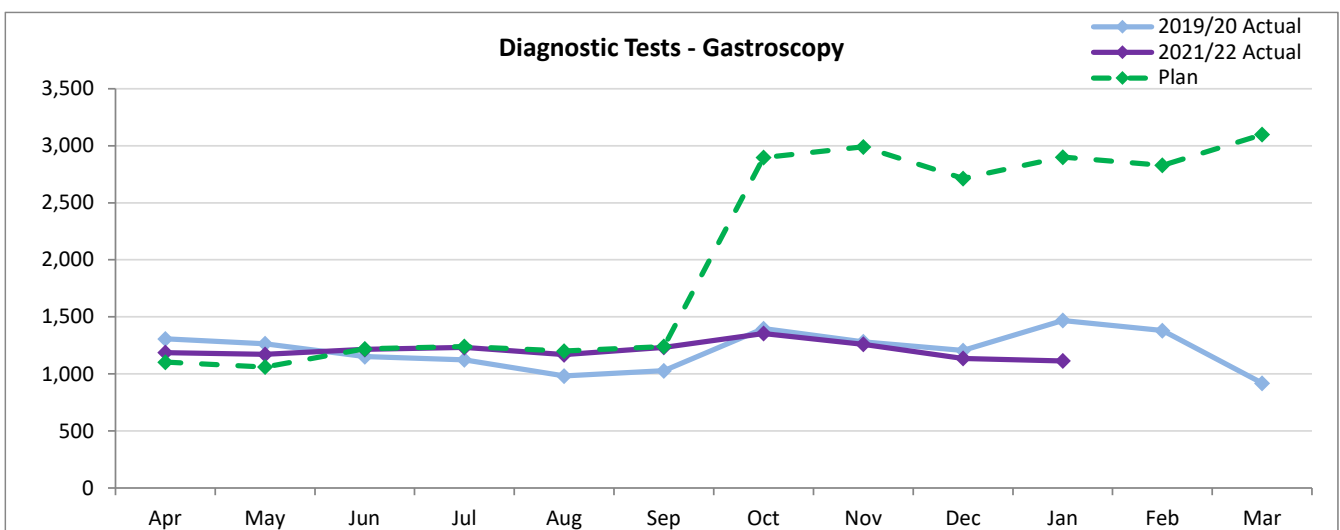
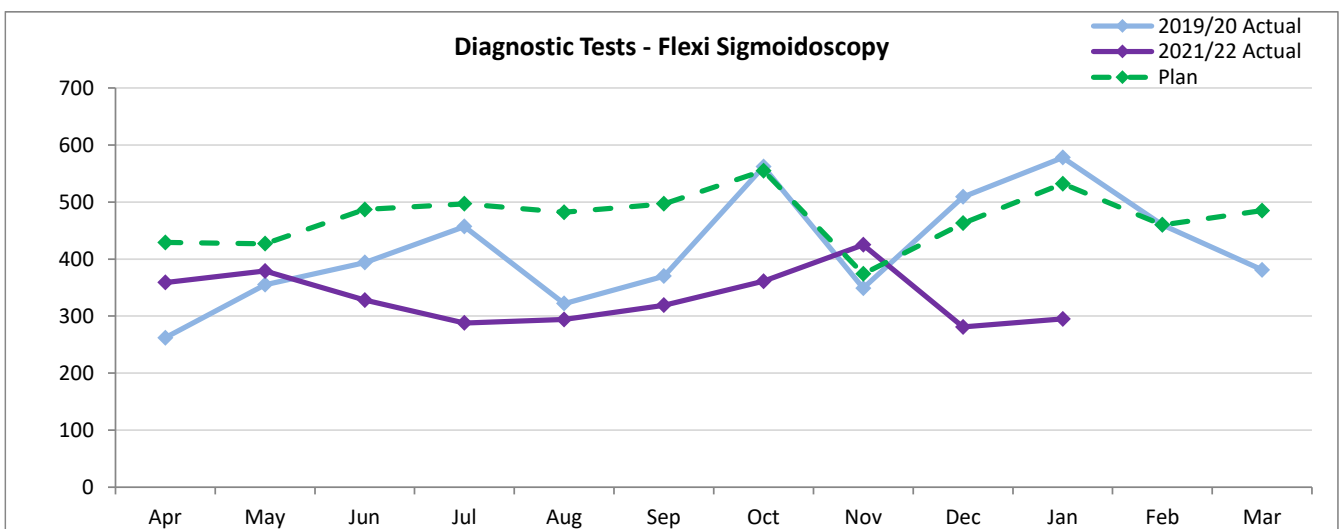
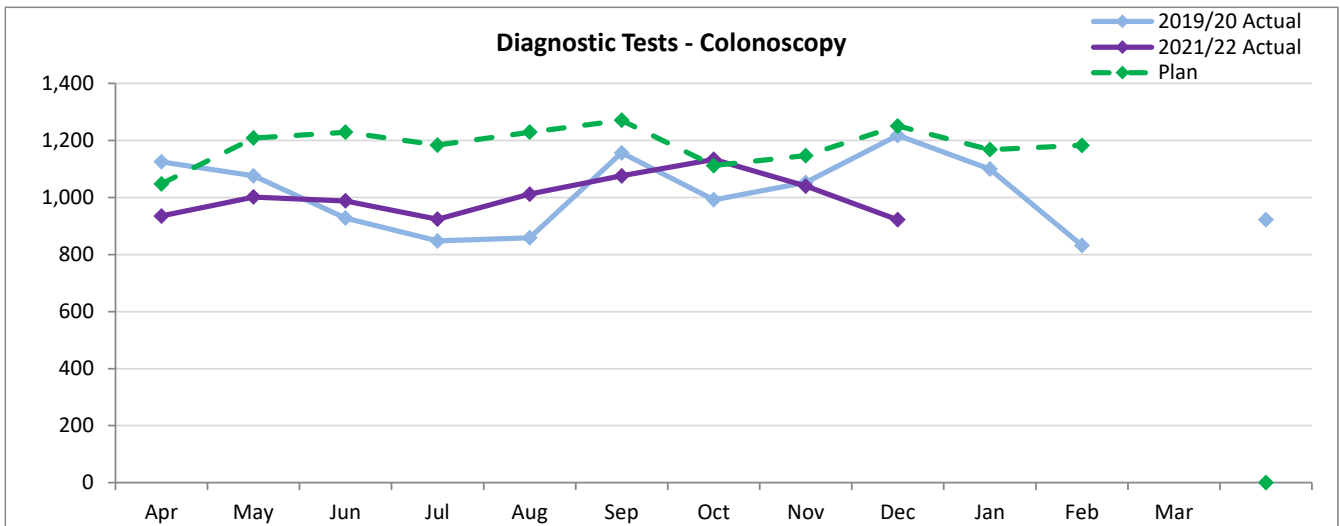
H2 Plans Monitoring (continued)

Diagnostics



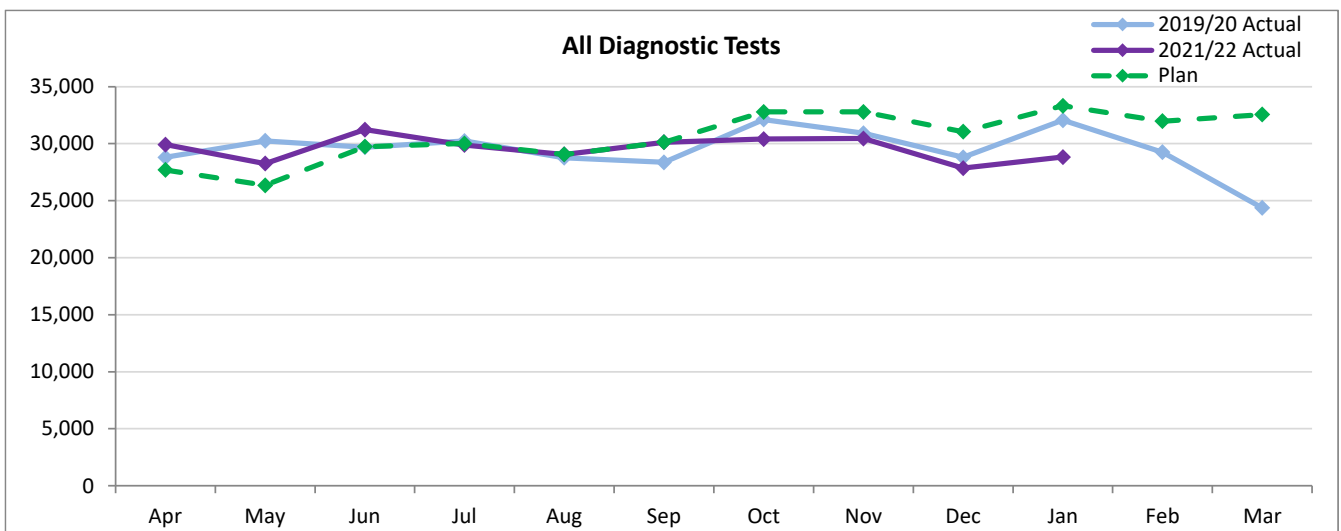
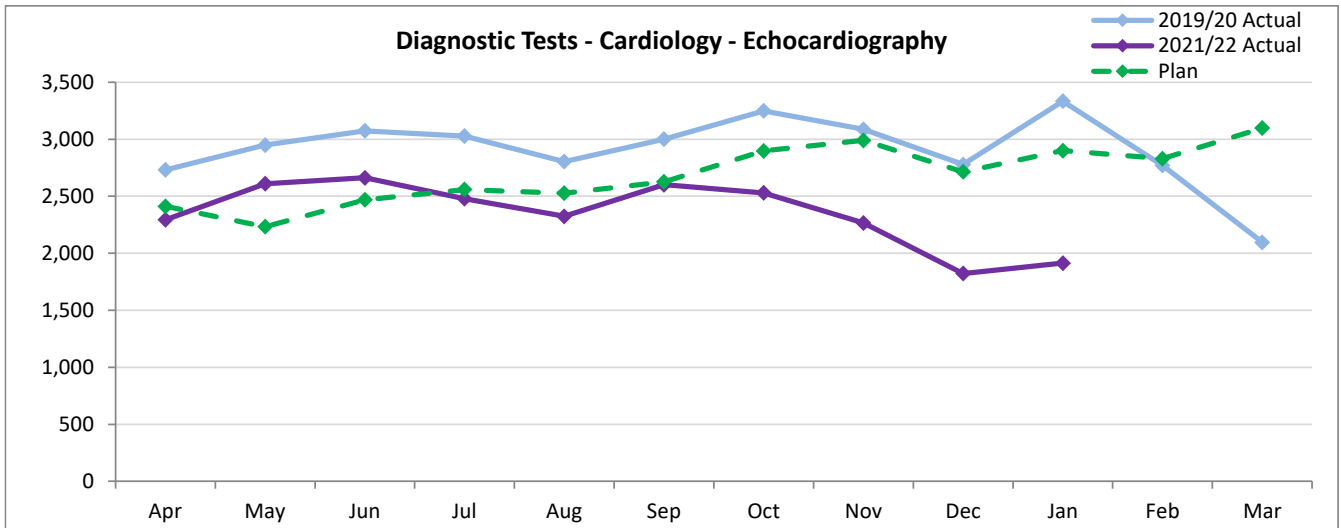
H2 Plans Monitoring (continued)

Diagnostics (continued)



H2 Plans Monitoring (continued)

Diagnostics (continued)



Theme	Indicator	Indicator	CCG Lead	Focus
Safe	C-Diff		Sandy Smith	CCG Acute Providers

C-Diff Total		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	TOTAL 2021-22
NHS	Plan	20	18	19	24	21	21	21	20	20	20	20	21	224	245
	COCA	6	3	6	3	8	3	3	0	8	3	1		44	44
	COIA	1	5	1	2	5	5	7	2	5	2	3		38	38
	COHA	8	4	6	8	8	3	5	8	4	4	1		59	59
	HOHA	5	6	6	11	13	11	12	9	9	9	13		104	104
	Total acquired	20	18	19	24	34	22	27	19	26	18	18	0	245	245
Cumulative Variance	0	0	0	0	13	14	20	19	25	23	21	0	21	0	
Sherwood	Plan	9	6	6	8	13	1	0	0	0	2	1	1	46	57
	COHA	5	4	4	4	5	1	3	3	1	3	0		33	15
	HOHA	4	2	2	4	8	6	8	1	1	3	3		42	13
	Total acquired	9	6	6	8	13	7	11	4	2	6	3	0	75	75
	Cumulative Variance	0	0	0	0	0	6	17	21	23	27	29	28	29	18
Nottingham	Plan	7	4	10	17	9	12	10	10	10	11	11	11	111	122
	COHA	4	0	3	6	4	2	2	6	5	3	1		36	18
	HOHA	3	4	7	11	5	10	5	9	13	6	8		81	30
	Total acquired	7	4	10	17	9	12	7	15	18	9	9	0	117	117
	Cumulative Variance	0	0	0	0	0	0	-3	2	10	8	6	-5	6	-5

Current issue/risk
CCG breached year to date plan 245/224
SFHT breached month 3/1 and year-end plan 75/57

Mitigating Actions (Provider)
There continues to be an increase in HOHA cases. SFHT have a remedial action plan in place and facilities for bed decontamination have been improved along with environmental cleaning.

Assurances (CCG)
System led IPC meetings are in place to support with CDI reviews and system actions. All cases are reviewed for individual learning

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Safe	MRSA		Sandy Smith	CCG Acute Providers

MRSA Total 2021-22		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	TOTAL 2021-22
NHS	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Community-onset	1	1	1	1	0	0	0	0	0	0	1		5	5
	Hospital-onset	0	0	0	0	0	0	0	0	0	1	0		1	1
	Total	1	1	1	1	0	0	0	0	0	1	0	0	6	6
	Cumulative Variance	1	2	3	4	4	4	4	4	4	5	5	6	6	6
Sherwood	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Hospital-onset	0	0	0	0	0	0	0	0	1	0	2		3	3
	Total	0	0	0	0	0	0	0	0	1	0	2		3	3
Cumulative Variance	0	0	0	0	0	0	0	0	1	1	3	3	3	3	
Nottingham	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Hospital-onset	0	0	0	0	0	0	0	0	0	1	0		1	1
	Total	0	0	0	0	0	0	0	0	0	1	0	0	1	1
	Cumulative Variance	0	0	0	0	0	0	0	0	0	1	1	1	1	1

Current issue/risk
There is a zero target for MRSA BSI. CCG is above year-end plan with 6 cases reported against 0 plan. SFHT reported 2 MRSA BSI in February.

Mitigating Actions (Provider)
A post infection review (PIR) has been initiated and any learning will be shared. Indications are that one case was a pre-48 hour community case not attributable to SFHT

Assurances (CCG)
System RCA group in place to share learning. PIRs will be completed to identify any actions for improvement.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Safe	E-Coli		Sandy Smith	CCG Acute Providers

E-Coli Total 2021-22		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	TOTAL 2021-22	
NHS Nottingham and Nottinghamshire CCG	Plan	76	76	76	76	76	76	76	76	76	76	76	75	836	911	
	COCA	55	38	39	54	56	51	49	45	37	44	31		499	484	
	COHA	14	17	14	17	11	14	14	16	12	10	13	15		153	119
	HOHA	16	11	13	13	12	14	12	11	13	13	8			136	134
	Total acquired	85	66	66	84	79	79	77	68	60	70	54	0	788	788	
Cumulative Variance	9	-1	-11	-3	0	3	4	-4	-20	-26	-48	-123		-48	-123	
Sherwood Forest Hospital NHS Trust	Plan	6	4	0	2	1	4	15	15	15	15	16	16	93	109	
	COHA	5	9	6	7	7	3	8	2	1	2	2		52	52	
	HOHA	6	4	0	2	1	4	4	3	3	4	2		33	33	
	Total acquired	11	13	6	9	8	7	12	5	4	6	4	0	85	85	
	Cumulative Variance	5	14	20	27	34	37	34	24	13	4	-8	-24	-8	-24	
Nottingham University Hospitals NHS Trust	Plan	14	7	16	14	12	16	37	37	38	38	38	38	267	305	
	COHA	10	10	11	12	5	14	8	10	10	14	14		118	118	
	HOHA	14	7	16	14	12	16	15	14	14	14	10		146	146	
	Total acquired	24	17	27	26	17	30	23	24	24	28	24	0	264	264	
	Cumulative Variance	10	20	31	43	48	62	48	35	21	11	-3	-41	-3	-41	

Current issue/risk
CCG on plan year to date.

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Safe	Klebsiella		Sandy Smith	CCG Acute Providers

Klebsiella Total 2021-22		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	TOTAL 2021-22
NHS Nottingham and Nottinghamshire CCG	Plan	18	18	18	19	19	19	19	19	19	19	19	18	206	224
	COCA	10	16	6	16	9	7	16	7	5	9	13		114	114
	COHA	6	2	4	9	3	7	7	5	4	4	4		55	55
	HOHA	6	6	8	9	8	8	5	6	11	14	3		84	84
	Total acquired	22	24	18	34	20	22	28	18	20	27	20	0	253	253
Cumulative Variance	4	10	10	25	26	29	38	37	38	46	47	29	47	29	
Sherwood Forest Hospital NHS Trust	Plan	0	1	2	0	0	3	2	2	2	3	3	2	18	20
	COHA	2	1	0	2	0	1	3	2	1	1	1		14	14
	HOHA	0	1	2	0	0	3	2	1	0	4	1		14	14
	Total acquired	2	2	2	2	0	4	5	3	1	5	2	0	28	28
	Cumulative Variance	2	3	3	5	5	6	9	10	9	11	10	8	10	8
Nottingham University Hospitals NHS Trust	Plan	7	4	8	12	12	12	12	14	16	16	16	15	129	144
	COHA	6	2	5	9	3	6	7	4	5	3	4		54	54
	HOHA	7	4	8	12	12	8	7	6	10	13	4		91	91
	Total acquired	13	6	13	21	15	14	14	10	15	16	8	0	145	145
	Cumulative Variance	6	8	13	22	25	27	29	25	24	24	16	1	16	1

Current issue/risk
New reduction objectives were released in July 21. CCG over monthly plan 20/19 and year-end plan 253/224 cases. SFHT have breached year-end plan 28/20 cases. NUHT have breached year-end plan 145/144.

Mitigating Actions (Provider)
UKHSA are supporting with case review to identify drivers, themes and any system actions

Assurances (CCG)
System led IPC RCA meetings in place to share learning and system actions. System IPC meeting planned to review BSI with urinary link

Theme	Indicator	Indicator Overview	CCG Lead	Focus
Safe	Pseudomonas		Sandy Smith	CCG Acute Providers

Pseudomonas Total 2021-22		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	TOTAL 2021-22
NHS Nottingham and Nottinghamshire CCG	Plan	6	6	7	7	7	7	6	6	6	6	6	6	70	76
	COCA	0	1	1	4	3	3	3	3	6	0	1		25	25
	COHA	1	1	2	2	2	1	0	2	0	1	4		16	16
	HOHA	2	1	1	6	5	2	2	2	4	3	3		31	31
	Total acquired	3	3	4	12	10	6	5	7	10	4	8	0	72	72
Cumulative Variance	3	5	8	16	23	26	28	32	36	40	47	47	2	-4	
Sherwood Forest Hospital NHS Trust	Plan	1	0	0	0	1	0	0	0	0	0	1	1	3	4
	COHA	0	0	0	0	1	0	0	0	0	0	0		1	1
	HOHA	1	0	0	0	1	2	1	0	1	1	0		7	7
	Total acquired	1	0	0	0	2	2	1	0	1	1	0	0	8	8
Cumulative Variance	0	0	0	0	1	3	4	4	5	6	5	4	5	4	
Nottingham University Hospitals NHS Trust	Plan	2	3	2	8	9	2	4	4	4	5	6	6	49	55
	COHA	1	2	3	1	1	2	0	2	1	4			18	18
	HOHA	2	3	2	8	9	2	6	3	3	4	2	3	44	44
	Total acquired	3	5	5	9	10	4	6	5	5	3	7	0	62	62
	Cumulative Variance	1	3	6	7	8	10	12	13	14	12	13	7	13	7

Current issue/risk
SFHT have breached year-end target 8/4 cases and NUHT have breached year-end plan 62/55.

Mitigating Actions (Provider)
SFHT/NUHT are reviewing all cases and a system assurance group is in place to support with this new work and to identify improvement actions.

Assurances (CCG)
System led IPC RCA meetings in place to share learning and system actions.

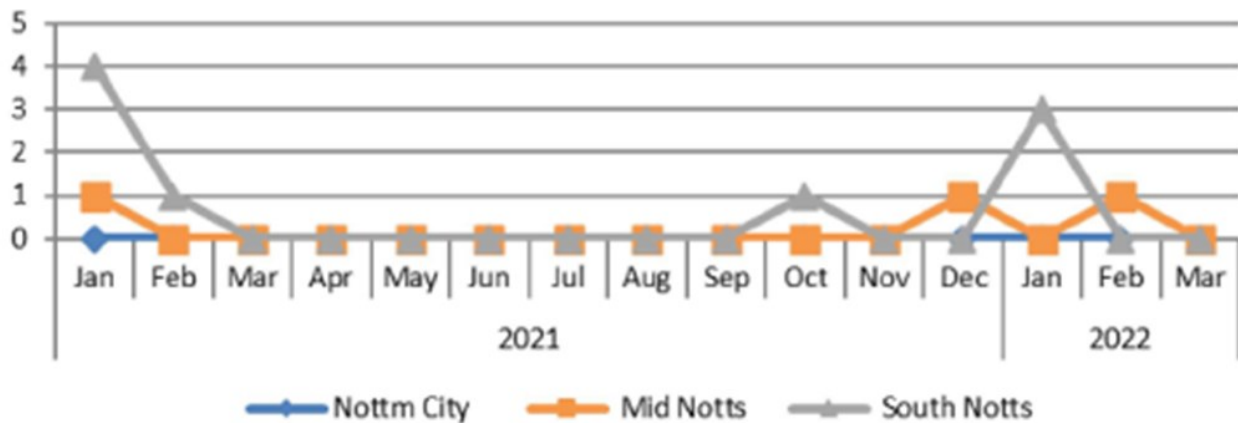
Theme	Indicator	Indicator Overview	CCG Lead	Focus
Safe	COVID-19		Sandy Smith	CCG Acute Providers

Number of confirmed COVID-19 swabbed within 8-14 days of admission	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD
													21-22
Sherwood Forest Hospital NHS Trust	2	0	0	0	3	4	5	7	13	19	17		70
Nottm University Hospitals NHS Trust	5	0	0	6	14	8	10	1	18	46	27		135

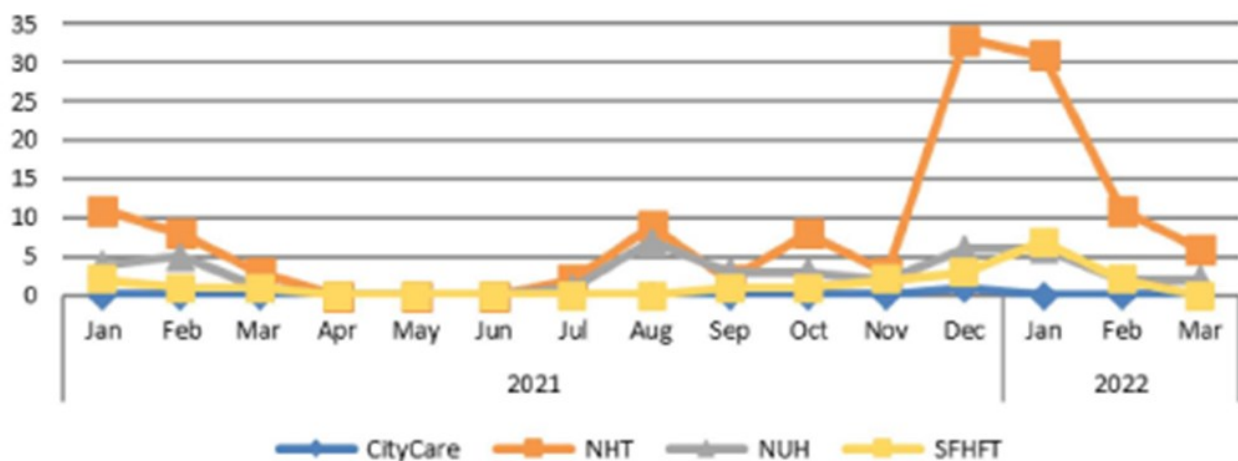
Number of confirmed COVID-19 swabbed within 15+ days of admission	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD
													2021-22
Sherwood Forest Hospital NHS Trust	0	0	1	0	1	9	4	20	26	26	13		100
Nottm University Hospitals NHS Trust	15	1	0	3	13	10	7	0	26	45	25		145

Number of COVID-19 deaths	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD
													2021-22
Sherwood Forest Hospital NHS Trust	3	1	0	9	26	27	26	30	40	45			207
Nottingham University Hospitals NHS Trust	7	6	2	21	39	61	42	47	81	93			399

New Outbreaks Reported by Primary Care ICP Over Time



New Outbreaks Reported by Provider Over Time



Current issue/risk

COVID-19 related outbreaks surged in January due to the new omicron variant. Community rates reduced initially but are starting to rise again following the easing of restrictions including the need to legally isolate. W/c 14/03/22 outbreaks are decreasing with 70 outbreaks in care homes and supported living services, 4 primary care, 5 NUHT, 2 SFHT, 18 NHC. NHS and social-care requirements are not aligned with public guidance in regard to isolation, testing and IPC requirements. This continues to cause challenges due to variation in expectations when patients and relatives are visiting services.

Mitigating Actions (Provider)

Provider BAF in use for action planning

Implementation of IPC advice, guidance and training support. Increased testing, cohorting/zoning positive cases, contact cases from those currently negative.

Enhanced cleaning schedules.; Monitoring PPE use with audits and 'spot checks' of compliance.

Reduced staff movement across different sites and services; Promoting staff vaccination.

Action plans developed following CIPCT audit. Review of outbreaks and nosocomial infections for shared learning and improvement

Use of air scrubbers to improve ventilation in primary and secondary care.

Public health messaging re IPC expectations when visiting health services and IPC system 'no change' poster.

Assurances (CCG)

- Weekly/Monthly IPC system assurance meetings with escalation to ICS Quality Group,
- Public Health COVID-19 outbreak meetings 3 x week. 3X weekly care homes taskforce meetings
- SI reporting of COVID deaths and those meeting criteria on StEIS, reports are shared with CCG quality team.

Theme	Indicator	Indicator	CCG Lead	Focus
Safe	Individual Funding Requests & Service Restricted Procedures		Sandy Smith	CCG Acute Providers

Type of Request	% of SRP assessments completed within 10 days (target 100%)	% of IFR decision made within 40 days (target >100%)	Approved						Not Approved					
			Jul	Aug	Sep	Oct	Nov	Dec	Jul	Aug	Sep	Oct	Nov	Dec
Fertility Requests	100%	100%	5	4	10	3	10	11	1	0	2	1	2	4
Online Prior Approval Requests	100%	100%	1228	1099	1362	1425	1369	1062	17	14	52	16	61	30
Prior Approval Requests	100%	100%	686	638	724	628	655	551	85	81	105	102	145	89
Out of Area Requests	100%	100%	2	3	0	3	0	0	3	0	2	0	0	0
Treatment Abroad Requests	100% NHSE Target of 7-day turnaround		0	0	0	1	0	0	0	0	0	0	0	0
IFR Requests		100%			0	1	2	0	4		4	4	5	5

Fertility Requests

NHS Nottingham & Nottinghamshire CCG updated the Gamete and Embryo storage eligibility criteria in July 2020. Of the 11 requests for storage, 10 patients were approved to store products prior to commencing treatment where they are at risk of permanent infertility, including those receiving cancer treatment and 1 request was not approved. 2 requests were for IVF, both requests were declined as the couple did not meet the eligibility criteria. 1 request was for IUI / AI / DI (prior to IVF), this was not approved, and 1 request was for Sub-Fertility Treatment, which was approved.

Online Prior Approval Requests

The IFR Team are responsible for the triaging and monitoring of online prior approvals from secondary care providers. We received a total of 1092 online prior approval requests. Out of the 1092, 1062 were approved and 30 were not approved. The 100% indicator refers to the turnaround time as stated in the Service Restriction Policy. Indicator remains consistent meeting the 100% target, so no exception reported is required.

Prior Approval Requests

The CCG IFR Team have a 10-working day turnaround from date of receipt for all Primary Care requests.

The IFR Team are responsible for the triaging and monitoring of prior approval request from GP's. We received a total of 640 prior approval requests. Out of the 640, 655 were approved and 145 were not approved. The 100% indicator refers to the turnaround time as stated in the Service Restriction Policy. Indicator remains consistent meeting the 100% target, so no exception reported is required.

Out of Area Treatment

The IFR Team are responsible for the triaging and monitoring of Out of Area Requests from both GP's and secondary care Consultants. No requests were received in December 2021.

Treatment Abroad

Nottingham and Nottinghamshire CCG IFR Team have been identified to the team as the appropriate lead to be able to provide them with a written response to treatment abroad requests. Whilst treatment abroad requests are not included in the service restricted policy, in the absence of any formal indicator the CCG IFR Team use the NHS E response time of 7 days. Indicator remains consistent meeting the 100% target, so no exception reported is required. No requests were received in December 2021.

IFR Requests

In line with the CCGs IFR Policy all requests must be acknowledged, screened, and considered by the Panel (if exceptionality is demonstrated within 40 days of the receipt of the application. 5 requests have been received this month; 5 requests were declined at the screening stage. Indicator remains consistent meeting the 100% target from last month and so no exception reporting is required.

Glossary

Acronym	Meaning	Acronym	Meaning
A&E	Accident and Emergency	LD	Learning Disabilities
A&E DB	Accident and Emergency Delivery Board	LoS	Length of Stay
ACS	Accountable Care System	LTWB	Let's Talk Well Being
ADD	Attention Deficit Disorder	MHST	Mental Health Support Team
ADHD	Attention Deficit and Hyperactivity Disorder	MN	Mid Nottinghamshire
ANP	Advanced Nurse Practitioner	MOU	Memorandum of Understanding
ASD	Autism Spectrum Disorder	NEL	Non-Elective
BAU	Business As Usual	NEMS	Nottinghamshire Emergency Medical Services
CBT	Cognitive Behavioural Therapy	NHCT	Nottinghamshire Healthcare NHS Trust
CCG	Clinical Commissioning Group	NHSE	NHS England
CETR	Care Education and Treatment Review	NHSI	NHS Improvement
CFIDD	Community Forensic Intellectual and Development Disability Service	NNICS	Nottingham & Nottinghamshire ICS
CHC	Continuing Healthcare	NICE	National Institute for Health and Care Excellence
CoP	Court of Protection	NUH	Nottingham University Hospitals NHS Trust
CQUIN	Commissioning for Quality and Innovation	OAPs	Out of Area Placements
CT	Computed Tomography	OBD	Occupied Bed Days
CV	Contract Variation	OP	Outpatient
CP	Children and Younger People	PCN	Primary Care Network
DCO	Director of Commissioning Operations	PHE	Public Health England
DST	Decision Supporting Tool	PHSMI	Physical Health for SMI patients
DToC	Delayed Transfer of Care	PICU	Psychiatric 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 Upper GI or Lower GI	SLA	Service Level Agreement
GN	Greater Nottingham	SLAM	Service Level Agreement Monitoring
HEE	Health Education England	SMI	Severe Mental Illness
HFID	Home First Integrated Discharge	SOP	Standard Operating Procedure
IAPT	Improving Access to Psychological Therapies	SRO	Senior Responsible Officer
IBN	Information Breach Notice	STP	Sustainability and Transformation Plan
ICATT	Intensive Community Assessment and Treatment Team	TCP	Transforming Care Partnership
ICP	Integrated Care Partnership	UEC	Urgent & Emergency Care
ICS	Integrated Care System	UTC	Urgent Treatment Centre
IR	Identification Rules	YOC	Year of Care
KMH	Kings Mill Hospital	YTD	Year to Date



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	Highlight report from the (virtual) meeting of the CCG's Audit and Governance Committee	Paper Reference:	GB 22 018
Chair of the meeting	Sue Sunderland, Non-Executive Director	Attachments/ Appendices:	-
Summary Purpose:	Approve <input checked="" type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
		Receive/Note for:	<input checked="" type="checkbox"/>
		<ul style="list-style-type: none"> • Assurance • Information 	

Summary of the Meeting

The Audit and Governance Committee met on the 3 March 2022. Due to the current Coronavirus (Covid-19) restrictions, the meeting was held virtually.

At the meeting, the Committee:

- **RECEIVED ASSURANCE** from regular reports on key areas of Committee business relating to:
 - The Tender Waiver Register
 - Off payroll arrangements
 - Counter Fraud
 - Information Governance
 - Training Compliance

- **REVIEWED** in detail the findings of an Internal Audit Report relating to the health service element of the Nottinghamshire Multi-Agency Safeguarding Hub (MASH), which had provided 'limited assurance'. The Committee commended the CCG for proactively requesting an Internal Audit review, which gave a helpful focus to address the issues raised in the report. Members sought, and received, assurance that no harm had come to service users because of the issues and that action was already being taken to address the concerns. The Committee agreed a way forward for the Quality and Performance Committee to receive regular updates on the progress of the action plan to address all concerns in the report.

- **REVIEWED** the findings of an Internal Audit Report relating to the CCG's financial systems, which had provided 'significant assurance'. However, one medium risk had been identified relating to the late processing of HR paperwork, which had the potential to lead to salary overpayments. The Committee received assurance that actions had already been out in place to mitigate this risk.

For this section of the meeting, the Committee met 'in common' with the Audit Committee of Bassetlaw CCG.

During this section, the Committee:

- **RECEIVED ASSURANCE** on the progress of the CCG's joint Due Diligence Plan, noting no significant risks or concerns to date. Due to the extended period of CCG operation, the timeline and plan for the completion of the due diligence work had been amended.
- **NOTED** the External Audit Value for Money Risk Assessments for both CCGs. These assessments summarised the areas where the CCGs had a risk that value for money was not being achieved. Two significant risks had been identified for both CCGs relating to financial sustainability and governance: risks that were commensurate with all other CCGs transitioning to Integrated Care Boards. Specifically, for Nottingham and Nottinghamshire CCG, the financial sustainability risk also included the issue of the underlying deficit; and for both CCGs, the governance risk also included the anticipated boundary change for Bassetlaw CCG. Work will now commence to assess to what extent the CCGs had mitigated these risks and an overall conclusion would be brought back to the committees in due course.

Key Messages for the Governing Body

- Good level of assurance received from all reports.

The ratified minutes of the meeting will be received by the Governing Body on the 6 April 2022.



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	2021/22 Governing Body Assurance Framework: Year-end Position and 2022/23 Q1 Proposal	Paper Reference:	GB 22 019
Sponsor:	Rosa Waddingham, Chief Nurse	Attachments/ Appendices:	Appendix A – 2021/22 GBAF Year-end Assessment Appendix B – Full 2021/22 GBAF
Presenter:	Lucy Branson, Associate Director of Governance		
Purpose:	Approve <input checked="" type="checkbox"/> Endorse <input type="checkbox"/> Review <input checked="" type="checkbox"/>	Receive/Note for: <input checked="" type="checkbox"/> <ul style="list-style-type: none"> • Assurance • Information 	

Executive Summary

The purpose of the paper is to present the year-end position of NHS Nottingham and Nottinghamshire CCG's 2021/22 Governing Body Assurance Framework (GBAF) for scrutiny and comment.

The paper also outlines the proposed approach for the GBAF for Q1 of 2022/23, in line with the anticipated disestablishment of the CCG on 30 June 2022 (subject to legislation).

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	<input checked="" type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input checked="" type="checkbox"/>
Financial Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input checked="" type="checkbox"/>
Performance Management	<input checked="" type="checkbox"/>	Procurement and/or Contract Management	<input checked="" type="checkbox"/>
Strategic Planning	<input checked="" type="checkbox"/>		

Conflicts of Interest:

No conflict identified

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not required for this paper.
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not required for this paper.

Risk(s):

Appendix B outlines the CCG's 16 strategic risks, which may impact achievement of the strategic objectives.

Confidentiality:

No

Recommendation(s):

1. **REVIEW** and **COMMENT** on the 2021/22 year-end position of NHS Nottingham and Nottinghamshire CCG's GBAF; and
2. **APPROVE** the proposed approach for the GBAF for Q1 2022/23, in line with the anticipated disestablishment of the CCG on 30 June 2022 (subject to legislation).

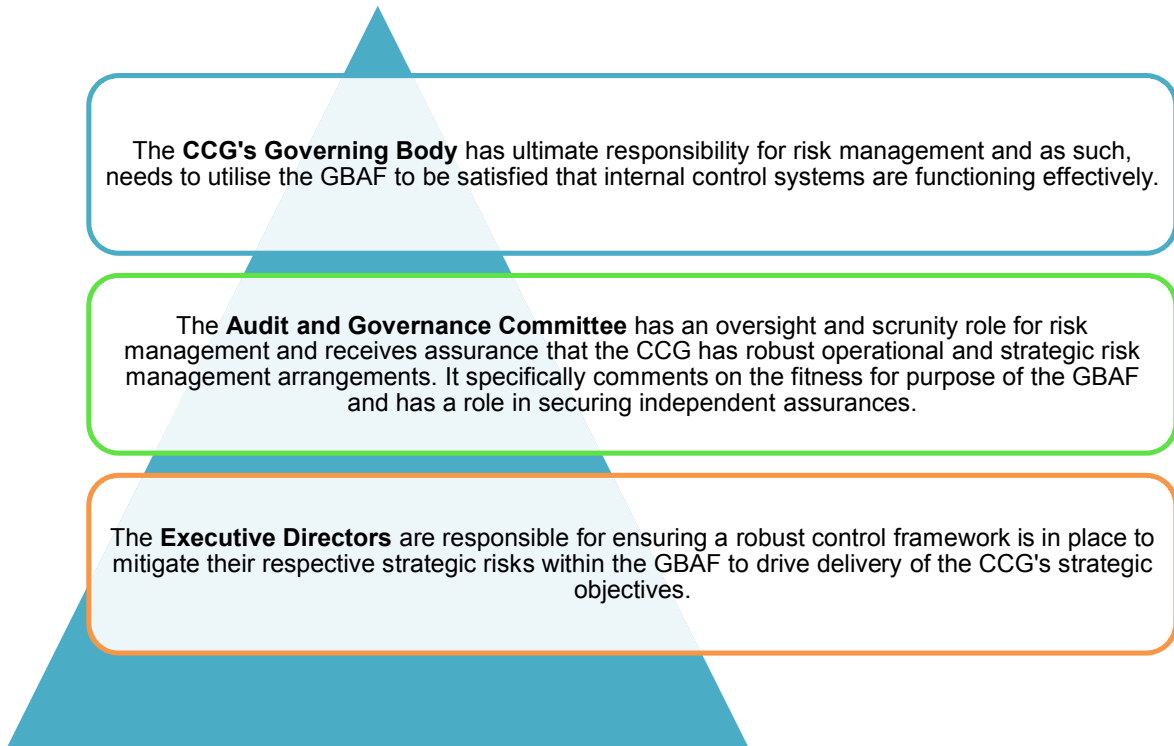
2021/22 Governing Body Assurance Framework: Year-end Position and 2022/23 Q1 Proposal

1. Introduction

- 1.1 The purpose of this paper is to present the year-end position of NHS Nottingham and Nottinghamshire CCG's 2021/22 Governing Body Assurance Framework (GBAF) for scrutiny and comment.
- 1.2 As a reminder, in recognition of 2021/22 being a year of transition (subject to legislation), 11 of the strategic risks were jointly owned by the CCG and the Nottingham and Nottinghamshire Integrated Care System (ICS). These 11 strategic risks, which were approved by the ICS Board in July 2021, also formed the basis of the ICS Board Assurance Framework.
- 1.3 The strategic risks shown in the Governing Body Assurance Framework have been identified as high-level, potential risks that are unlikely to be fully mitigated unless the external environment changes significantly.
- 1.4 The paper also outlines the proposed approach for the GBAF for Q1 2022/23, in line with the anticipated disestablishment of the CCG on 30 June 2022 (subject to legislation).

2. The role of the Governing Body Assurance Framework

- 2.1 Strategic risk management processes are centred around an Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of an organisation's aims/objectives. It provides the Governing Body with confidence that what needs to be happening is happening in practice. More specifically it enables the Governing Body to:
 - a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks;
 - b) Consider the types of assurance currently obtained and whether they are effective and efficient;
 - c) Identify areas where assurance activities are not present or are insufficient (i.e. assurance gaps), or where assurances may be duplicated or disproportionate (i.e. where there is scope for efficiency gains or reduction of duplication of effort); and
 - d) Identify areas where existing controls are failing (i.e. control gaps), and consequently, the risks that are more likely to occur.
- 2.2 The GBAF plays an important role in informing the production of the Accountable Officer'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.
- 2.3 The GBAF is the tool by which the CCG manages its strategic risks. Roles and responsibilities in relation to the GBAF are described in the diagram below:



3. Executive summary

3.1 The Assurance Framework provides assurance to Governing Body members on the robustness of the CCG's system of internal controls through the identification of controls, assurances and management of any 'gaps'. 2021/22 has been another atypical year for the CCG and this has had a direct impact on the GBAF. This is described in more detail at section 4 of this paper, however, despite this, Governing Body members can be assured that:

- Robust monitoring and reporting arrangements in relation to the GBAF have been in place throughout 2021/22 enabling the Governing Body and Audit and Governance Committee to discharge their duties in relation to the review and scrutiny of the Assurance Framework. This has been independently verified by 360 Assurance (the CCG's Internal Audit providers) as part of the annual Head of Internal Audit Opinion (see section 5).
- A clear control framework has been in place, throughout the year, for all 16 of the CCG's strategic risks. 'Gaps' in controls identified in the opening GBAF largely related to the need to define and implement (in 'shadow') governance arrangements, establish clear roles and responsibilities and undertake a comprehensive review and refresh of corporate strategies and policies in preparation for the establishment of the Integrated Care Board (ICB) (subject to legislation); all of which were 'unknowns' at the time, rather than 'gaps' in the CCG's established control framework as a statutory body.

- Despite committee agendas having to be streamlined in response to the Omicron variant of the COVID-19 pandemic¹, there has continued to be a high volume of assurances received, the majority of which provide a positive assurance against the key controls to which they relate.
 - Actions required to address 'gaps' in controls and assurances have progressed, where they have been able to, however, the majority of these relate to the development and embedment of controls and routine assurance reporting for the Integrated Care Board (ICB); all of which have been directly impacted by the nationally deferred timeframes (see section 4).
- 3.2 Overall, members should be assured that the CCG has an effective system of internal control. Full details of the GBAF year-end assessment are set out at **Appendix A** and the fully populated GBAF is provided at **Appendix B**.

4. Impact of the ongoing COVID-19 incident response and delay of the Integrated Care Board (ICB) establishment

- 4.1 In completing the year-end assessment, it has been important to recognise the impact the Omicron variant of the COVID-19 incident response, and more latterly, the national delay of the Integrated Care Board (ICB) establishment, have had on the GBAF.
- 4.2 The continued need to respond to the Omicron variant of the COVID-19 pandemic resulted in committee agendas being streamlined during the period December 2021 to March 2022; this supported the CCG in redirecting resource to support the vaccination programme. A large proportion of the CCG's planned internal assurances relate to reporting to the Governing Body and/or committees, and as such, this had some impact on the receipt of 'pending' assurances which are outlined in the GBAF. However, the proposed approach to the CCG's GBAF for Q1 2022/23 will enable these 'pending' assurances to be received by the end of the reporting period (see section 6).
- 4.3 NHS England published the 2022/23 priorities and operational planning guidance on 24 December 2021². The guidance states that, to allow sufficient time for the passage of the Health and Care Bill through Parliament, a new target date of 1 July 2022 was agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established; replacing the previously stated target date of 1 April 2022.
- 4.4 As previously highlighted, the large majority of the 'gaps' identified in the Governing Body Assurance Framework relate to the development and embedment of controls and routine assurance reporting for the ICB. As a result of the national deferral, it is unlikely that these actions would be achieved by the originally agreed implementation dates. It is important to note, however, that deferral of actions is unlikely to present the organisation with any increased likelihood of strategic risks materialising. Further detail in relation to delivery of actions was provided in the targeted GBAF update to the Audit and Governance Committee in January 2022.

¹ During the period December 2021 to March 2022

² [B1160-2022-23-priorities-and-operational-planning-guidance.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/wp-content/uploads/2021/12/B1160-2022-23-priorities-and-operational-planning-guidance.pdf)

5. Head of Internal Audit Opinion

- 5.1 Strategic risk management, including the use of the GBAF, is a key component of the CCG’s year-end Head of Internal Audit Opinion, provided by 360 Assurance (the Internal Audit provider for the CCG).
- 5.2 The Head of Internal Audit Opinion work programme reviews ‘*the extent to which organisations utilise the Governing Body Assurance Framework to support the management of strategic risk and achievement of organisational objectives*’. Internal Audit confirmed that robust risk management processes are in place, including the use of the Assurance Framework as a ‘live’ strategic risk management tool. It was also commented that the format of the Assurance Framework provides for effective reporting and monitoring of controls, assurances and actions relating to the CCG’s strategic risks and includes all key expected elements.
- 5.3 Output from Stage 1 of the Head of Internal Audit Opinion was presented to the November 2021 meeting of the Audit and Governance Committee. There was one low risk recommendation made within the report relating to the format/template of the Governing Body Assurance Framework. This was actioned in line with the agreed timeframe.
- 5.4 The draft Head of Internal Audit Opinion was published on 11 March 2022 and provided the CCG with a ‘significant assurance’ opinion. There were no recommendations identified as a result of the Stage 2 or final Head of Internal Audit Opinion output.

6. Proposed approach to Q1 2022/23

- 6.1 Consideration has been given as to how the Assurance Framework will operate during Q1 2022/23, in line with the current timeline of ICB establishment on 1 July 2022 (subject to legislation). The proposed approach has been discussed, and agreed, with members of the CCG’s Executive Team and Internal Audit provider (360 Assurance).
- 6.2 A conventional approach to the development of an Assurance Framework is to produce and agree the organisation’s strategic objectives at the beginning of the financial year; enabling the control framework and assurances to be ‘built’ forming the Framework. However, given the CCG will only exist in its current statutory form until 30 June 2022 and it will have a continued focus on the delivery of the current objectives, it is proposed that the current strategic objectives and GBAF are ‘rolled forward’ for the three-month period from April 2022.
- 6.3 As a reminder, the CCG’s strategic objectives are outlined below:

- To improve the health and well-being of our population**
- To improve the overall quality of care and life our service users, and carers, are able to have and receive**
- To improve the effective utilisation of our resources**
- To establish an NHS Integrated Care Board (ICB) (*Enabling Objective*)**

- 6.4 An exercise has been undertaken to review the 16 strategic risks, controls, assurances and actions to confirm their continued 'fitness for purpose' for the three-month period. No significant amendments are required.
- 6.5 It is proposed that a comprehensive targeted update on the delivery of GBAF actions relating to 'gaps' in controls and assurances will be presented to the June 2022 meeting of the CCG's Audit and Governance Committee. At this stage, a proposal for the establishment of a Board Assurance Framework (BAF) for the ICB will also be presented.

7. Recommendations

- 7.1 The Governing Body is requested to:
- **REVIEW and COMMENT** on the 2021/22 year-end position of NHS Nottingham and Nottinghamshire CCG's GBAF; and
 - **APPROVE** the proposed approach for the GBAF for Q1 2022/23, in line with the anticipated disestablishment of the CCG on 30 June 2022 (subject to legislation).

Siân Gascoigne

Head of Corporate Assurance

April 2022

Appendix A: 2021/22 Governing Body Assurance Framework Year-end Assessment

The following paragraphs provide a summary of the key themes from the Governing Body Assurance Framework (GBAF) against the areas the Governing Body will be seeking answers to.

1. How robust have the monitoring and scrutiny arrangements been?

The reporting cycle for the CCG's 2021/22 Assurance Framework is described below.

	Apr-21	Jun-21	Oct-21	Jan-22	Apr-22
Governing Body: Governing Body Assurance Framework	✓ <i>(Strategic Objectives)</i>	✓ <i>(Opening Position: Strategic risks)</i>	✓ <i>(Mid-year position)</i>		✓ <i>(Closing position)</i>
Audit and Governance Committee: GBAF Targeted Assurance Report				✓ <i>(Quarter 3 position)</i>	

Alongside opening, mid-year and closing position reporting of the 2021/22 GBAF to the Governing Body, the Audit and Governance Committee received a Q3 targeted update during January to enable a focused review on progress with the actions identified to remedy any identified gaps in controls and assurances.

Meetings have been held with Executive Directors prior to each reporting period to identify the controls and assurances in place for their respective strategic risks, as well as to talk through any 'gaps' and progress with actions.

2. How robust is the CCG's control framework?

Key controls were considered for each strategic risk across key category areas (e.g., roles and responsibilities, policies and/or frameworks, operational groups/forums and training). Considering controls across these key category areas supported the identification of any 'gaps'.

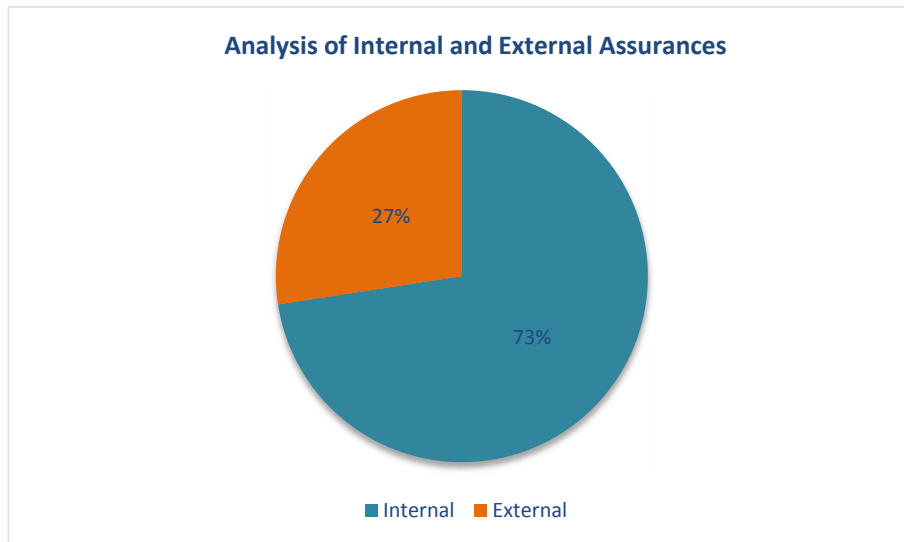
Key controls identified across the 16 risks largely relate to:

- Robust governance arrangements within the CCG, including all the component parts of the Governing Body committee structure, CCG involvement in partner governance arrangements (e.g., Health and Wellbeing Boards), incident response governance, the establishment 'system' operational groups and forums, as well as transition governance arrangements (e.g., ICS Transition and Risk Committee);
- The CCG's established governance framework, including its standing documents and corporate policy management framework, alongside the development and delivery of CCG and 'system' strategies and plans; and
- Defined roles and responsibilities across the CCG and ICB executive and senior teams.

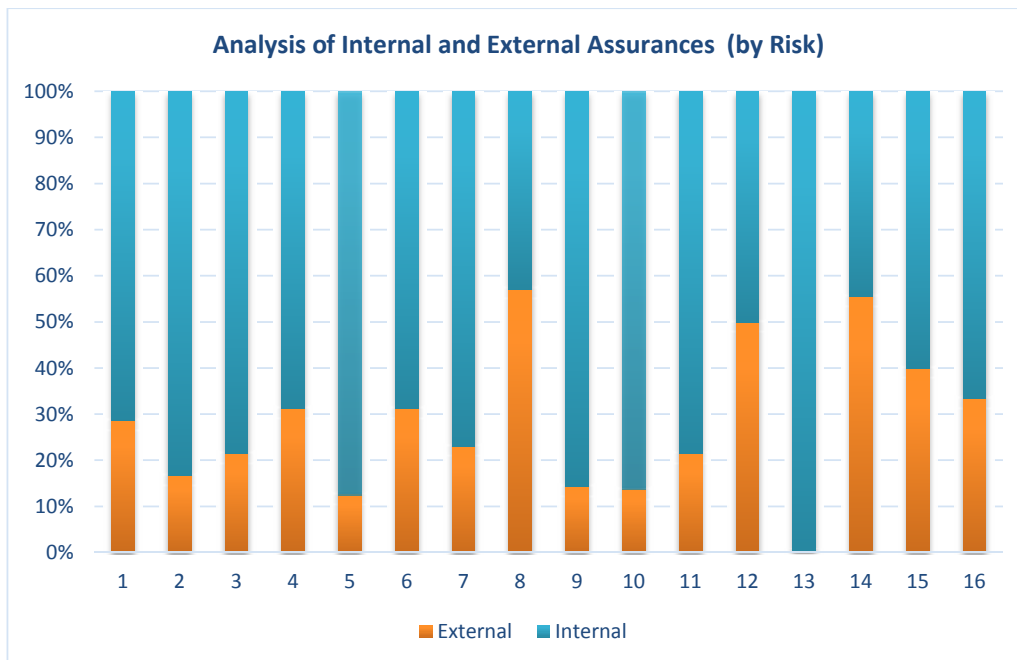
Where have our assurances come from?

A review of the internal and external assurances set out within the Assurance Framework has been completed. This has shown that the overall split of internal and external assurances against all identified controls is 73% internal and 27% external, which we believe is at an acceptable level.

As a reminder, internal assurances are classed as any which are produced by the CCG, or system partners; and external assurances relate to parties which are independent to the CCG and its partners (e.g., regulators, internal and external audit providers).



A further assessment of the number of internal and external assurances per strategic risk has also been undertaken.



Analysis found that strategic risk 13 (Equality, Diversity and Inclusion) is the only risk which does not have any external assurances listed.

As highlighted in the mid-year update to the Governing Body, this will be considered as part of the due diligence and ‘handover’ arrangements from the CCG (and NHS Bassetlaw CCG) to the new Integrated Care Board; an assessment of strategic risk areas will be undertaken to determine what the content of a future ICB Internal Audit Plan may look like.

3. What are the assurances telling us?

A total of 175 assurances are listed within the year-end GBAF; this is an increase of 31 assurances since the mid-year position. There has been a significant increase in the planned assurances associated with the system partnership working and the ICS operating model, which is as expected as the CCG moves closer to its disestablishment.

Although there are some assurances still 'pending', the majority have been received (or are being routinely received) via CCG governance arrangements. Those which are outstanding are either tailored to the end of the year (such as delivery of External Audit plans) or are clearly linked to the establishment of ICB governance and assurance arrangements, which will be in place by 30 June 2022.

Of those assurances which have been received, all, but one, provide positive assurance, meaning that the controls in place are largely functioning effectively. The one negative assurance relates to an Internal Audit review of the CCG's Multi-Agency Safeguarding Hub (MASH). The Quality and Performance Committee is overseeing delivery of actions identified as a result of weaknesses in the MASH's control framework. Progress has already been made to address these.

It is recognised that assurances within the GBAF reflect the systems and processes in place within the organisation; not necessarily the outcomes. As such, 'positive' assurances could be received around the robustness of the organisation's mechanisms to monitor performance or financial position (for example), however, this does not indicate that risks to the outcomes in these areas do not exist. It is important to note that 'live', operational risks around key areas (such as health inequalities, finance, quality improvement) continue to be monitored, reported and escalated via the CCG's Corporate Risk Register.

4. How have we addressed and monitored the 'gaps'?

Actions were identified in relation to all 'gaps' and allocated named responsible officers and clear implementation timelines were agreed. Progress in relation to actions was reported to the Audit and Governance Committee in January 2022, as part of the Q3 GBAF targeted update.

It was highlighted to the Audit and Governance Committee that many of the 'gaps' identified related to system-led work that is underway to deliver against the nine ICS Transition Workstreams, ICS System Development Plan and ICB 'Readiness to Operate' statement. However, the national deferral of the ICB establishment, and key tasks associated with this, has impacted delivery of actions identified to address these 'gaps'.

Of the 44 actions identified, 39 relate to the development of shadow governance, accountability and assurance arrangements for the ICB, including the appointment to (and clarification of) Executive and other senior leadership roles. Work has progressed against the majority of these actions; however, the anticipated completion date has been amended to be in line with national directive. All actions are now due to be complete by 30 June 2022.

Of the remaining five actions, two are complete (relating to H2 planning and development of a Health Inequalities Plan) and work is underway in relation to the other three. The development of the Agile Working Policy and Freedom to Speak Up Policy is being undertaken as part of the establishment of a suite of ICB policies, and work around the NHIS Cyber Strategy is largely complete.

5. What impact have the controls and assurances had on strategic risk scores?

Target risk scores were set for each of the strategic risks, in line with the CCG's risk appetite, at the beginning of the financial year. The current, and target, risk scores were specifically discussed with Executive leads prior to the year-end position being reported; in particular, whether the national deferral of ICB establishment has had any specific impact on these.

There has been some movement in risk scores since the GBAF (mid-year position) was presented to the Governing Body at the October 2021 meeting. More specifically:

- The scores for 11 (of the 16) strategic risks have reduced, five of which are now in line with the target risk scores;
- The scores for five strategic risks have remained the same, three of which were already in line with the target risk score.

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 GBAF (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).

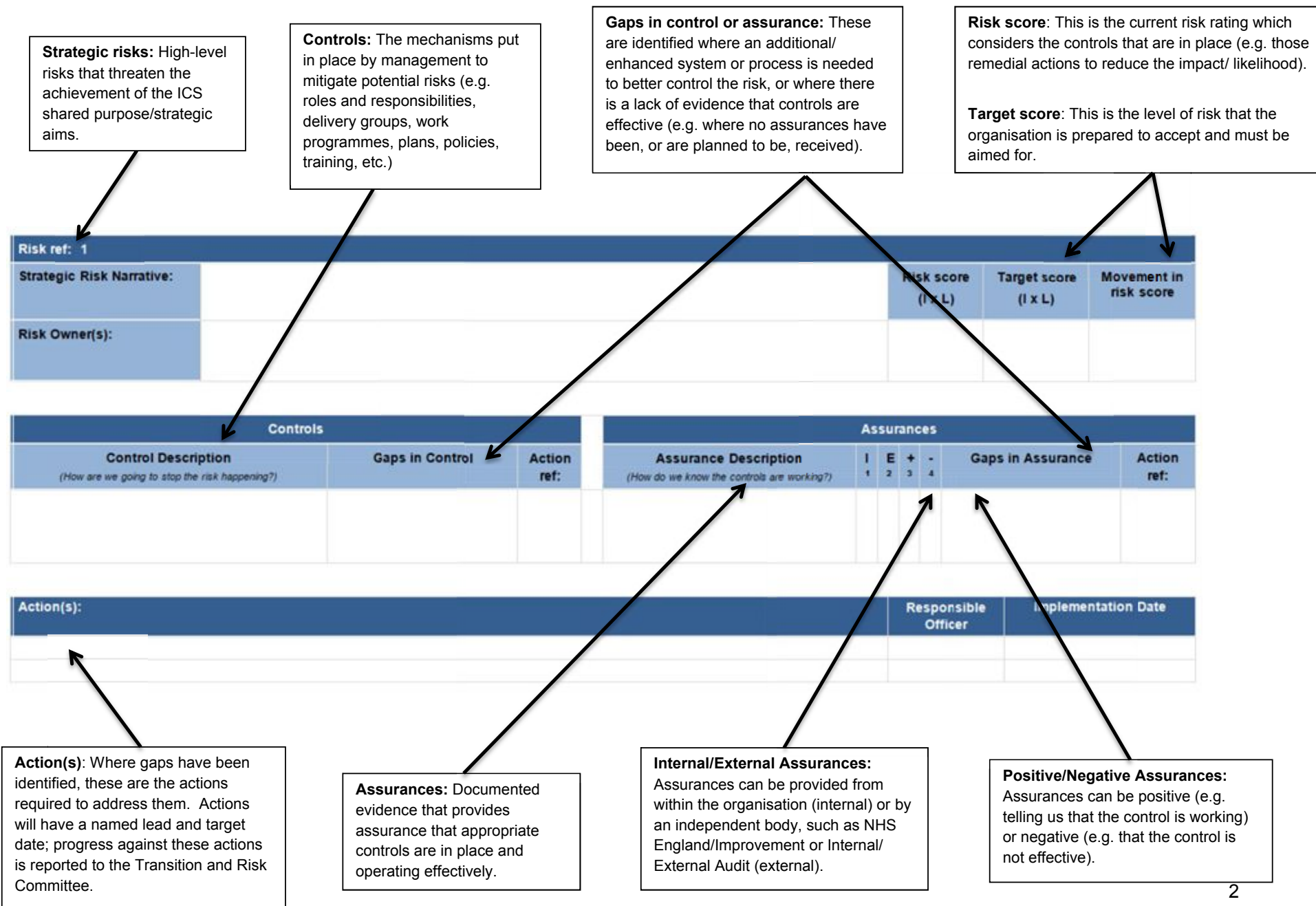


Nottingham and Nottinghamshire
Clinical Commissioning Group

Governing Body Assurance Framework

April 2022


How to read the Assurance Framework



Strategic Risks	CCG Strategic Objectives				Executive Lead (Risk Owner)		Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)	Movement in Risk Score <i>(between mid-year and year-end positions)</i>
	To improve the health and well-being of our population	To improve the overall quality of care and life our service users, and carers, are able to have and receive	To improve the effective utilisation of our resources	To establish an ICS NHS Body (subject to legislation)	CCG	ICS				
Risk 1: Culture and partnership working Failure to establish a cohesive system culture, conducive of successful partnership working.			✓	✓	Accountable Officer	Independent Chair and Executive Lead	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓
Risk 2: Recover and transform services Failure to work effectively across the system to recover and transform services, in line with 2021/22 priorities, to ensure current and future demand is met.	✓	✓	✓		Chief Commissioning Officer	Executive Lead	Red (5 x 3)	Red (5 x 3)	Amber / Red (5 x 2)	↔
Risk 3: Health inequalities Failure to adequately address the health inequalities experienced by Nottingham and Nottinghamshire citizens.	✓	✓			Chief Commissioning Officer	Health Inequalities SRO	Red (5 x 4)	Red (5 x 3)	Amber / Red (5 x 2)	↓
Risk 4: Quality improvement Failure to maintain and improve the quality of services.	✓	✓			Chief Nurse	Chief Nurse	Red (5 x 4)	Red (5 x 3)	Amber / Red (5 x 2)	↓
Risk 5: Clinical and multi-professional leadership Failure to establish and maintain a robust and distributed clinical and multi-professional leadership model to drive clinical and care prioritisation and transformation.	✓	✓	✓	✓	Chief Nurse / Joint Clinical Leaders	Chief Nurse / Medical Director	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓

Strategic Risks	CCG Strategic Objectives				Executive Lead (Risk Owner)		Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)	Movement in Risk Score <i>(between mid-year and year-end positions)</i>
	To improve the health and well-being of our population	To improve the overall quality of care and life our service users, and carers, are able to have and receive	To improve the effective utilisation of our resources	To establish an ICS NHS Body (subject to legislation)	CCG	ICS				
Risk 6: Patient and public involvement Failure to effectively engage with the diverse local population and ensure that patient and public insights inform decision making.		✓		✓	Director of Comms and Engagement	Director of Comms and Engagement	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓
Risk 7: Workforce Failure to ensure sufficient capacity, capability and wellbeing support within the local workforce.	✓	✓	✓		Chief Finance Officer	People and Culture SROs	Red (5 x 4)	Red (5 x 3)	Amber / Red (5 x 2)	↓
Risk 8: Finance Failure to establish robust financial governance and resource allocation arrangements.			✓		Chief Finance Officer	Director of Finance	Red (4 x 4)	Amber (4 x 2)	Amber (4 x 2)	↓
Risk 9: Data, analytics, information and technology Failure to deliver digital transformation and establish effective system intelligence solutions.		✓	✓		Chief Finance Officer	DAIT SRO	Red (4 x 4)	Amber / Red (4 x 3)	Amber (4 x 2)	↓
Risk 10: ICS Operating Model Failure to establish an effective operating model at ICS and 'place' level.				✓	Accountable Officer	Executive Lead	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓
Risk 11: Governance and decision-making Failure to establish robust governance, accountability and assurance arrangements.	✓	✓	✓	✓	Chief Nurse	Executive Lead	Amber / Red (4 x 3)	Amber (4 x 2)	Amber (4 x 2)	↓

Strategic Risks	CCG Strategic Objectives				Executive Lead (Risk Owner)		Initial Risk Score (I x L)	Current Risk Score (I x L)	Target Risk Score (I x L)	Movement in Risk Score <i>(between mid-year and year-end positions)</i>
	To improve the health and well-being of our population	To improve the overall quality of care and life our service users, and carers, are able to have and receive	To improve the effective utilisation of our resources	To establish an ICS NHS Body (subject to legislation)	CCG	ICS				
Risk 12: Emergency preparedness, resilience and response Failure to be adequately prepared to respond to major and/or business continuity incidents.		✓	✓		Chief Commissioning Officer	N/A	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↔
Risk 13: Equality, Diversity and Inclusion Failure to comply with the general and specific Public Sector Equality Duties.	✓	✓			Chief Nurse	N/A	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↔
Risk 14: Safeguarding Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.		✓			Chief Nurse	N/A	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↔
Risk 15: Cyber Security Failure to prevent potential cyber-attacks.		✓	✓		Chief Finance Officer (SIRO)	N/A	Red (5 x 3)	Red (5 x 3)	Amber / Red (4 x 3)	↔
Risk 16: CCG Disestablishment (subject to legislation) Failure to transfer CCG functions, staff and assets safely and effectively.				✓	Chief Nurse	N/A	Red (5 x 3)	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓

Risk ref: 1 Culture and partnership working				
Strategic Risk Narrative:	Failure to establish a cohesive system culture, conducive of successful partnership working.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Accountable Officer	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Independent Chair and Executive Lead			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I 1	E 2	+ 3	- 4	Gaps in Assurance	Action ref:
a) ICS Independent Chair's role to promote a culture of openness and transparency with all organisations 'acting as one organisation' and stimulate wider engagement across the health and social care community.	None identified.		a) Reports from the Independent Chair and Executive Lead to the ICS Board (latest March 2022, PENDING May 2022).	✓				None identified.	
b) Joint ICS Executive Lead and CCG Accountable Officer.	None identified.		b) Standing ICS Board agenda item to 'review meeting against the Partnership Agreement' (latest March 2022).	✓				None identified.	
c) Transformation Senior Responsible Officers (SROs) and Programme Leads are appointed from across system partners.	None identified.		c) Review of System Development Plan iterations by the ICS Transition and Risk Committee (latest February 2022, final plan March 2022).	✓				None identified.	
d) ICS Partnership Agreement, which has been signed-up to by all system partners and demonstrates a commitment to work effectively together for the benefit of all communities and citizens within Nottingham and Nottinghamshire.	None identified.		d) Reporting against delivery of System Development Plan / 'Readiness to Operate' Assessments with NHSE/I (e.g. 'Checkpoints') (quarterly, latest March 2022).		✓	✓		None identified.	

¹ Internal assurances,
² External assurances
³ Positive assurance
⁴ Negative assurance

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I 1	E 2	+3	- 4	Gaps in Assurance	Action ref:
e) System Development Plan, which outlines the ambition of the system and progress against 20 development actions to ensure the ICS is prepared to become a statutory body in April 2022 (subject to legislation).	None identified.		e) System assurance arrangements with NHSE/I.		✓	✓		None identified.	
f) System Executive Group and membership of all delivery groups are comprised of representatives from system partners.	To establish and embed in 'shadow' governance, accountability and assurance arrangements for the new ICB statutory organisation.	1.1							
g) ICS Board Development Sessions to ensure successful future partnership working. Topics (to date) include the role and membership of the Integrated Care Board, the role of Place, the Integrated Care Partnership and how engagement will function effectively in partnership.	None identified.								
a) CCG's commitment to the ICS Partnership Agreement.	None identified.		a) System Development Update presented to the Governing Body Development Session (September 2021).	✓				None identified.	
			b) ICB Transition Arrangements Update presented to the Governing Body Development Session (January 2022).	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 1:1: To establish and embed in 'shadow' governance, accountability and assurance arrangements for the new ICB statutory organisation (subject to legislation) and wider system forums (Integrated Care Partnership Board, for example).	ICS Executive Lead	Q4 2024/22 Q1 2022/23

Risk ref: 2 Recover and transform services				
Strategic Risk Narrative:	Failure to work effectively across the system to recover and transform services, in line with 2021/22 priorities, to ensure current and future demand is met.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Commissioning Officer	Red (5 x 3)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Executive Lead			


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) The role and remit of the System Executive Group to monitor and oversee the recovery and transformation of services, in line with the 2021/22 priorities* <i>* Set out within the NHSEI 2021/22 Priorities and Operational Planning Guidance as:</i> <ul style="list-style-type: none"> - Supporting the health and wellbeing of staff and taking action on recruitment and retention. - Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19. - Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services. - Expanding primary care capacity to improve access, local health outcomes and address health inequalities. - Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay. - Working collaboratively across systems to deliver on these priorities. 	None identified.		a) Integrated Performance Report, including the **System Delivery Dashboard, presented to the ICS Board on a bi-monthly basis, provides updates in relation to: <ul style="list-style-type: none"> - System incident management. - 2021/22 Planning and Transformation. - Integrated Performance (quality, service delivery, finance, people). - ICS Development and Transition. (latest March 2022). **System Delivery Dashboard outlines performance in relation to: <ul style="list-style-type: none"> - Quality of Care, Access and Outcomes (Urgent Care, Mental Health, Planned Care, Quality, Cancer and GP Appointments); - Preventing Ill-Health and Reducing Inequalities; - Finance and Use of Resources; - People; 	✓				None identified.	
b) The role and remit of the ICS System Oversight Meeting, which has collective accountability for the performance of the ICS.	To ensure the ICS System Oversight Meeting is established and operating in practice.	2.1							

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
c) The ICS Transformation and Efficiency Plan (2021 to 2025), which is the prioritised delivery plan for the NHS Long Term Plan and ICS Outcomes Framework, alongside operational H1 and H2 planning processes for 2021/22.	None identified.		<ul style="list-style-type: none"> - <i>Local Strategic Priorities (which includes Quality Improvements, Elective Recovery and Financial Sustainability);</i> - <i>Constitutional and H1 Plan Metrics Delivery; and</i> - <i>Progress against System Plans (which includes Finance Group, People and Culture Group, and Capacity Cell).</i> 						
d) Establishment of nominated Senior Responsible Officers (SROs), Programme Leads and Clinical, Workforce, Analytical and Finance Leads for each transformation programme.	To review the ongoing appropriateness of nominated leads as part of the establishment of the ICB.	2.2	b) Routine reporting to the ICS System Oversight Meeting to enable the systematic monitoring and oversight of the recovery and transformation of services.	✓				To establish systematic reporting in relation to delivery of all priorities / transformation programmes to the ICS System Oversight Meeting.	2.4
e) The requirement for each transformation programme to develop annual operational plans, alongside Project Charters and Project Initiation Documents (PIDs).	None identified.		c) Reporting against delivery of System Development Plan / 'Readiness to Operate' Assessments with NHSE/I (e.g. 'Checkpoints') (quarterly, latest March 2022).		✓	✓		None identified.	
f) ICS Strategy and Delivery Group, whose duties include oversight of delivery of the ICS Transformation and Efficiency Plan, supported by the System Planning Group and System Transformation Group. Meetings have a dual focus of 'grip' on delivery and focus on development of future plans.	None identified.		d) System assurance arrangements with NHSE/I.		✓	✓		None identified.	
g) Role of the System Analytics and Intelligence Unit (SAIU), which will take forward the ICS population health management (PHM) programme and individual 'outputs'.	To ensure the operation of the SAIU becomes embedded within the ICS operating model.	2.3	e) Assurance reporting in line with the NHS System Performance Oversight Framework via the ICS Performance Group and ICS Strategy and Delivery Group.	✓				To implement NHS System Performance Oversight Framework assurance and/or escalation reporting programmes to the ICS System Oversight Meeting.	2.5
h) Establishment of transformation programme boards and/or governance structures to support each of the programmes (e.g.	None identified.		f) 2022/23 Operational Plan presented to the ICS Partnership Board for approval (March 2022).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
Planned Care Transformation Board, Mental Health Prevention Board, Primary Care Transformation Group (formally known as Primary Care Incident Management Group), etc.).									
i) Role and remit of the Combined COVID-19 Tactical Co-ordination Group (formally known as the HSCETCG).	None identified.								
j) Role and remit of the ICS Performance Oversight Group and Quality Assurance and Improvement Group in relation to overseeing recovery of services.	None identified.								
k) Role and remit of the Mid Nottinghamshire and South Nottinghamshire A&E Delivery Boards and supporting governance groups/workstreams (including Discharge2Assess, Right Place, First Time).	None identified.								
l) Role and remit of the People and Culture Board, and supporting operational groups, to ensure sufficient workforce capacity and capability within the system to meet current and future demand.	To review the operational infrastructure of the People and Culture Board in line with the ICS operating model.	2.6							
a) Chief Finance Officer as Executive lead for planning at the Governing Body.	None identified.		a) Strategic Planning and Prioritisation – Development of the single system plan presentation presented to the Governing Body (February 2021).	✓				None identified.	
b) Chief Commissioning Officer as Executive lead for commissioning at the Governing Body.	None identified.		b) 2021/22 H2 Plans presented to the Prioritisation and Investment	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
c) CCG's 2020-2022 Commissioning Strategy which describes the approach to transition from tactical to strategic commissioner (including, for example, the development of provider alliances /collaborations, development of outcomes-based incentives, and local 'place based' commissioning).	None identified.		Committee for endorsement and Governing Body approval (November 2021).						
d) Prioritisation and Investment Committee's duty to oversee the development of the CCG's commissioning strategies, plans and joint commissioning arrangements.	None identified.		c) 2022/23 Operational Planning Briefing presented to the Governing Body (February 2022).	✓				None identified.	
e) Quality and Performance Committee's duty to scrutinise arrangements for monitoring the performance of commissioned services and ensuring the needs of the population are being met.	None identified.		d) System Development Update presented to the Governing Body Development Session (September 2021).	✓				None identified.	
f) Primary Care Commissioning Committee's duty to promote increased co-commissioning to increase quality, efficiency, productivity and value for money within primary care.	None identified.		e) Committee minutes, and highlight reports, presented to the Governing Body (each meeting).	✓				None identified.	
g) The role and remit of the CCG's Integrated Urgent Care Programme Group.	None identified.		f) Ad-hoc transformation programme updates provided to the Prioritisation and Investment Committee (for information).	✓				None identified.	
			g) Routine integrated performance reporting to the: - Governing Body (bi-monthly); and - Quality and Performance Committee (monthly).	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 2.1: To ensure the ICS System Oversight Meeting is established and operating in practice.	ICS Executive Lead	Complete.
Action 2.2: To review the ongoing appropriateness of nominated leads as part of the establishment of the ICB.	ICS Executive Lead	Q4 2021/22 Q1 2022/23
Action 2.3: To ensure the operation of the SAIU becomes embedded within the ICS operating model.	ICS Executive Lead	Complete.
Action 2.4: To establish systematic reporting in relation to delivery of all priorities / transformation programmes to the ICS System Oversight Meeting	ICS Executive Lead	Complete.
Action 2.5: To implement NHS System Performance Oversight Framework assurance and/or escalation reporting. programmes to the ICS System Oversight Meeting.	ICS Executive Lead	Complete.
Action 2.6: To review the operational infrastructure of the People and Culture Board in line with the ICS operating model.	ICS Executive Lead	Q4 2021/22 Q1 2022/23

Risk ref: 3 Health inequalities				
Strategic Risk Narrative:	Failure to adequately address the health inequalities experienced by Nottingham and Nottinghamshire citizens.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Commissioning Officer	Red (5 x 3)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Health Inequalities SRO			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Joint Strategic Needs Assessments (JSNAs) for Nottingham City and Nottinghamshire County, which describe current and future health and social care needs which need to be met. The aim of the JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages.	None identified.		a) Joint Strategic Needs Assessments (JSNAs): Future development and alignment with Nottingham and Nottinghamshire ICS (presentation to the July 2021 ICS Board meeting).	✓				None identified.	
b) Nottingham City's Joint Health and Wellbeing Strategy 2016 to 2020 and Nottinghamshire Health and Wellbeing Board Joint Health and Wellbeing Strategy 2018 to 2022, both of which exist to translate City and Country JSNA findings into remedial action.	None identified.		b) Implementation of the ICS Health Inequalities Strategy Update to the ICS Board (September 2021, March and April 2022).	✓				None identified.	
c) Establishment of an SRO and nominated Programme Leads for Health Inequalities.	None identified.		c) System assurance arrangements with NHSEI, focusing on delivery of the system's HI priorities (as described in the 2021/22 Priorities and Operational Plan submission).		✓	✓		None identified.	
d) ICS Health Inequalities Strategy (2020-2024), which outlines five key objectives: <ul style="list-style-type: none"> Protect the most vulnerable from COVID-19; Restore health and care services inclusively; Digitally enabled care which increases inclusion; 	None identified.		d) Health Inequalities and Prevention Group assurance reporting to the System Executive Group (SEG) and ICS Quality and Inequalities Committee (PENDING).	✓				To establish routine assurance reporting in relation to delivery of the HI Strategy within the ICS governance structure.	3.3

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
<ul style="list-style-type: none"> Accelerate preventative programmes; Particularly support those who suffer from mental ill-health. 									
e) Health Inequalities and Prevention Group, which has oversight of delivery of the ICS Health Inequalities Strategy.	To finalise the Terms of Reference for the HI and Prevention Group.	3.1	e) Integrated Performance Report, including the System Delivery Dashboard, presented to the ICS Board on a bi-monthly basis (latest November 2021).	✓				None identified.	
f) Health Inequalities Implementation Plan(s) at ICS, Place and PCN level.	To develop the HI Implementation Plans.	3.2	f) Improving Health and Wellbeing for 2021/22 priority population groups paper presented to the ICS Board (July 2021).	✓				None identified.	
g) ICS Outcomes Framework, which includes a set of health inequalities metrics to progress delivery of the Strategy.	None identified.		g) Tackling Health Inequalities as part of the COVID-19 Vaccination Programme presented to the ICS Board (May 2021).	✓				None identified.	
h) Establishment of the System Analytics Unit (SAU), which will take forward the ICS population health management (PHM) programme and individual 'outputs'.	To ensure the operation of the SAIU becomes embedded within the ICS operating model.	3.3	h) Health Inequalities Plan Update presented to the ICS Board Development Session (February 2022).	✓				None identified.	
i) Health Equity Assessments which are undertaken as part of transformation programmes.	None identified.		i) Health Inequalities Plan presented to the ICS Board (PENDING due May 2022).	✓				None identified.	
a) All Governing Body members have a shared responsibility for ensuring that the CCG is commissioning to meet the needs of the Nottingham and Nottinghamshire population.	None identified.		a) Reporting of H&WB Board minutes via AO Report to the Governing Body (Bi-monthly dependent on timings of H&WB Board meetings)		✓	✓		None identified.	
b) Chief Commissioning Officer as Executive lead for commissioning and health inequalities at the Governing Body.	None identified.		b) Annual Research and Evidence Assurance Report to the Governing Body (June 2021).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
c) Prioritisation and Investment Committee's duty to oversee the development of the CCG's commissioning strategies, plans and joint commissioning arrangements. This includes ensuring alignment with the Integrated Care System's (ICS) Outcomes Framework and delivery of the CCG's duty to reducing inequalities of access and inequalities of outcomes.	None identified.		c) ICS HI Strategy reported to the Quality and Performance Committee (May 2021).	✓				None identified.	
d) CCG/Governing Body membership of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.	None identified.		d) Integrated Performance Report (IPR) included a section on HI (in relation to outpatient activity) presented to the Quality and Performance Committee (monthly).	✓				None identified.	
e) CCG/Governing Body membership of the ICS Board (Accountable Officer and Non-Executive Director, who is also Vice Chair of the ICS Board).	None identified.		e) NHSE/1's 2020/21 CCG Annual Assessment against 14 national determined Key Lines of Enquiry and five key priority areas (quality of services, reducing health inequalities, involving and consulting the public, compliance with financial duties and leadership and governance) (June 2021).		✓	✓		None identified.	
f) CCG's 2020-2022 Commissioning Strategy which describes the approach to transition from tactical to strategic commissioning, as well as the need to reduce health inequalities.	None identified.								
g) CCG membership on JSNA Steering Groups (for City and County).	None identified.								
h) Role and remit of the CCG's Research and Evidence Team.	None identified.								
i) CCG's Evaluation Framework, which will help assess to what extent services are useful to the population they are targeted at, (e.g. addressing health inequalities), as well as their clinical effectiveness. This helps inform	None identified.								

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
the development of service plans and pathways.									

Action(s):	Responsible Officer	Implementation Date
Action 3.1: To finalise the Terms of Reference for the Health Inequalities and Prevention Group.	Chief Commissioning Officer / Health Inequalities SRO	Q4 2021/22
		Q1 2022/23
Action 3.2: To develop the Health Inequalities Implementation Plan.		Complete.
Action 3.3: To ensure the operation of the SAIU becomes embedded within the ICS operating model.		Complete.
Action 3.4: To establish routine assurance reporting in relation to delivery of the HI Strategy within the ICS governance structure.		Q4 2021/22
		Q1 2022/23

Risk ref: 4 Quality improvement				
Strategic Risk Narrative:	Failure to maintain and improve the quality of services.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse	Red (5 x 3)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Chief Nurse			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) ICS Clinical Leadership and Engagement Workstream; the main aim of which is to develop and mobilise clinical leadership and engagement arrangements to support quality improvement.	None identified.	4.1	a) ICS Clinical Leadership and Engagement Workstream Highlight Reports to the ICS Transition and Risk Committee (latest March 2022).	✓				None identified.	4.4
b) ICS Quality, Inequalities and People Committee (in development).	To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICB Quality, Inequalities and People Committee.		b) QAIG reporting to the ICS Board (bi-monthly) (latest March 2022).	✓				To establish routine assurance reporting from the ICB Quality, Inequalities and People Committee to the ICB Board.	
c) ICS Quality Assurance and Improvement Group (QAIG) with system membership, with responsibilities to: <ul style="list-style-type: none"> ensure the fundamental standards of quality are delivered (which includes, but is not limited to, managing quality and risks, addressing inequalities and variation); and continually improve the quality of services, in a way that makes a real difference to the people using them. ICS QAIG is supported by other operational groups, including an ICS Patient Safety Specialist	None identified.		c) System assurance arrangements with NHSEI.		✓	✓		None identified.	
			d) Integrated Performance Report, including the System Delivery Dashboard, presented to the ICS Board on a bi-monthly basis (latest March 2022).	✓				None identified.	


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
Group and Infection, Prevention and Control Group.									
d) ICS Quality Strategy (in development)	To continue developing an ICS Quality Strategy.	4.2							
a) Chief Nurse as Executive lead for quality improvement and Chair of the ICS Quality Assurance and Improvement Group (QAIG).	None identified.		a) Routine nursing and quality reporting to the Quality and Performance Committee (quarterly, plus monthly exception reports), which includes the Safe Today metrics, enabling potential areas of hidden harm to be considered.	✓				None identified.	
b) Quality and Performance Committee's duty to scrutinise arrangements for monitoring the quality of commissioned services and ensure quality outcomes and benefits in commissioned services are being achieved.	None identified.		b) Quality 'deep dive' thematic reviews to the Quality and Performance Committees (bi-monthly) in the following areas:	✓				None identified.	
c) Primary Care Commissioning Committee's duty to promote increased co-commissioning to increase quality, efficiency, productivity and value for money within primary care.	None identified.		<ul style="list-style-type: none"> - NUH Maternity Services (latest March 2022); - Nottinghamshire Healthcare NHS Foundation Trust (latest April 2022); - Nottingham University Hospitals NHS Trust (latest March 2022); - Urgent Care (NUH and SFH) (October 2021); and - Cancer and Elective Waits (February 2022). 						
d) Prioritisation and Investment Committee's duty to quality assure business case proposals, including assessment of any associated equality and quality impacts arising from proposals and feedback from patient and public engagement/consultation activities where necessary.	None identified.								
e) CCG's 2019-2022 Quality Strategy which outlines the CCG's approach to improving outcomes for the population, supported by a Quality Strategy Delivery Plan.	None identified.								
f) CCG's Service Benefit Review Policy which requires EQIAs to be completed as part of service reviews and pathway redesigns.	To fully review the CCG's SBR Policy to	4.3	c) Grant Thornton Review – CCG's Quality Assurance Arrangements presented to the Quality and		✓	✓		None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
	determine its fitness for purpose for the ICB NHS statutory body.		Performance Committee (January 2022).						
g) CCG's Patient Experience (Complaints, Concerns and Enquiries) Policy which set out the organisation's approach to handling complaints and concerns about commissioned services.	None identified.		d) Ad-hoc specific quality assurance reporting, covering: <ul style="list-style-type: none"> Planned Care (Waiting List backlog) (latest February 2022); Care Homes and Home Care (August 2020); Swabbing and Testing (May 2020); Personal Protective Equipment (PPE) (May 2020); Safeguarding (June 2020); IPC (July 2020); Flu Plan (August 2020); Focus on harm (September 2020); Outbreak report (latest March 2021); Vaccination programme (latest March 2021). <i>*The above for part of the Quality Assurance Report (from April 2021).</i>	✓				None identified.	
h) The CCG's quality framework processes (including the Safe Today Programme), which include: <ul style="list-style-type: none"> Risk-based quality insight visits across primary, community and secondary care; Monitoring of provider compliance with key quality indicators; and Arrangements for sharing good practice and lessons learnt (including incident management, complaints investigations and adult and children's safeguarding arrangements). 	None identified.								
i) Primary Care Quality Groups (per ICP footprint), which have responsibility for delivery and improvement of quality services within primary care.	None identified.		e) Routine integrated performance reporting to the: <ul style="list-style-type: none"> Governing Body (bi-monthly); and Quality and Performance Committee (monthly). 	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
			f) Annual reporting to the Quality and Performance Committee: <ul style="list-style-type: none"> - Safeguarding Annual Reports (including LAC and SEND) (September 2021); - Learning Disability Mortality Review (LeDeR) Annual Report (June 2021); - Serious Incidents Bi-annual Report (July 2021); - Patient Experience Annual Report (including complaints) (May 2021); and - Infection, Prevention and Control Annual Report (November 2021). 	✓				None identified.	
			g) Assurance reports relating to the safe and effective management of medicines, including the Controlled Drugs Annual Report and the Nottinghamshire Area Prescribing Committee's Annual Report (February 2022).	✓				None identified.	
			h) Quality and Performance Committee Annual Report (March 2022).	✓				None identified.	
			i) Routine reporting to the Primary Care Committee in relation to Primary Care quality and	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
			performance (quarterly, latest February 2022).						
			j) Receipt of annual Quality Accounts prepared by the CCG's main providers prior to final sign off; with specific responsibility for approval of the CCG's insert within the document (June 2021).		✓	✓		None identified.	
			k) 2021/22 Internal Audit Review – Liberty Protection Standards (Mental Capacity Act) (Q3 PENDING)		✓			None identified.	
			l) NHSE/I's 2020/21 CCG Annual Assessment against 14 national determined Key Lines of Enquiry and five key priority areas (quality of services, reducing health inequalities, involving and consulting the public, compliance with financial duties and leadership and governance) (June 2021).		✓	✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 4.1: To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICB Quality, Inequalities and Workforce Committee.	Associate Director of Governance	Q4 2021/22 Q1 2022/23
Action 4.2: To continue developing an ICS Quality Strategy.	Chief Nurse	April 2022
Action 4.3: To fully review the CCG's SBR Policy to determine its fitness for purpose for the ICB NHS statutory body.	Chief Commissioning Officer	Superseded
Action 4.4: To establish routine assurance reporting from the ICB Quality, Inequalities and Workforce Committee to the ICS Board.	Chief Nurse	Q4 2021/22 Q1 2022/23

Risk ref: 5 Clinical and multi-professional leadership				
Strategic Risk Narrative:	Failure to establish and maintain a robust and distributed clinical and multi-professional leadership model to drive clinical and care prioritisation and transformation.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse / Joint Clinical Leaders	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Chief Nurse / Medical Director			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Nursing and Medical Directors, as a mandatory member of the Integrated Care Board.	To appoint to the ICB Medical Director role.	5.1	a) ICS Clinical Leadership and Engagement Workstream reporting to the ICS Transition and Risk Committee (latest March 2022).	✓				None identified.	
b) Establishment of a Clinical Leadership and Engagement Workstream, as a transition workstream.	None identified.		b) ICS Transition and Risk Committee highlight reports presented to the ICS Board (latest March 2022).	✓				None identified.	
c) The role and remit of the Clinical and Professional Leadership Group (CPLG) (formally known as the Clinical Executive Group) within the ICS governance structure.	To develop and finalise Terms of Reference for the CPLG.	5.2	c) Reporting against delivery of System Development Plan / 'Readiness to Operate' Assessments with NHSE/I (e.g. 'Checkpoints') (latest March 2022).		✓	✓		None identified.	
d) Clinical membership of the ICB Board and its Committees (to be described in the ICB Constitution and Governance Handbook).	To formalise and agree clinical membership of Committees/Groups in the ICB governance structure.	5.3	d) Clinical and Care Professional Leadership Model Update presented to the ICS Board for discussion (PENDING due May 2022).	✓				None identified.	
e) Programme of engagement in relation to the establishment of the Clinical Transformation Partnership.	None identified.		e) Clinical and Care Professional Leadership Model Update presented to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Joint Clinical Leaders of the CCG with shared responsibility for providing clinical leadership to the development of strategic commissioning to secure continuous improvement in the quality of healthcare services and outcomes for patients.	None identified.		a) Joint Clinical Leader Reports to the Governing Body (latest April 2022).	✓				None identified.	
b) GP Representatives 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); alongside the roles of the ICP and PCN Clinical Directors.	None identified.		b) Prioritisation and Investment Committee minutes, and highlight reports, presented to the Governing Body (each meeting).	✓				None identified.	
c) Prioritisation and Investment Committee's duty to set the CCG's ethical decision-making framework and prioritisation methodology and process, and evaluate, scrutinise and quality assure the clinical and cost effectiveness of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services.	None identified.		c) Primary Care Commissioning Committee minutes, and highlight reports, presented to the Governing Body (each meeting).	✓				None identified.	
d) Primary Care Commissioning Committee's remit to manage relevant primary medical services contracts including by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety).	None identified.								
e) Clinical membership of the Governing Body and Committees, as described in the CCG's Constitution and Governance Handbook.	None identified.								

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
f) The Clinical Design Authority (CDA) exists to provide clinical leadership in relation to the commissioning of health services for the population of the CCG. The CDA provides advice in relation to clinical policies, clinical pathways and referral guidelines, with the aim of meeting the health needs of the CCG's population within limited resources, whilst reducing unwarranted clinical variation and improving consistency of pathways.	None identified.								
g) CCG's Ethical Decision-Making Framework which outlines four key ethical principles that form the basis of decisions made in accordance with the Service Benefit Review Policy, with rationale 2 specifically linked to improvement in health outcomes.	None identified.								
h) Service Restriction Policy, and supporting processes, which ensures the CCG funds treatment only for clinically effective interventions delivered to the right patients.	None identified.								
i) Twice-monthly Executive Management Team meetings with ICP Clinical Leads, chaired by the CCG Joint Clinical Leaders.	None identified.								
j) Role and responsibilities of the CCG's Research and Evidence team to support the work of the CDA.	None identified.								

Action(s):	Responsible Officer	Implementation Date
Action 5.1: To appoint to the ICB Medical Director role.	ICS Executive Lead	Complete.
Action 5.2: To develop and finalise Terms of Reference for the Clinical and Professional Leadership Group (CPLG)	ICS Executive Lead (with support from the Chief Nurse / Medical Director)	Q4 2021/22 Q1 2022/23
Action 5.3: To formalise and agree clinical membership of Committees/Groups in the ICB governance structure.	ICS Executive Lead (with support from the Nursing and Medical Directors and Associate Director of Governance)	Q4 2021/22 Q1 2022/23

Risk ref: 6 Patient and public involvement				
Strategic Risk Narrative:	Failure to effectively engage with the diverse local population and ensure that patient and public insights inform decision making.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Director of Communications and Engagement	Amber / Red (5 x 2)	Amber / Red (5 x 2)	↓
ICS Risk Owner(s):	Director of Communications and Engagement			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) ICS Transition Communications and Engagement Workstream; the aims of which are: <ul style="list-style-type: none"> - To describe to citizens, stakeholders and staff the benefits of working in a more integrated way across health and care - To ensure that staff and stakeholders are informed and involved in the development and establishment of the statutory ICS. - To establish the structures and approach required for citizen and patient involvement in the ICS from April 2022. Secondary: - To ensure that citizens are informed about the establishment of the statutory ICS 	None identified.		a) Routine engagement assurance reporting to the ICS Quality and Inequalities Committee (when established) (PENDING).	✓				To establish routine engagement assurance reporting to the ICB Quality, Inequalities and Workforce Committee.	6.6
b) ICS Health and Care Workstream; the main aim of which is the statutory establishment of the ICS Health and Care Partnership functions, accountability and governance.	None identified.		b) Citizen / Patient stories presented to the ICS Board (latest September 2021, PENDING May 2022).		✓	✓		None identified.	
c) Establishment of an appropriate patient engagement /involvement/ partnership forum	To establish an appropriate patient engagement /involvement/ partnership forum within the Integrated	6.1	c) ICS Communications and Engagement Workstream Highlight Reports to the ICS Transition and Risk Committee (latest March 2022).	✓				None identified.	
			d) ICS Health and Care Workstream Highlight Reports to the ICS Transition and Risk Committee (latest March 2022).	✓				None identified.	
			e) Update to the ICS Board on implementing <i>ICS implementation guidance on working with people and communities</i> including	✓				None identified.	


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
within the Integrated Care Board's governance structure.	Care Board's governance arrangements.		presentation of the Public Involvement and Engagement Strategy (March 2022).						
d) 2022/23 Engagement Development Plan which will lay the groundwork for a framework for public involvement that can inform transition to ICS led strategic commissioning (in development).	To finalise and deliver against the 2022/23 Engagement Development Plan.	6.2	f) Public Involvement and Engagement Update to the ICS Transition and Risk Committee (February 2022).	✓				None identified.	
e) Involvement and Engagement Policy (in development)	To produce an Involvement and Engagement Policy as part of the ICB establishment.	6.3							
f) ICS Board Development Sessions to how engagement will function effectively in partnership.	None identified.								
a) Accountable Officer with overall Executive responsibility for patient and public engagement on the CCG's Governing Body.	None identified.		a) Patient and Community Engagement Indicator 2020/21 CCG Annual Assessment (e.g. compliance with statutory guidance on patient and public participation in commissioning health and care) (PENDING; 2019/20 was 'amber').	✓	✓			None identified.	
b) Director of Communication and Engagement as senior management lead for communication and engagement.	None identified.								
c) Non-Executive Director lead for Patient and Public Involvement on the CCG's Governing Body.	None identified.		b) Patient and Community Engagement Indicator 2021/2022 CCG Annual Assessment (PENDING)	✓				None identified.	
d) Patient and Public Engagement Committee, which provides an interface between communities and networks across CCG's 'footprint' for the purposes of providing a patient and public perspective in the planning and commissioning of health care services.	None identified.		c) Patient and Public Engagement Committee (PPEC) minutes, and highlight reports, presented to the Governing Body (bi-monthly).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
e) Prioritisation and Investment Committee's duty to quality assure business case proposals, including feedback from patient and public engagement/consultation activities where necessary.	None identified.		d) 2021/22 Patient and Public Involvement Annual Assurance Report to Quality and Performance Committee (PENDING due April 2022).	✓				None identified.	
f) Quality and Performance Committee's duty to scrutinise arrangements for ensuring that patient feedback and engagement are embedded in the commissioning cycle and meeting legal duties.	None identified.		e) Recovery Insight reporting to the Governing Body and associated action plan (October 2020).	✓				None identified.	
g) CCG's 2019-2021 Communications and Engagement Strategy which sets out the strategic approach for engagement for the CCG.	None identified.		f) Patient and Public Engagement assurance reporting to the Quality and Performance Committee (latest March 2022).	✓				None identified.	
h) CCG's Equality, Diversity and Inclusion (EDI) Policy, which recognises patient and public engagement as one of the CCG's key business activities where due regard to the general public sector equality duty is required. The policy requires a range of different mechanisms to be used to ensure meaningful engagement with people from all protected characteristic and disadvantaged groups in the CCG's population, particularly those whose voices may not be routinely heard.	None identified.		g) Annual Engagement Report 2020/21 presented to Quality and Performance Committee (PENDING due April 2022).	✓				None identified.	
i) CCG's Service Benefit Review Policy which sets out the importance to identify and engage with key stakeholders when developing proposals to change services.	To fully review the CCG's SBR Policy to determine its fitness for purpose for the ICS NHS statutory body.	6.4	h) Healthwatch Report presented to the PCCC meeting (June 2020).	✓				None identified.	
			i) NHSE/I's 2020/21 CCG Annual Assessment against 14 national determined Key Lines of Enquiry and five key priority areas (quality of services, reducing health inequalities, involving and consulting the public, compliance with financial duties and leadership and governance) (June 2021).		✓	✓		None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
j) CCG's Ethical Decision-Making Framework which outlines four key ethical principles that form the basis of decisions made in accordance with the Service Benefit Review Policy (Principle1: Rationale must consider views of key stakeholders).	To establish an Ethical Decision-Making Framework for the ICB NHS statutory body.	6.5	j) Internal Audit Review – Compliance with <i>ICS implementing guidance on working with people and communities</i> guidance (PENDING due Q4).		✓			None identified.	
k) Recovery Insight framework, and supporting action plan, which outlines how the CCG is listening to patients and taking their views on board.	None identified.								
l) Engagement with Health Scrutiny Committees as part of the CCG's commissioning decision making (Health Scrutiny Committees are responsible for carrying out the statutory health scrutiny function in Nottingham/shire).	None identified.								
m) CCG's relationship and engagement with Healthwatch Nottingham and Nottinghamshire (Healthwatch is an independent consumer champion for health and social care), including membership within the CCG's PPEC.	None identified.								

Action(s):	Responsible Officer	Implementation Date
Action 6.1: To establish an appropriate patient engagement /involvement/ partnership forum within the Integrated Care Board's governance arrangements, as well as at 'Place' and neighbourhood level.	Director of Communications and Engagement	Q4 2024/22 Q1 2022/23
Action 6.2: To finalise and deliver against the 2022/23 Engagement Development Plan.	Director of Communications and Engagement	March 2022 Q1 2022/23
Action 6.3: To produce an Involvement and Engagement Policy.	Director of Communications and Engagement	March 2022 Q1 2022/23

Action 6.4: To fully review the CCG's SBR Policy to determine its fitness for purpose for the ICS NHS statutory body.	Chief Commissioning Officer	Superseded.
Action 6.5: To establish an Ethical Decision-Making Framework for the ICB NHS statutory body.	Chief Commissioning Officer	April 2022 Q1 2022/23
Action 6.6: To establish routine engagement assurance reporting to the ICB Quality, Inequalities and Workforce Committee.	Director of Communications and Engagement	Q4 2021/22 Q1 2022/23

Risk ref: 7 Workforce				
Strategic Risk Narrative:	Failure to ensure sufficient capacity, capability and wellbeing support within the local workforce.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Finance Officer	Red (5 x 3)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	People and Culture SROs			


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Nominated People and Culture SRO.	To further define role and responsibilities of the People and Culture SRO as part of the statutory ICB leadership arrangements.	7.1	a) Integrated Performance Report, including the System Delivery Dashboard, presented to the ICS Board on a bi-monthly basis (latest March 2022).	✓				None identified.	
b) ICS People and Culture Strategy (2019 to 2029), which outlines five strategic priorities: <ul style="list-style-type: none"> Planning, attracting and recruiting people to work in our health and care system; Retaining staff and trainees, promoting career paths and talent management; Role redesign and embedding new roles; Developing and preparing people to work in new ways, including digital skills development; Enabling cultural change and leadership development to maximise system effectiveness. 	None identified.		b) People and Culture: Update on the delivery of the ICS People Plan 2020/21 to the ICS Board (February 2021, PENDING due May 2022).	✓				To establish routine assurance reporting in relation to delivery of the People and Culture Strategy within the ICB governance structure.	7.6
c) ICS People and Culture Two-year Delivery Plan (2019 to 2021).	None identified.		c) People and Culture: Overview of Staff Wellbeing presentation to the ICS Board (January 2021).	✓				None identified.	
d) Primary Care Workforce Strategy; supported by the Nottinghamshire Alliance Training Hub General Practice Nurse Strategy 2021/22 and	None identified.		d) People and Culture update presented to the ICS Board Development Session (October 2021).	✓				None identified.	
			e) People and Culture update scheduled for a future meeting of the ICS Transition and Risk	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
Primary Care Workforce Transformation Proposals 2021/22. e) Establishment of a People and Culture Committee, which is supported by a comprehensive governance structure, including the: <ul style="list-style-type: none"> • People, Culture and Inclusion Collaborative, which has five individual workstreams (Resourcing, OD, EDI, Wellbeing, Just and Restorative Culture); and • Primary Care Delivery Board. 	To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICB People and Culture Committee.	7.2	Committee (PENDING due April 2022).						
a) Chief Finance Officer as Executive lead for workforce and organisational development at the Governing Body. b) Finance and Resources Committee's role to: <ul style="list-style-type: none"> • Oversee the development and implementation of the CCG's Workforce Strategy (as approved by the Governing Body), including establishment of, and monitoring performance against, a set of key workforce indicators. • 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. 	None identified. None identified.		a) CCG's 2020 Staff Survey results reported to the Finance and Resources Committee and Governing Body (via Highlight Report) (March and April 2021). b) CCG's 2021 Staff Survey results reported to the Finance and Resources Committee (March and April 2022). c) Workforce Report, which includes employee turnover, vacancy rates, sickness absence, appraisals and an analysis of workforce demographics, presented to the Finance and Resources Committee (latest March 2022).		✓	✓		None identified. None identified. None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
c) CCG's 2019-2021 Organisational Development Strategy which sets out plans to devise a new culture, establish a clear vision and role as a single strategic commissioner.	None identified.		d) Workforce Report to the Governing Body (via FRC Highlight Report) (latest April 2022).	✓				None identified.	
d) CCG's 2019-2021 People Strategy which outlines plans to ensure the CCG has the right people, with the right skills, knowledge, values and experience in the right place at the right time.	None identified.		e) Bi-annual Mandatory Training Compliance Reports to the Audit and Governance Committee which outline performance (%) against all statutory and mandatory training targets (latest March 2022).	✓				None identified.	
e) Introduction of the CCG's agile working model supported by an Agile Working Policy (in development).	To finalise and publish the CCG's Agile Working Policy.	7.3	f) Health & Safety assurance reporting to the Audit and Governance Committee (twice yearly) (latest November 2021).	✓				None identified.	
f) Suite of Human Resources (HR) policies to ensure best practice in terms of: <ul style="list-style-type: none"> - Organisational change; - Flexible working; - Training and development; - Statutory and mandatory training; - Capability; and - Recruitment and selection. 	To review all HR policies to reflect implementation of the CCG's agile working model.	7.4	g) Annual Health & Safety Report to the Governing Body (via Audit and Governance Highlight Report) (PENDING due June 2022).	✓				None identified.	
g) Suite of Health and Safety Policies to ensure staff wellbeing in terms of: <ul style="list-style-type: none"> - Health, safety and security at work; - Fire safety at work; - Display Screen Equipment (DSE) use; and - Incident reporting. 	To review all H&S policies to reflect implementation of the CCG's agile working model.	7.5	h) 2021/22 Internal Audit Review – Primary Care Workforce Development (PENDING due Q4).		✓			None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
h) Staff Engagement Group, whose role is to stimulate and support an empowered, engaged and well-supported workforce.	None identified.								
i) CCG's BAME and LGBTQIA+ Staff Networks to ensure staff that identify with these protected characteristics are supported and have a safe area to talk through concerns.	None identified.								
j) CCG's Disability and Wellbeing Network (DAWN) to ensure that staff with disabilities or long-term mental or physical health conditions have a voice within the CCG and can contribute to the changing culture of the CCG.	None identified.								
k) Health, Safety and Security Steering Group exists to develop, and oversee the implementation of, comprehensive and effective health and safety (including fire and security management) arrangements within the CCG.	None identified.								
l) Role-related and personal development training, as identified through the staff appraisal process.	None identified.								
m) Monthly virtual Staff Briefings available for all staff to access 'live' and recording publicised for retrospective viewing.	None identified.								
n) Intranet Wellbeing Hub which provides all the Occupational Health Service resources offered through the Sugarman contract. This includes counselling services, financial advice and legal support.	None identified.								

Action(s):	Responsible Officer	Implementation Date
Action 7.1: To further define role and responsibilities of the People and Culture SRO as part of the statutory ICB leadership arrangements.	ICS Executive Lead	Q4 2021/22 Q1 2022/23
Action 7.2: To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICS People and Culture Committee.	Associate Director of Governance	Q4 2021/22 Q1 2022/23
Action 7.3: To finalise and publish the CCG's Agile Working Policy.	Chief Finance Officer	March 2022 Q1 2022/23
Action 7.4: To review all HR policies to reflect implementation of the CCG's agile working model (and as part of the establishment of the ICB).	Chief Finance Officer	March 2022 Q1 2022/23
Action 7.5: To review all H&S policies to reflect implementation of the CCG's agile working model (and as part of the establishment of the ICB).	Chief Nurse	March 2022 Q1 2022/23
Action 7.6: To establish routine assurance reporting in relation to delivery of the People and Culture Strategy within the ICS governance structure.	People and Culture SROs	Q4 2021/22 Q1 2022/23


Risk ref: 8 Finance				
Strategic Risk Narrative:	Failure to establish robust financial governance and resource allocation arrangements.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Finance Officer	Amber (4 x 2)	Amber (4 x 2)	
ICS Risk Owner(s):	Director of Finance			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) ICB Finance, Performance and Digital Committee (in development), supported by an operational ICS Directors of Finance Group.	To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICB Finance and Performance Committee.	8.1	a) Finance Group reporting to the ICS Board (bi-monthly) (latest March 2022).	✓				To establish routine assurance reporting from the Finance, Performance and Digital Committee to the ICB Board.	8.4
b) ICB Audit and Governance Committee (in development)	To develop Terms of Reference and Annual Work Programme for the ICB Audit and Governance Committee.	8.2	b) System assurance arrangements with NHSEI, focusing on collective finance and performance figures across the ICS.		✓	✓		None identified.	
c) ICS Finance Strategy (in development)	To finalise the development of an ICS Finance Strategy.		c) Integrated Performance Report, including the System Delivery Dashboard, presented to the ICS Board on a bi-monthly basis (latest March 2022).	✓				None identified.	
d) ICS Finance Framework, which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA).	None identified.	8.3	d) Governance Update from the Chief Finance Officer presented to the ICS Board (November 2021).	✓				None identified.	
a) Chief Finance Officer as Executive lead for financial management at the Governing Body.	None identified.		a) NHSE/I's 2020/21 CCG Annual Assessment against 14 national determined Key Lines of Enquiry and five key priority areas (quality		✓	✓		None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
b) Operational Directors of Finance with senior operational responsibility for delivery of the CCG's statutory financial duties.	None identified.		of services, reducing health inequalities, involving and consulting the public, compliance with financial duties and leadership and governance) (June 2021).						
c) Finance and Resources Committee's role to scrutinise arrangements for ensuring the delivery of the CCG's statutory financial duties, including delivery of the Financial Recovery Plan.	None identified.		b) Routine financial reporting to the: - Governing Body (bi-monthly); and - Finance and Resources Committee (monthly).	✓				None identified.	
d) Audit and Governance Committee's duties to monitor the integrity of the financial statements and financial performance.	None identified.		c) Finance and Resources Committee's minutes and highlight reports presented to the Governing Body (bi-monthly).	✓				None identified.	
e) Prioritisation and Investment Committee's role to evaluate and scrutinise the cost effectiveness of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services.	None identified.		d) Audit and Governance Committee's minutes and highlight reports presented to the Governing Body (six times a year).	✓				None identified.	
f) CCG's Standing Financial Instructions set out the CCG's high-level control environment for managing the organisation's financial affairs and include delegated limits for decision-making.	None identified.		e) 2020/21 Annual Accounts Audits (KPMG) (June 2021).		✓	✓		None identified.	
g) CCG's 2019-2024 Financial Strategy which outlines strategic plans to achieve the best possible value for every pound of allocation the CCG's spend.	None identified.		f) 2021/22 Annual Accounts Audits (KPMG) (PENDING due May/June 2022).		✓			None identified.	
h) H1 2021/22 Financial Plan and Opening Budgets which outline financial planning	To develop the H2 2021/22 financial plans, in line with national guidance.	8.5	g) 2020/21 Internal Audit Review – Integrity of the general ledger, financial reporting and budgetary control (May 2021).		✓	✓		None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
assumptions for the first six months of the financial year.			h) 2021/22 Internal Audit Review – Integrity of the general ledger, financial reporting and budgetary control (March 2022).		✓			None identified.	
i) CCG’s budget management framework which sets out operational financial management arrangements (e.g. budget monitoring, approval limits, etc.), including the refreshed Budget Holder Manual which has been published for all staff.	None identified.		i) 2020/21 Internal Audit Review – Investments and Disinvestments (March 2021).		✓	✓		None identified.	
j) Establishment of a CCG officer-led Financial Savings Group, focusing on the delivery of those savings schemes which fall within the remit of the CCG’s control (e.g. Prescribing, etc.)	None identified.		j) 2021/22 Internal Audit Review – Contracting for Continuing Healthcare (Significant).		✓	✓		None identified.	
k) CCG’s business case and service benefit review processes, which ensure affordability and Return on Investment (ROI) are key considerations in investment / disinvestment decision making.	None identified.								


Action(s):	Responsible Officer	Implementation Date
Action 8.1: To develop Terms of Reference and Annual Work Programme for the Non-Executive chaired ICB Finance, Performance and Digital Committee.	Associate Director of Governance	Q4 2021/22 Q1 2022/23
Action 8.2: To develop Terms of Reference and Annual Work Programme for the ICB Audit and Governance Committee.		Q4 2021/22 Q1 2022/23
Action 8.3: To continue developing an ICS Finance Strategy.	Chief Finance Officer	Q4 2021/22 Q1 2022/23
Action 8.4: To establish routine assurance reporting from the Finance, Performance and Digital Committee to the ICB Board.	Chief Finance Officer	Q4 2021/22 Q1 2022/23
Action 8.5: To develop the H2 2021/22 financial plans, in line with national guidance.	Chief Finance Officer	Complete.

Risk ref: 9 Data, analytics, information and technology				
Strategic Risk Narrative:	Failure to deliver digital transformation and establish effective system intelligence solutions.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Finance Officer	Amber / Red (4 x 3)	Amber (4 x 2)	
ICS Risk Owner(s):	DAIT SRO			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Nominated Data, Analytics, Information and Technology (DAIT) SRO.	To further define role and responsibilities of the DAIT SRO as part of the statutory ICB leadership arrangements.	9.1	a) DAIT Strategy Implementation Plan presented to the ICS Board (January 2021, PENDING due May 2022).	✓				To establish routine assurance reporting in relation to delivery of the DAIT Strategy within the future ICB governance structure.	9.3
b) Data, Analytics, Information and Technology (DAIT) Strategy (2020 to 2024), which outlines five strategic initiatives: <ul style="list-style-type: none"> Develop our Public Facing Digital Services; Develop our Population Health Management capability, aligned with powerful Analytics and Intelligence to support all initiatives; Complete the digitisation of providers by 2024; Develop a single summary health and care record and supported workflows, by interoperability of our health and care data and systems; and to Improve the digital literacy of the workforce and the capability and capacity of our digital and informatics specialists and develop our culture, investment and governance. 	None identified.		b) Reporting against delivery of System Development Plan / 'Readiness to Operate' Assessments with NHSE/I (e.g. 'Checkpoints') (quarterly, latest March 2022).		✓	✓	None identified.		
			c) DAIT Update presented to the ICS Board Development Session (October 2021).	✓				None identified.	
			d) DAIT Update presented to the ICS Transition and Risk Committee (February 2022).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
c) Data, Analytics, Information and Technology (DAIT) Group and supporting delivery group structure.	To review and revise Terms of Reference for the Digital and Data Group in line with the future ICB governance arrangements.	9.2							
d) Establishment of the System Analytics and Intelligence Unit, which will take forward the ICS population health management (PHM) programme and individual 'outputs'.	None identified.								
a) GP Information Technology (IT) Steering Group which exists to develop, support and implement the necessary IT infrastructure within the CCG's CP member practices.	None identified.		a) GP IT Steering Group routine reporting to the Primary Care Commissioning Committee (latest February 2022, update due April 2022).	✓				None identified.	
b) Primary Care Information Technology Strategy (2021-2026) which sets out the enhanced five-year strategy, specifically aimed at IT services and functionality for primary care, most notably GP practices.	None identified.		b) Primary Care Information Technology Strategy (2021-2026) presented to the Primary Care Commissioning Committee and Finance and Resource Committee (September 2021).	✓				None identified.	
			c) Update on timeframes and delivery against the Primary Care Information Technology Strategy (PENDING due April 2022).	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 9.1: To further define role and responsibilities of the DAIT SIRO as part of the statutory ICB leadership arrangements.	ICS Executive Lead	Q4 2021/22 Q1 2022/23
Action 9.2: To develop a clear Terms of Reference for the Digital and Data Group as part of the future ICB governance arrangements.	DAIT SRO	Q4 2021/22 Q1 2022/23
Action 9.3: To establish routine assurance reporting regarding delivery of the DAIT Strategy within the future ICB governance structure.	DAIT SRO	Q4 2021/22 Q1 2022/23

Risk ref: 10 ICS Operating Model				
Strategic Risk Narrative:	Failure to establish an effective operating model at ICS and 'place' level.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Accountable Officer	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	Executive Lead			


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) ICS Partnership Agreement, which has been signed-up to by all system partners and demonstrates a commitment to work effectively together for the benefit of all communities and citizens within Nottingham and Nottinghamshire.	None identified.		a) System Development Plan Updates (including the ICS Progression Tool) presented to the ICS Transition and Risk Committee (latest March 2022, PENDING April 2022).	✓				None identified.	
b) System Development Plan, ICS Progression Tool and 'Readiness to Operate Statement' which all exist to ensure the ICS has established an effective operating model for 1 April 2022.	None identified.		b) Reporting against delivery of System Development Plan / System 'Readiness to Operate' Checkpoints with NHSEI (quarterly, latest March 2022).		✓	✓		None identified.	
c) Establishment of transition workstreams, with nominated SROs and Programme Leads, in relation to: <ul style="list-style-type: none"> Integrated Care Partnership Workstream; Integrated Care Board Establishment, Accountability and Governance; CCG Transition; Joint Commissioning for Integrated Care; Integrated Commissioning with NHSEI; Provider Collaboratives; 	None identified.		c) ICS Workstream Highlight reporting to the Transition and Risk Committee (monthly, latest March 2022).	✓				None identified.	
			d) ICS Progression Tool Self-Assessment / Readiness to Operate Assessment presented to the ICS Transition and Risk Committee (March 2022).	✓				None identified.	
			e) NHS Bassetlaw CCG Boundary Decision Updates presented to the ICS Transition and Risk Committee	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
<ul style="list-style-type: none"> Place Model; Communications & Engagement; and Clinical Leadership and Engagement. 			(February 2022, March 2022 and PENDING April 2022).						
d) Place Workstream, specifically established to oversee and support the development of Places within Nottingham and Nottinghamshire, ensuring they are a key pillar for the local integrated care model enabling decisions to be taken as close to the local population as possible.	None identified.		f) ICS Transition and Risk Committee Highlight Reports to the ICS Board (latest March 2022).	✓				None identified.	
e) ICS Transition and Risk Committee, with duty to oversee the system transition to meet NHSEI requirements to establish a statutory NHS ICS Body and an Integrated Care Partnership (subject to legislation) by 1 April 2022.	None identified.		g) 360 Assurance (Internal Audit) attendance at monthly ICS Transition and Risk Committee meetings.		✓	✓		None identified.	
f) Fortnightly operational ICS and CCG Transition meetings with all workstream leads.	None identified.		h) Internal Audit Review of ICS Transition Programme plans/assurance (No Opinion, January 2022).		✓	✓		None identified.	
g) Establishment of a Primary Care Transition Oversight Group to support the delivery of the Integrated Commissioning with NHSEI Workstream.	None identified.		i) Integrated Care Partnership (ICP) Update presented to the ICS Board for discussion (February and March 2022).	✓				None identified.	
h) ICS Board Development Sessions to ensure successful future partnership working. Topics (to date) include the role and membership of the Integrated Care Board, the role of Place, the Integrated Care Partnership and how engagement will function effectively in partnership.	None identified.		j) Clinical and Care Professional Leadership Model Update presented to the ICS Board for discussion (PENDING due May 2022).	✓				None identified.	
			k) Provider Collaborative Update presented to the ICS Board for discussion (PENDING due May 2022).	✓				None identified.	
			l) Place Based Partnerships Update presented to the ICS Board for	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
i) Nottingham and Nottinghamshire ICS Organisational Development (OD) Plan (in development)	To develop and implement the ICS' OD Plan.	10.1	discussion (PENDING due May 2022).						
			m) Transition Equality Impact Assessment presented to the ICS Transition and Risk Committee (March 2022).	✓				None identified.	
			n) Organisational Development Update to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	
			o) 'Deep Dive' Provide Collaboratives at Scale Update to the ICS Transition and Risk Committee (March 2022).	✓				None identified.	
			p) ICB Constitution and Governance Arrangements Update to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	
			q) 'Deep Dive' Joint Commissioning for Integrated Care and Place-Based Partnerships to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	
			r) Clinical and Care Professional Leadership Model Update to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
			s) System Oversight Arrangements between NHSE and ICB Update to the ICS Transition and Risk Committee (PENDING due April 2022).	✓				None identified.	
			t) 'Deep Dive' PCN Development Update to the ICS Transition and Risk Committee (March 2022).	✓				None identified.	
a) Alignment of CCG structure/workforce as part of the merger to a single strategic commissioner in April 2021.	None identified.		a) System Development Update presented to the Governing Body Development Session (September 2021).	✓				None identified.	
			b) ICB Establishment Update presented to the Governing Body Development Session (January 2022).	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 10.1: To develop and implement the ICS' OD Plan.	ICS Programme Director	Q3 2024/22 Q4 2021/22

Risk ref: 11 Governance and decision-making				
Strategic Risk Narrative:	Failure to establish robust governance, accountability and assurance arrangements.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse	Amber (4 x 2)	Amber (4 x 2)	
ICS Risk Owner(s):	Executive Lead			


Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) ICS Partnership Agreement, which has been signed-up to by all system partners and demonstrates a commitment to work effectively together for the benefit of all communities and citizens within Nottingham and Nottinghamshire.	None identified.	11.1	a) Report from the Independent Chair and Executive Lead to the ICS Board (latest March 2022).	✓				None identified.	
b) Statutory ICS Establishment, Accountability and Governance Workstream; which will enable the ICB statutory establishment in support of ICB functions.	None identified.		b) Highlight reports from the ICS Transition and Risk Committee to the ICS Board (latest March 2022).	✓				None identified.	
c) ICB Board and Committee structure, which ensures robust accountability and decision-making arrangements, including an ICB Constitution and Governance Handbook.	To establish and embed in 'shadow' governance, accountability and assurance arrangements for the new ICB statutory organisation.		c) ICS Governance update presented to the ICS Board, outlining the transition governance and strategic risks (July 2021).	✓				None identified.	
d) System Development Plan, which outlines the ambition of the system and progress against 20 development actions to ensure the ICS is prepared to become a statutory body in April 2022 (subject to legislation).	None identified.		d) System Development Plan iterations presented to the ICS Transition and Risk Committee (February 2022, March 2022 and PENDING May 2022).	✓				None identified.	
e) ICS Progression Tool and 'Readiness to Operate Statement' which all exist to ensure	None identified.		e) Workstream Highlight Reports presented to the ICS Transition and Risk Committee (monthly; latest March 2022).	✓				None identified.	
			f) ICB Constitution and Governance Arrangements Update to the ICS	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
the ICS has established an effective operating model for the 1 April 2022.			Transition and Risk Committee (PENDING due April 2022).						
f) ICS Board Development Sessions; topics (to date) include the role and membership of the Integrated Care Board, the role of Place, the Integrated Care Partnership and how engagement will function effectively.	None identified.								
a) All Governing Body and Committee member roles in relation to ensuring that standards of business conduct are upheld, and meetings of the Governing Body and Primary Care Commissioning Committee are held in public.	None identified.	11.2	a) Minutes for all CCG corporate committees (including Governing Body) outlining any conflicts of interest and how these have been managed.	✓				None identified.	
b) Accountable Officer's specific responsibilities for ensuring proper governance arrangements are in place.	None identified.		b) Tender Waiver Register presented to the Audit and Governance Committee (latest March 2022).	✓				None identified.	
c) Chief Nurse as Executive lead for corporate governance on the Governing Body.	None identified.		c) Probity Update presented to the Audit and Governance Committee (latest September 2021).	✓				None identified.	
d) Non-Executive Directors nominated as Conflicts of Interest Guardian and Freedom to Speak Up Guardian.	To continue to develop Freedom to Speak Up Guardian arrangements in line with the Staff Survey action plan.		d) 2020/21 Annual Governance Statements submitted to NHSEI (May 2021).	✓				None identified.	
e) Associate Director of Governance as senior management lead for corporate governance.	None identified.		e) 2021/22 Annual Governance Statement (PENDING due May 2022).	✓				None identified.	
f) Audit and Governance Committee's role to scrutinise every instance of non-compliance with the CCG's Standing Documents and monitoring compliance with the CCG's	None identified.		f) 2021/22 Internal Audit Review – Conflicts of Interest (August 2021).		✓	✓		None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
Conflict of Interest, Gifts, Hospitality and Sponsorship and Whistleblowing Policies.			g) 2021/22 Annual Self Review Tool (SRT) submission to NHS Counter Fraud Authority (PENDING).		✓			None identified.	
g) Conflicts of Interest Policy sets out the CCG's requirements in relation to openness and transparency in business transactions, including: <ul style="list-style-type: none"> • Maintenance and publication of a Register of Declared Interests; • Arrangements for managing standing declared interests and those declared in meetings; • Specific requirements for managing interests in procurements; and • Maintenance and publication of a Procurement Decisions Log. 	None identified.		h) Bi-annual Mandatory Training Compliance Reports to the Audit and Governance Committee which outline performance (%) against all statutory and mandatory training targets (latest March 2022).		✓			None identified.	
h) Gifts, Hospitality and Sponsorship Policy sets out the CCG's requirements to maintain and publish a Gifts, Hospitality and Sponsorship Register.	None identified.								
i) Raising Concerns (Whistleblowing) Policy sets out arrangements for employees of the CCG to voice any concerns they have in relation to the conduct of the organisation.	None identified.								
j) Fraud, Bribery and Corruption Policy, which sets out the arrangements to manage anti-fraud, corruption and bribery within the CCG.	None identified.								
k) Procurement Policy describes the CCG's approach to the procurement, commissioning and contract management of goods, services	None identified.								

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
and works, whilst ensuring probity in spending public funds.									
I) Mandatory Conflict of Interest training (annual). Role related Conflict of Interest training (Levels 2 and 3).	None identified.								


Action(s):	Responsible Officer	Implementation Date
Action 11.1: To establish and embed in 'shadow' governance, accountability, and assurance arrangements for the new ICB statutory organisation.	ICS Executive Lead	January 2022 Q1 2022/23
Action 11.2: To continue to develop Freedom to Speak Up Guardian arrangements in line with the Staff Survey action plan.	Chief Nurse	Complete Q1 2022/23

Risk ref: 12 Emergency Preparedness, Resilience and Response				
Strategic Risk Narrative:	Failure to be adequately prepared to respond to major and/or business continuity incidents.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Commissioning Officer	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	N/A			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Nominated CCG Non-Executive Director lead for Emergency Preparedness, Resilience and Response (EPRR).	None identified.		a) 2020/21 EPRR statement of assurance submission to NHSE/I presented to the Governing Body (October 2020).		✓	✓		None identified.	
b) CCG's Emergency Preparedness, Resilience and Response (EPRR) Policy, which outlines how the CCG complies with its statutory responsibilities and EPRR obligations, planning and responding to a major incident and or a business continuity incident.	None identified.		b) 2020/21 EPRR statement of assurance submission to NHSE/I presented to the Audit and Governance Committee (November 2021).		✓	✓		None identified.	
c) CCG's Incident Response Plan which describes the systems and processes that will be followed when responding to major incidents and emergencies in line with the requirements of the Civil Contingencies Act.	None identified.		c) Peer review of Incident Response Plan by the Local Health Resilience Partnership (LHRP), of which the CCG is a member.		✓	✓		None identified.	
d) CCG's Business Continuity Plan, which sets out the roles, responsibilities and actions to be taken to enable continuity and recovery of the key parts of the service following a significant disruption.	None identified.		d) Routine COVID-19 updates provided to the Governing Body via Accountable Officer's Reports.	✓				None identified.	
e) CCG's On-Call Handbook / Action Cards (and rota) which ensure a robust and consistent approach to the implementation of on-call	None identified.		e) EPRR and business continuity updates provided to the Audit and Governances Committee (latest	✓				None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
arrangements. Annual refresher training for all Silver and Gold On-Call			November 2021, further update due March 2022).						
f) CCG's COVID-19 Emergency Response structure, including the Incident Management Team (IMT) and escalation to the System CEO Team and Health and Social Care Economy Tactical Co-ordinating Group (HSCETCG).	None identified.		f) EPRR and COVID-19 Pandemic Response Update presented to the Governing Body Development Session (January 2022).	✓				None identified.	
g) CCG representative on the Local Health Resilience Partnership (LHRP), which provide a strategic forum for local organisations to facilitate health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level.	None identified.								
h) CCG representative on the Nottingham and Nottinghamshire Local Resilience Forum (LRF), which identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.	None identified.								

Action(s):	Responsible Officer	Implementation Date
None.		


Risk ref: 13 Equality, Diversity and Inclusion				
Strategic Risk Narrative:	Failure to comply with the general and specific Public Sector Equality Duties (PSED).	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	N/A			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) 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.	None identified.		a) Compliance with the PSED incorporated within the CCG's 2020/21 Annual Reports, presented to the Audit and Governance Committee (May/June 2021).	✓				None identified.	
b) Chief Nurse as Executive lead for equality, diversity and inclusion on the Governing Body.	None identified.		b) Routine reporting against the CCG's Annual Equality Improvement Plan and Equality Objectives to the Finance and Resources Committee and Quality and Performance Committee (September 2021).	✓				None identified.	
c) Executive champions for specific protected characteristic areas: <ul style="list-style-type: none"> BAME Champion – Chief Finance Officer LGBTQIA+ Champion – Chief Nurse DAWN (Disability) Champion – Chief Nurse 	None identified.		c) Annual Equality Assurance Report to the Governing Body (October 2021).	✓				None identified.	
d) The Quality and Performance Committee's responsibility for monitoring the CCG's equality performance in relation to its role as a commissioner of health services.	None identified.		d) Reporting of the CCG's performance against the NHS WRES as part of Workforce Report to the Finance and Resources Committee (September 2021).	✓				None identified.	
e) The Finance and Resources Committee's responsibility for monitoring the CCG's	None identified.								

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
<p>equality performance in relation to its role as an employer.</p> <p>f) The Prioritisation and Investment Committee's responsibility 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.</p> <p>g) The Remuneration and Terms of Service Committee's responsibilities for overseeing compliance with the gender pay gap requirements set out in the Equality Act 2010.</p> <p>h) Equality, Diversity and Inclusion (EDI) 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.</p> <p>i) Key CCG business activities where due regard to the general public sector equality duty is required include:</p> <ul style="list-style-type: none"> • Assessing the health needs of our population; • Public engagement and communications; • Equality impact assessments; • Procurement and contract management; • Recruitment, selection and the working environment; and • Cultural competence. 	<p>None identified.</p> <p>None identified.</p> <p>None identified.</p> <p>None identified.</p>		<p>e) Bi-annual Mandatory Training Compliance Reports to the Audit and Governance Committee which outline performance (%) against all statutory and mandatory training targets (latest March 2022).</p> <p>f) Gender Pay Gap Report to the EDI Steering Group, RATS Committee and Governing Body (March 2022 to EDI, PENDING).</p>	<p>✓</p> <p>✓</p>				<p>None identified.</p> <p>None identified.</p>	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
j) The CCG's compliance with (or working toward the principles of) the: <ul style="list-style-type: none"> NHS Accessible Information Standard NHS Workforce Race Equality Standard (WRES) The NHS Workforce Disability Equality Standard (DES). 	None identified.								
k) The Equality, Diversity and Inclusion Steering Group exists to monitor the CCG's compliance with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations). The Group drives the equality, diversity and inclusion agenda within the CCG and provides a focal point for the discussion, development and implementation of ways to improve the CCG's equality performance.	None identified.								
l) The Equality and Quality Impact Assessment (EQIA), which will monitor the effectiveness of arrangements in place within the CCG in relation to the completion of equality impact assessments when planning, changing or removing a service, policy or function.	None identified.								
m) Mandated Equality and Diversity training (three-yearly).	None identified.								


Action(s):	Responsible Officer	Implementation Date
None.		

Risk ref: 14 Safeguarding				
Strategic Risk Narrative:	Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	N/A			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) Chief Nurse as Executive lead for safeguarding.	None identified.		a) 2020/21 Annual Safeguarding Reports to the Quality and Performance Committee (including Adults, Children and LAC).	✓				None identified.	
b) Designated and Named Professionals in line with the Royal College of Nursing (RCN) Intercollegiate guidance.	None identified.		b) 2021/22 Annual Safeguarding Reports to the Quality and Performance Committee (including Adults, Children and LAC).	✓				None identified.	
c) Quality and Performance Committee's duty to scrutinise arrangements for safeguarding vulnerable adults and children in line with the CCG's statutory requirements	None identified.		c) Routine nursing and quality reporting to the Quality and Performance Committee (quarterly, plus monthly exception reports), which includes safeguarding.	✓				None identified.	
d) CCG's Safeguarding Policy (incorporating PREVENT and Safeguarding Training Strategy) describes how the CCG discharges its safeguarding responsibilities for commissioning health services.	None identified.		d) NHS England Safeguarding Commissioning Assurance Tool submissions (PENDING).		✓			None identified.	
e) Policy and Procedure for Managing Allegations and Concerns That an Employee or Those Who Act in the Capacity of Employees May pose a risk to a Child, Young Person or an Adult in Need of Safeguarding.	None identified.		e) Bi-annual Mandatory Training Compliance Reports to the Audit and Governance Committee which outline performance (%) against all	✓				None identified.	
f) Mental Capacity Act (MCA) 2005 Policy which outlines the duties placed on health and social care staff and how various processes within	None identified.								

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
the MCA should be followed (in development).			statutory and mandatory training targets (latest March 2022).						
g) Executive Oversight Group, which is a quarterly meeting with all safeguarding designated professionals across Nottingham and Nottinghamshire.	None identified.		f) Safeguarding Children and Adults Boards / Strategic Partnerships minutes presented to the Governing Body (via Accountable Officer report).		✓	✓		None identified.	
h) Safeguarding Assurance Group (SAG), which has operational responsibilities for ensuring delivery of the CCG's statutory safeguarding duties.	None identified.		g) External scrutiny via members on the Partnership Boards (e.g. Local Authority members).		✓	✓		None identified.	
i) Mandated safeguarding training (three yearly). Role-related safeguarding training.	None identified.		h) 2021/22 Internal Audit Review – Safeguarding Review (PENDING due Q4)		✓			None identified.	
j) CCG partner of the Local Safeguarding Adults Boards and Multi Agency Public Protection (MAPPA) Strategic Management Board (City and County).	None identified.		i) 2021/22 Internal Audit – Review of CCG Multi-Agency Safeguarding Hub (MASH) (Limited Assurance).		✓		✓	None identified.	
k) CCG's statutory membership on the Children's Partnership Boards (City and County).	None identified.								
l) Routine safeguarding assurance processes, such as the completion of Section 11 Audits, Serious Case Reviews, Domestic Homicide Reviews and Multi Agency Audits.	None identified.								


Action(s):	Responsible Officer	Implementation Date
None.		

Risk ref: 15 Cyber Security				
Strategic Risk Narrative:	Failure to prevent potential cyber-attacks.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Finance Officer (SIRO)	Red (5 x 3)	Amber / Red (4 x 3)	
ICS Risk Owner(s):	N/A			

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
a) NHIS Cyber Security Strategy which outlines compliance with the 10 Steps to Cyber Security.	Refresh of the NHIS Cyber Security Strategy	15.1	a) Information Governance Compliance reporting to the Audit and Governance Committee (latest March 2022).	✓				None identified.	
b) Data Security and Protection Toolkit (DSPT), which includes the requirement to comply with standards relating to cyber security.	None identified.		b) 2020/21 Internal Audit Review – Cyber Security (March 2021).		✓	✓		None identified.	
c) Information Governance Management Framework which outlines the strategic framework for managing and supporting the information governance agenda of the CCG.	None identified.		c) NHIS Cyber Security Assurance Highlight Reports, which are routinely produced for the IG Steering Group (latest March 2022).	✓				None identified.	
d) Information Security Policy (2020 to 2023) which defines security measures applied through technology and encompasses the expected behaviour of those who manage information within the organisation.	None identified.		d) Bi-annual Mandatory Training Compliance Reports to the Audit and Governance Committee which outline performance (%) against all statutory and mandatory training targets (latest March 2022).	✓				None identified.	
e) NHIS Cyber Assurance Programme Board and Cyber Assurance Delivery Group, both of which representatives of the CCG are members.	None identified.		e) 2021/22 Internal Audit Review – Data Security Standards (PENDING due Q4).		✓				

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
f) Joint CCG and NHIS Cyber Resilience exercise (September 2020), which tested the response to a cyber-attack with the aim of understanding our level of preparedness and to identify any gaps.	None identified.								
g) Mandatory IG training / data security training for all staff (annual requirement).	None identified.								
h) Cyber Security training for all Governing Body members.	To agree plan for cyber training for all future ICB Board members.	15.2							
i) NHIS ISO 27001 accreditation, which is a recognised industry standard for maintaining an Information Security Management System within the NHS.	None identified.								
j) NHIS Cyber Assurance Programme Board and Cyber Assurance Delivery Group, both of which representatives of the CCG are members.	None identified.								

Action(s):	Responsible Officer	Implementation Date
Action 15.1 To undertake a refresh of the NHIS Cyber Security Strategy.	Chief Finance Officer (SIRO)	Q4 2024/22 Q1 2022/23
Action 15.2 To agree plan for cyber training for all future ICB Board members.	Chief Finance Officer (SIRO)	By March 2022 By June 2022

Risk ref: 16 CCG Disestablishment (subject to legislation)				
Strategic Risk Narrative:	Failure to transfer CCG functions, staff and assets safely and effectively.	Risk score (I x L)	Target score (I x L)	Movement in risk score
CCG Risk Owner(s):	Chief Nurse	Amber / Red (5 x 2)	Amber / Red (5 x 2)	
ICS Risk Owner(s):	N/A			

Controls			Assurances							
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:	
a) CCG Disestablishment and Transition Workstream, specifically established to oversee and management the disestablishment of NHS Nottingham and Nottinghamshire CCG.	None identified.	16.1	a) ICS Workstream Highlight reporting to the Transition and Risk Committee (monthly, latest March 2022).	✓				None identified.		
b) CCG membership on the ICS Transition and Risk Committee, with duty to oversee the system transition to meet NHSEI requirements to establish a statutory NHS ICB Body (subject to legislation) by 1 July 2022.	None identified.		b) System Development Update presented to the Governing Body Development Session (September 2021).	✓				None identified.		
c) CCG attendance at fortnightly operational ICS and CCG Transition meetings with all workstream leads.	None identified.		c) Due Diligence Assurance reports to the Audit and Governance Committee (November 2021, January 2022 and March 2022).	✓				None identified.		
d) Due Diligence Plan, People Impact Assessment, Equality Impact Assessment and Management of Change Process	Due Diligence Plan, People Impact Assessment, Equality Impact Assessment and Management of Change Process to be finalised.		d) Internal Audit Review of ICS Transition Programme plans/assurance (January 2022, No opinion).		✓	✓			None identified.	
e) Establishment of a Due Diligence 'Task and Finish' Group, which oversees delivery of the requirements within the NHSEI Due Diligence Checklist.	None identified.		e) Reporting against delivery of System Development Plan / 'Readiness to Operate' Assessments with NHSE/I (e.g. 'Checkpoints') (quarterly, latest March 2022).		✓	✓			None identified.	

Controls			Assurances						
Control Description <i>(How are we going to stop the risk happening?)</i>	Gaps in Control	Action ref:	Assurance Description <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Assurance	Action ref:
			f) ICB Establishment Update presented to the Governing Body Development Session (January 2022).	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 16.1 To finalise Due Diligence Plan, People Impact Assessment, Equality Impact Assessment and Management of Change Process.	Associate Director of Governance	Q3 2021/22 Q4 2021/22 Q1 2022/23



Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Governing Body (Open Session)	Date:	06 April 2022
Paper Title:	Corporate Risk Report	Paper Reference:	GB 22 020
Sponsor:	Rosa Waddingham, Chief Nurse	Attachments/ Appendices:	-
Presenter:	Lucy Branson, Associate Director of Governance		
Purpose:	Approve <input type="checkbox"/>	Endorse <input type="checkbox"/>	Review <input type="checkbox"/>
			Receive/Note for: <input checked="" type="checkbox"/> <ul style="list-style-type: none"> • 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	<input checked="" type="checkbox"/>	Wider system architecture development (e.g. ICP, PCN development)	<input type="checkbox"/>
Financial Management	<input checked="" type="checkbox"/>	Cultural and/or Organisational Development	<input checked="" type="checkbox"/>
Performance Management	<input type="checkbox"/>	Procurement and/or Contract Management	<input type="checkbox"/>
Strategic Planning	<input type="checkbox"/>		

Conflicts of Interest:

No conflict identified

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	Not applicable to this report
Data Protection Impact Assessment (DPIA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>	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. **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 **twelve** major (**red**) operational risks in its Corporate Risk Register. This is an overall increase of two major risks since the last meeting; which is comprised of one risk being archived, one risk score being reduced and four new major risks.

A summary of the latest position regarding these risks is outlined in Section 2.1 below.

The table to the right shows the profile of the current risk scores for **all** operational risks on the Corporate Risk Register.

Risk Matrix						
Impact	5 - Very High					1
	4 – High		3	6	10	1
	3 – Medium		3	5	2	
	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 098 <i>(July 2019)</i>	<p>The risk of over reliance on non-recurrent (one-off) funds / mitigations to temporarily offset recurring (year on year) pressures may result in:</p> <ul style="list-style-type: none"> • Deterioration in the CCG’s recurrent underlying financial position. • Depletion of non-recurrent funds available. • Over-reliance becoming a substitute for not needing to take recurrent corrective actions. • Adverse impact on overall financial position in the medium to long term. <p>Update: <i>The CCG is forecasting a breakeven year-end position for 2021/22. However, given the continued reliance on underspends and non-recurrent solutions for both this financial year, and within 2022/23 planning, it is considered appropriate for the risk score to remain at 16.</i></p>	Overall Score 16: Red (14 x L4)	Finance & Resources Committee

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
<p>RR 116 (Oct 2019)</p>	<p>Lack of assurance regarding systematic improvements in the quality of mental health and community services provided by Nottinghamshire Healthcare Trust (NHCT), may present a risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for members of the CCG's population.</p> <p>Update: <i>The Trust continues to be on an 'improvement journey' with examples of good practice particularly around the performance indicators. Improvements are also being made in relation to suicide prevention, establishment of improvement boards and Trust-wide quality governance.</i></p> <p><i>The Quality Team continues to work with the Trust as part of their organisational-wide Improvement Plans. There is improved openness and transparency with the CCG, however, there continues to be concerns regarding the pace of change and it is clear that more work is required to evidence the scale of change required.</i></p> <p><i>Following discussions with the Chief Nurse, it was advised that recent external visits have been undertaken at the Trust and until the output of these has been formally received, and subsequent assurance regarding any actions required, the score should remain at 16. A 'deep dive' review into mental health is being undertaken at the April meeting of the Quality and Performance Committee at which time the risk score will be reviewed.</i></p>	<p>Overall Score 16: Red (14 x L4)</p>	<p>Quality & Performance Committee</p>
<p>RR 130 (May 2020)</p>	<p><i>Health inequalities may be exacerbated across the population of Nottingham and Nottinghamshire if robust processes are not in place to ensure the prompt restoration of services.</i></p> <p>Update: <i>The Planned Care Transformation Board continues to oversee progress with elective recovery, supported by the Elective Hub. Clinical prioritisation is the priority in addressing waiting list backlogs. This is undertaken by clinicians in line with the P1, P2, P3 etc. pathways and using national Royal College guidance. Work is also underway to analyse waiting lists through a deprivation and ethnicity 'lens' to help inform understanding of health inequalities.</i></p> <p><i>The ICS Health Inequalities Group continues to meet, reporting to the System Executive Group. The Group brings together all partners along with the Directors of Public Health and the Health and Wellbeing Board Chairs. Assurance reporting will be via the ICS Quality, People and Inequalities Committee when in place. An operational ICS Health Inequality, Prevention and Wider Determinants Group also exists. There is also dedicated resource within the System Assurance Intelligence Unit (SAIU) which focuses on analysis of Health Inequalities data to support the mitigation of this risk.</i></p>	<p>Overall Score 16: Red (14 x L4)</p>	<p>Prioritisation & Investment Committee</p>

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
	<i>The System continues to develop its Health Inequalities Plan, as well as developing and agreeing health gain metrics and progressing plans for the ICS as an Anchor Institution.</i>		
RR 156 (Nov 2020)	<p>Lack of assurance regarding systematic improvements required in the quality of maternity services provided by Nottingham University Hospitals NHS Trust (NUH), may present a risk of unsafe care, poor clinical outcomes and/or patient safety issues for members of the CCG's population.</p> <p>Update: <i>NUH Maternity Services continue to be a priority focus area of the ICS Quality Assurance and Improvement Group (QAIG). Daily NUH Safe Today calls are in place and mutual aid has been provided from neighbouring providers and system partners.</i></p> <p><i>A comprehensive briefing in relation to NUH Maternity Services was provided at the March meeting of the Quality and Performance Committee; although assurances were provided around the work being undertaken through the NUH Quality Assurance Group (QAG), it was recognised that further demonstrable assurances were required regarding improvements to patient experience and outcomes. Workforce also continues to have a significant impact on this risk. As such, the risk is to remain at 25.</i></p>	Overall Score 25: Red (15 x L5)	Quality & Performance Committee
RR 158 (April 2021)	<p>The transition to system-led financial accountability, coupled with the continued expectation that each constituent organisation achieves its statutory organisational requirements, presents a potential risk that the CCG may not deliver its 2021/22 financial duties (e.g. if individual organisation-led objectives for 2021/22 are not congruent with system level objectives (and vice versa)).</p> <p>This risk may be further exacerbated given the underlying, deficit position across the system.</p> <p>Update: <i>Monitoring of the system-wide financial position continues. Work continues to be undertaken as part of the Governance/Accountability workstream to develop and implement transition governance arrangements, with support from the Chief Finance Officer and Operational Directors of Finance. The operational ICS Directors of Finance Group continues to meet. Proposals regarding 'shadow' ICB governance arrangements are being revised following the national deferral of ICB establishment.</i></p> <p><i>An ICS Finance Framework has been produced and 'signed off' by the ICS Chief Executives Group and ICS Board, which sets out the rules which govern the way finances are managed within the ICS. The Framework was revisited at the ICS Directors of</i></p>	Overall Score 16: Red (14 x L4)	Finance & Resources Committee

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
	<p><i>Finance meeting during November 2021 to reaffirm some of the principles contained within.</i></p> <p><i>Work has also been undertaken to develop a formal financial 'risk sharing' agreement; this has been used as part of the H2 planning exercise to achieve a balanced plan and the principles are being further defined as part the 2022/23 planning process. A new risk relating to the 2022/23 financial year has been drafted; with this risk being proposed for archiving in line with Month 12 reporting.</i></p>		
<p>RR 160 (Oct 2019)</p>	<p>Sustained levels of significant pressure on primary care workforce, due to the COVID vaccination programme, management of long term conditions and the impact of deferrals/delays in secondary care activity, present a potential risk in relation to staff exhaustion and 'burn out'.</p> <p>Update: <i>The quality of primary care services continues to be monitored by the CCG; this includes work which has been undertaken to develop the Primary Care Support and Assurance Framework which is now routinely presented to the Primary Care Commissioning Committee meetings. The LMC also continues to provide support to GP Practices as and when required. The primary care OPEL reporting has been revised; reporting level 1 (green) indicates that resource is able to be provided in support of other GP practices. PCN workforce planning and 'roving' workforce support is also in place.</i></p> <p><i>Routine mechanisms are in place to enable Locality Directors to meet PCN leaders regularly at Place level regarding resilience, business continuity and the vaccination programme, maintaining relationships and trust.</i></p> <p><i>However, in response to discussions at Committee meetings, it was recognised that there continues to be a high level of sustained pressure within primary care, which is exacerbating the risk around staff exhaustion and 'burn out'. The risk score remains at 16.</i></p>	<p>Overall Score 16: Red (14 x L4)</p>	<p>Primary Care Commissioning Committee</p>
<p>RR 162 (May 2021)</p>	<p>A number of potential, and actual, complex and significant quality issues have been identified at Nottingham University Hospitals NHS Trust (NUH).</p> <p>Lack of assurance regarding systematic improvements in the quality of services provided by the Trust may present a risk of unsafe care, poor clinical outcomes and/or patient safety issues for members of the CCG's population.</p> <p>Update: <i>System partners and Regulators have agreed to refresh oversight arrangements for NUH trust-wide with the establishment of three core subgroups as part of ongoing surveillance and support:</i></p>	<p>Overall Score 20: Red (14 x L5)</p>	<p>Quality & Performance Committee</p>

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
	<p>i. <i>Maternity Assurance Sub-Group;</i></p> <p>ii. <i>Emergency Department Assurance Sub-Group;</i></p> <p>iii. <i>Well-Led & Governance Assurance Sub-Group.</i></p> <p><i>As part of centralising assurance and providing a single shared route of escalation, a NUH QAG has been established for the subgroups to report into. This enables monitoring of overarching action plans, provides a focus on key cross cutting themes, and develops a shared agreement of assurance and risks with clear measurable outcomes.</i></p> <p><i>Following discussions with the Chief Nurse, and discussions at the March meeting of the Quality and Performance Committee, it was agreed that the risk score should remain at 20.</i></p>		
<p>RR 171 (Oct 2021)</p>	<p>There is a potential risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports, known quality issues, as well as growing public concerns regarding increasing waiting list times and access to General Practice.</p> <p>Lack of confidence may impact the extent to which citizens interface with healthcare services. This, in turn, presents a risk of increased pressure on urgent and emergency care services as services will not be accessed until a point of crisis.</p> <p>Update: <i>The Accountable Officer has advised that loss of public confidence remains a significant risk for the CCG, in particular, due to the continued growth in demand and increasing waiting lists/times for appointments, diagnosis and treatment. It is recognised that public confidence continues to be impacted by potential adverse media coverage around frontline services, GP access and specialist areas (such as NUH Maternity).</i></p> <p><i>Work continues through planning and recovery structures to address issues around access and waiting lists/times, alongside work being undertaken by the CCG's Communications Team. There continues to be a focus on GP access, mental health support and how the public should access urgent care services.</i></p>	<p>Overall Score 16: Red (14 x L4)</p>	<p>Quality & Performance Committee/ Primary Care Commissioning Committee</p>
<p>RR 183 (New)</p>	<p>Nottingham and Nottinghamshire ICS System Partners are submitting an unbalanced financial plan for 2022/23. This presents a risk that the system, as a collective, may not achieve its agreed control total by 31 March 2023.</p> <p>This risk may be further exacerbated given the significant underlying deficit position across the system and non-achievement of elective recovery targets.</p> <p>Update: <i>New risk approved at the March meeting of the Finance and Resources Committee.</i></p>	<p>Overall Score 16: Red (14 x L4)</p>	<p>Finance & Resources Committee</p>

Risk Ref	Risk Narrative	Current Risk Score	Responsible Committee
RR 184 (New)	<p>There is a potential risk that NHS Nottingham and Nottinghamshire CCG may not meet its statutory financial duties for 2022/23.</p> <p>Factors which may impact this risk include, but are not limited to, the following:</p> <ul style="list-style-type: none"> The organisation's underlying position (UDL); and Non-achievement of the required levels of efficiencies (including, for example, unforeseen delays in transformation programme delivery). <p><i>It should be noted that this risk will be 'transferred' over to the ICB from 1 July 2022.</i></p> <p>Update: New risk approved at the March meeting of the Finance and Resources Committee.</p>	Overall Score 16: Red (14 x L4)	Finance & Resources Committee
RR 186 (New)	<p>There is a potential risk of poor patient outcomes and/or experiences as a result of increasing secondary care elective (planned care) waiting times; this includes, but is not limited to, cancer patients. The likelihood of this risk may continue to increase if elective recovery targets are not met.</p> <p>This risk may also be further exacerbated by poor, or delayed, communication with the public/patients in relation to their position on waiting lists.</p> <p>Update: New risk approved at the March meeting of the Quality and Performance Committee.</p>	Overall Score 16: Red (14 x L4)	Quality & Performance Committee
RR 187 (New)	<p>There is a potential risk of poor patient outcomes and/or experience as a result of increasing mental health waiting lists. This risk may be exacerbated by rising levels of demand on mental health services.</p> <p>Update: New risk approved at the March meeting of the Quality and Performance Committee.</p>	Overall Score 16: Red (14 x L4)	Quality & Performance Committee

- 2.2 Risk **RR 151** was identified in September 2020 and relates to the potential risk that the CCG may incur increased costs of service provision due to COVID related requirements and the resulting reduction in productivity.
- 2.3 A comprehensive update in relation to the approach to contracting for 2022/23 was provided to the February meeting of the Finance and Resources Committee. It outlined that the System is producing a Financial Framework to support an alternative contract structure; the principles of which are based around finance, quality and performance information. The proposal is that there will be an allocated finance envelope to each NHS provider (with an expectation that they deliver their services within this envelope). Any variation to the envelope will be by system agreement and not bilaterally between

one provider and commissioner. It was advised the system is working as a whole to establish the principles behind the contract approach.

- 2.4 The approach to contracting for 2022/23 supports the mitigation of risk **RR 151**. As such, the likelihood score has been reduced to 3, in line with the proposed approach, and likely to be fully mitigated once contracts are established from 31 March 2022.
- 2.5 Comprehensive updates in relation to elective recovery and cancer performance were provided to the February meeting of the Quality and Performance Committee. As a result of these discussions, it was agreed that it would be beneficial for the CCG's Corporate Risk Register to reflect specific risks in relation to the potential impact on quality in these areas, as well as mental health performance; superseding the overarching quality risk linked to the direct (and indirect) impact of COVID-19 (risk **RR 129**). As such, risk **RR 129** was approved for archiving and two new risks articulated (see **RR 186** and **RR 187** above).
- 2.6 Following discussions at the March meeting of the Quality and Performance Committee, it was agreed that a new risk relating to the impact of non-elective and urgent pressures on quality and outcomes should be articulated. This work is currently underway and will be presented to the April meeting of the Committee.

3. Recommendations

- 3.1 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) **HIGHLIGHT** any risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

Siân Gascoigne

Head of Corporate Assurance

April 2022



Nottingham and Nottinghamshire
Clinical Commissioning Group

**Minutes of the Nottingham and Nottinghamshire
Patient and Public Engagement Committee
held virtually on Tuesday 25 January 2022
3 pm to 4 pm**

Attendees;

Jasmin Howell, Vice Chair in the Chair
Chitra Acharya, Patient Leader/Carer
Teresa Burgoyne, Nottingham West
Michael Conroy, My Sight Nottinghamshire
Kerry Devine, Improving Lives
Gilly Hagen, Patient Leader/Sherwood Patient Participation Groups
Jane Hildreth, Community Voluntary Sector representing Mid Nottinghamshire ICP
Amdani Juma, African Institute for Social Development
Roland Malkin, Nottinghamshire Cardiac Support Group
Helen Miller, Healthwatch Nottingham and Nottinghamshire
Paul Midgley, Rushcliffe
Carolyn Perry, Community Voluntary Sector representing, South Nottinghamshire ICP
Daniel Robertson, Nottingham and Nottinghamshire Refugee Forum
Jules Seblin, Community Voluntary Sector representing City ICP

In attendance (NHS Nottingham & Nottinghamshire Clinical Commissioning Group's Staff):

Julie Andrews, Engagement Manager
Alex Ball, Director of Communications and Engagement (Joined towards the end of the meeting)
Katie Swinburn, Engagement Officer
Jane Hufton, Engagement Assistant (minute taker)
Prema Nirgude, Head of Insights and Engagement
Sasha Bipin, Engagement Officer
Stephanie Chadwick, Group Equality and Inclusion Programme Manager, Northern Care Alliance
Stephen Murdock, Head of Primary Care IT CCG
Ian Trimble, Independent GP advisor Primary Care

Apologies for absence were received from;

Sue Clague, Chair
Colin Barnard, Patient Leader/Diabetes
Mike Deakin, Nottinghamshire County Council
Becky Law, Community Voluntary Sector representing Bassetlaw
Deb Morton, Healthwatch
Mary Spencer, representing Bassetlaw PPGs

NN/01/01/22	Welcome and introductions
	Jasmin Howell, Vice-Chair welcomed everyone to a streamlined, shorter meeting of the Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) that she would Chair in the absence of Sue Clague.

NN/02/01/22	Declarations of interest
	<p>Jasmin Howell 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.</p> <p>Declaration of interests were made by all members of the Voluntary Sector Alliance (VSA) in relation to the information item on the agenda VSA PPE Contract Highlight Reports. Jasmin Howell confirmed that there would be no decision making in relation to this item and the attendance of VSA colleagues would not constitute a conflict of interest.</p>
NN/03/01/22	Minutes of the last meeting
	<p>The minutes of the last PPEC meeting held on 30 November 2021 were discussed and these were agreed as an accurate record of the discussion that took place at that meeting.</p>
NN/04/01/22	Matters arising including Action Log
	<p>An updated copy of the Action Log had been circulated to PPEC members prior to the meeting and was noted.</p> <p>Julie Andrews confirmed that the completed actions were accurate. Julie Andrews continued to highlight the outstanding actions for discussion which included:-</p> <p>NN/202/10/2 - Arrange a follow up conversation with Andrew Fearn and Gilly Hagen and Emma Lucas. It was highlighted that this had not taken place and was still ongoing. Julie Andrews agreed to follow up again and update the action with the date the email was sent to Andrew Fearn.</p> <p>Action: Julie Andrews to contact Andrew Fearn to discuss arranging a conversation with PPEC members around IT issues and update the action with the date the email was sent to Andrew Fearn</p> <p>NN/157/06/21 and NN/168/07/21 - Engaging with ethnically diverse communities through the Mid Nottinghamshire Health Inequalities Group.</p> <p>Jane Hildreth provided an update and confirmed that Diane Carter had met with Amdani Juma from the African Institute to understand more about the issue raised. PPEC members were advised that engagement is taking place with ethnically diverse communities across Mid Nottinghamshire focusing on those groups and communities with low levels of vaccine uptake and those not registered with a GP. Examples were shared of initiatives to engage with Eastern European communities residing in Mansfield and Newark, Muslim community in Newark, Sikh community in Ashfield and the Gypsy Roma Travelling community in Newark via Newark and Sherwood District Council. PPEC members agreed that this action could be marked as completed.</p> <p>NN/213/11/21 - Children and Young Peoples Holistic Healthy Lifestyle Service engagement would be assessed using the PPEC effectiveness framework and PPEC members were invited to express an interest in joining a task and finish group to help take this work forward. Jasmin Howell confirmed that dates would be shared with members after the meeting and anyone interested was asked to contact Julie Andrews</p>



	<p>by email before the end of February 2022 in order for the work to be completed by the end of March 2022.</p> <p>Action: Jasmin Howell will propose dates for a Task & Finish Group to take place in February and March 2022 for circulation to all PPEC members.</p> <p>NN/216/11/21 - Elective Recovery Update had been delayed due to the CCG being in a level 4 incident and lack of capacity. It has been rescheduled for the February PPEC meeting.</p> <p>NN/216/11/21 - Schedule item on Pharmacy, Optometry, Dentistry pathway redesign opportunities. PPEC members were asked to suggest any services that could be delivered within primary care for further discussion in February's PPEC meeting. Members agreed that they would like Mental Health, Intraocular pressures and allowing direct referrals from the opticians to secondary care, Dementia Care, Audiology, Podiatry pathways to be suggested for consideration. Julie Andrews agreed to send an email detailing these suggestions from PPEC members.</p> <p>Action: Julie Andrews to send an email to Lucy Dadge with the suggestions from PPEC members around possible pathways to streamline within Primary Care.</p>
<p>NN/05/01/22</p>	<p>Covid Update</p>
	<p>Prema Nirgude, Head of Insights and Engagement gave an update regarding Covid 19 Pandemic and shared a presentation highlighting the latest information.</p> <p>Prema Nirgude informed PPEC members that Covid infection rates in Nottingham and Nottinghamshire had dropped by 50% over the past 2 weeks and were lower than across England. The number of hospital beds occupied remained high but not as high as originally feared. The vaccination programme was proving effective in terms of keeping people out of hospital.</p> <p>With the lifting of restrictions and the move to Plan A, PPEC members were reminded that it would still be necessary to wear face coverings in all healthcare settings.</p> <p>There remain a number of communities who are yet to receive their 1st and 2nd vaccinations. Therefore, the CCG are working to target these areas with bespoke clinics for low uptake areas including women-only clinics, needle phobia clinics and clinics for pregnant women. Pop-up clinics are taking place in Mosques and question and answers sessions in local areas. The next Community Covid-19 Briefing will take place on Thursday 27th January 2022 at 11 am via Zoom.</p> <p>Prema Nirgude updated members that the booster vaccinations had opened to anyone over 16 years of age. Additionally, information on different age groups being vaccinated and where to access their appointments can be found on the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) website https://nottscg.nhs.uk/covid-19/covid-19-vaccinations/groups-being-vaccinated/.</p> <p>Prema Nirgude took questions and concerns from PPEC members which included a query regarding availability of leaflets in Braille. It was confirmed leaflets are available in Braille.</p>

NN/06/01/22	Let's Talk Events, Northern Care Alliance
	<p>Stephanie Chadwick, Group Equality and Inclusion Programme Manager, Northern Care Alliance gave an overview of the Let's Talk Events that are planned.</p> <p>The Northern Care Alliance (NCA) had been commissioned to work with Nottingham and Nottinghamshire Clinical Commissioning Group to progress staff awareness on equality, diversity and inclusion (EDI). NCA will host a series of Let's Talk events on different EDI topics in the coming months. The informally facilitated sessions, held online, will have two speakers exploring relevant topics.</p> <p>Two of the sessions will relate specifically to health inequalities. The other scheduled sessions include Race, LGBT and Disability. PPEC members were asked to consider which areas of health inequalities they would like the final two Let's Talk Events to focus on and recommend speakers to participate in the events.</p> <p>Members of PPEC shared their initial ideas which included mental health, Covid recovery, young people and families, young people with care experience and young adults impacted by trauma and knife crime.</p> <p>Stephanie Chadwick asked PPEC members to email Julie Andrews with any further suggestions.</p> <p>Action: PPEC members were asked to send any ideas for future Let's Talk Events to Julie Andrews via email.</p>
NN/07/01/22	Primary Care IT Strategy
	<p>Stephen Murdock, Head of IT Primary Care and Ian Trimble, GP advisor in Primary Care shared a presentation with PPEC members prior to the meeting along with an overview of the Primary Care Information Technology Strategy.</p> <p>The Primary Care IT strategy for Nottingham and Nottinghamshire had been created in conjunction with and linking to the Integrated Care System (ICS) plans and priorities especially the Data, Analytics, Information and Technology (DAIT) and Primary Care strategies. Delivery of the strategy would be ongoing from 2021 to 2026 and consists of 6 key strategic aims. The strategic aim - Improving Citizen Access to Information and Care Records- would enable patients to self-manage their own health needs, improve access to services through the use of technology and improve health outcomes through access to information. Furthermore, it aims to tackle digital exclusion to ensure all citizens can equitably access care and information.</p> <p>Ian Trimble added to the presentation that the use of digital access to make appointments, view records and order prescriptions for patients along with the offer of face-to-face consultations would be available in the future for Primary Care with more emphasis on Public Facing Digital Services such as the NHS App and Patient Knows Best.</p> <p>PPEC members were requested to comment on the strategy and provide information on the approach proposed within Primary Care.</p> <p>PPEC members commented on digital exclusion in relation to the Primary Care IT Strategy and offered to work with the ICS to co-produce the development of solutions</p>

	<p>to achieve digital inclusion. This approach was welcomed and it was agreed that initial contact would be facilitated with Rose Atkin, Connected Notts. and further discussion would be scheduled to take place at a future PPEC meeting.</p> <p>Action: Ian Trimble to make connections between PPEC members and Rosie Atkin from Connected Notts for support with IT training for members of the community.</p> <p>Action: Ian Trimble to attend a future PPEC meeting to progress the conversation about digital exclusion and solutions including accessibility, the NHS App and Patient Knows Best.</p>
NN/08/01/22	Items circulated for information
	<p>A number of papers were circulated to PPEC members prior to the meeting for information, which included:-</p> <ul style="list-style-type: none"> • ICS Establishment Update • Nottingham and Nottinghamshire Compact • Voluntary Sector Alliance PPE Contract Highlight Reports • Platform One Practice Transition of Patients <p>It was agreed that the papers circulated were for information and did not require any further discussions at PPEC at this time.</p>
NN/09/01/22	Governing Body and Committee Feedback
	<p>Jasmine Howell stated that the Governing Body meeting held on 1 December 2021 had been attended by Sue Clague and therefore highlights would be shared with members at the next meeting.</p> <p>Key messages from PPEC to highlight at the next Governing Body meeting on 2 February 2022 were;-</p> <ul style="list-style-type: none"> • The Primary Care IT Strategy for Nottingham and Nottinghamshire generated specific interest in relation to tackling digital exclusion to enable all citizens to equitably access care and information. PPEC members requested that they be actively involved in the journey to achieve this strategic aim. Time would be dedicated to this at a future PPEC meeting. • Highlight reports detailing engagement undertaken by the Voluntary Sector Alliance through the CCG commissioned service during quarter 3 were noted by PPEC members. • PPEC members made suggestions for areas of health inequalities to include in the programme of the Let's Talk Events. Suggestions included mental health, Covid recovery, young people and families, young people with care experience and young adults impacted by trauma and knife crime.
NN/10/01/22	Any Other Business
	<p>Teresa Burgoyne asked members if they were aware of any funding available for Crisis Cafes in Nottinghamshire because there is currently funding available in</p>

	<p>Leicester. Unfortunately, members were unaware of any funding within Nottinghamshire area.</p> <p>Alex Ball thanked Julie Andrews on behalf of PPEC members for all the work done over the years and wished Julie Andrews good luck with her retirement as this was going to be her last PPEC attendance. Alex Ball also mentioned that Sue Clague wanted to send her thanks to Julie who had developed a trusted relationship with colleagues and had been an ambassador for engagement.</p> <p>Jasmin Howell also expressed thanks to Julie for her professionalism and humble nature who had been a huge support in terms of her work. Along with the efficiency to coordinate and manage all that came through this meeting.</p> <p>PPEC members agreed and congratulated Julie Andrews on her pending retirement.</p>
NN/11/01/22	Date of Next Virtual Meeting
	<p>The next PPEC meeting will be held virtually on Tuesday 22 February 2022 from 2 pm to 4 pm.</p>



**Minutes of the Nottingham and Nottinghamshire
 Patient and Public Engagement Committee
 held virtually on Tuesday 22 February 2022
 2.30 pm to 4 pm**

Attendees;

Sue Clague, Chair
 Jasmin Howell, Vice Chair
 Chitra Acharya, Patient Leader/Carer
 Teresa Burgoyne, Nottingham West
 Colin Barnard, Patient Leader/Diabetes
 Michael Conroy, My Sight Nottinghamshire *Joined 3.10 pm*
 Kerry Devine, Improving Lives
 Jane Hildreth, Community Voluntary Sector representing Mid Nottinghamshire ICP
 Becky Law, Community Voluntary Sector representing Bassetlaw
 Helen Miller, Healthwatch Nottingham and Nottinghamshire
 Paul Midgley, Rushcliffe
 Carolyn Perry, Community Voluntary Sector representing, South Nottinghamshire ICP
 Jules Seblin, Community Voluntary Sector representing City ICP

In attendance (NHS Nottingham & Nottinghamshire Clinical Commissioning Group's Staff):

Therese Easom, Communications Manager Tomorrow's NUH Programme
 Lisa Durant, System Delivery Director; Planned Care, Cancer and Diagnostics *Joining at 3.30 pm*
 Jon Higman, Head of Elective Transformation *joining at 3.30 pm*
 Jane Hufton, Engagement Assistant (minute taker)
 Prema Nirgude, Head of Insights and Engagement
 Katie Swinburn, Engagement Manager

Apologies for absence were received from;

Mike Deakin, Nottinghamshire County Council
 Gilly Hagen, Patient Leader/Sherwood Patient Participation Groups
 Amdani Juma, African Institute for Social Development
 Roland Malkin, Nottinghamshire Cardiac Support Group
 Deb Morton, Healthwatch
 Daniel Robertson, Nottingham and Nottinghamshire Refugee Forum
 Mary Spencer, Community Voluntary Sector representing Bassetlaw ICS

NN/12/02/22	Welcome and introductions
	Sue Clague, Chair welcomed everyone to the Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) meeting extending a warm welcome to Katie Swinburn who has taken over from Julie Andrews as Engagement Manager and will be supporting PPEC going forward.
NN/13/02/22	Declarations of interest
	Sue Clague 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.

NN/14/02/22	Minutes of the last meeting
	<p>The minutes of the last PPEC meeting held on 25 January 2022 were discussed and these were agreed as an accurate record of the discussions that took place at that meeting.</p>
NN/15/02/22	Matters arising including Action Log
	<p>An updated copy of the Action Log had been circulated to PPEC members prior to the meeting and was noted.</p> <p>Katie Swinburn shared a copy of the action log and confirmed that the completed actions were accurate. Katie Swinburn continued to highlight the outstanding actions for discussion which included:-</p> <p>NN/07/01/22 – Primary Care Strategy a meeting has been arranged with Rosie Atkin on 4th March 2022 after a conversation with Andrew Fearn, Emma Lucas and Gilly Hagan. PPEC members interested in participating should inform the Engagement Team to receive an invitation. Sue Clague asked if this would include digital and primary care strategy in March and this was confirmed.</p> <p>NN/213/11/21 Children & Young People’s Holistic Healthy Lifestyle Service was to be reviewed using the PPEC Effectiveness Framework. Meetings have been scheduled in where PPEC members were asked to express interest in joining the Task and Finish Group via the Engagement Team. Tentative meetings have been set up in March 2022.</p> <p>NN/216/11/21 – Discussion around agenda on PODs pathway redesign opportunities at place. PPEC members were asked to think about the topics they would like to include and provide feedback.</p>
NN/16/02/22	Covid Update
	<p>Prema Nirgude, Head of Insights and Engagement gave an update regarding Covid 19 Pandemic and shared a presentation highlighting the latest information.</p> <p>Prema Nirgude informed PPEC members that overall the number of vaccinations administered is looking positive with a good proportion of people over the age of 18 years old having had 2 doses of the vaccination and about half of the 12 – 15 year olds have received at least 1 dose.</p> <p>The next cohort will be the 5 – 11 year olds who are clinically at risk or live with someone who is immunosuppressed and they will receive 2 doses by local NHS services or their GP. The 12 – 15 year olds will still be offered the vaccination through their school or asked to attend specific clinics, times and dates are available on the CCG website https://nottscg.nhs.uk/covid-19/covid-19-vaccinations/groups-being-vaccinated/12-15-year-olds/</p> <p>There are still some hesitancy amongst certain communities but clinics have been arranged to assist and give support to these communities including needle phobia clinics, visually impaired and ethnic minorities. The CCG are continuing to offer pop up clinics and information clinics across Nottinghamshire too.</p>

	<p>The announcement from the Government around restrictions has been released which can be accessed here and comes into place from Thursday 24th February 2022. Additionally testing kits will no longer be available free there will be charge for the Lateral Flow Tests.</p> <p>Guidance around further boosters for the over 75 years old, 12 +immunosuppressed, and care home residents will be rolled out later in the year and further information will be shared once this is available.</p> <p>Additionally, information on different age groups being vaccinated and where to access their appointments can be found on the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) website https://nottscg.nhs.uk/covid-19/covid-19-vaccinations/groups-being-vaccinated/.</p> <p>The next Covid-19 Briefing will take place on Thursday 24th February 2022 at 11 am via Zoom. It was noted by all members that by holding these briefings they have built and established good relationships with communities and the CCG will be looking at how these will be developed in the future by possibly covering a number of topics not just covid such as measles and seasonal topics.</p> <p>PPEC members have a few concerns around the vaccination hesitancy and unvaccinated community members paying for Lateral Flow Tests and would they be subsidised if on a low income. Prema Nirgude was unsure and would find out and confirm with PPEC members.</p> <p>Action: Prema to confirm to PPEC members whether the purchasing of testing kits will be subsidised for families on low income.</p>
NN/17/02/22	ICS Transition; Working people and communities
	<p>Prema Nirgude, Head of Insights and Engagement informed members on the progress of the Integrated Care System (ICS) transition and shared a presentation highlighting the proposed system format along with the ICS design principles and structures of citizens intelligence. Working with communities will be different as the CCG move into the ICS by including more intelligence but ensuring the delivery of expectations and guidance is embedded.</p> <p>Prema Nirgude also highlighted the work undertaken by the VCSE Alliance and how this needs to be a coordinated approach when transitioning into the (ICS).</p> <p>The ICS implementation guidance includes</p> <ul style="list-style-type: none"> • A strong and effective ICS will have a deep understanding of all the people and communities it serves”. • The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems. • The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities. <p>The proposed engagement structures will include VCSE Alliance, Engagement Practitioners Forums, 4 place based committees and citizen intelligence advisory group. The insights gathered from patients, staff, carers members of the public will be</p>



	<p>able to influence service changes and a number of mechanisms are taking place appropriately and effectively which include experts practitioners, officers of Healthwatch, local authorities and chair of the VSCE. Prema Nirgude confirmed that bringing together leads from across the system will give an opportunity to work more collaboratively.</p> <p>In addition, Prema Nirgude confirmed that these plans were only in draft format and have not been agreed but would like to gain PPEC members thoughts on the system structure and how the patient voice will fit in.</p> <p>PPEC members expressed strong concerns of the design and the mechanisms to ensure that the patient voice would continue and be strong through out the process of engagement within strategic commissioning feedback. There was a request to have non-executive director presence on the advisory group which would facilitate the opportunity to represent the patients' voice within the system. There were a number of unanswered questions on how the engagement team will be able to support communities at place and neighbourhood levels. Jasmin Howell also highlighted the loss of expertise of PPEC members linking in with their communities, especially vulnerable groups.</p> <p>In summary Sue Clague said that a new forum for patient engagement will take place from July 2022 was encouraged by the fact that, going forward patient engagement is a national priority and clearing identified within Nottingham and Nottinghamshire system work. Sue Clague also acknowledged and thanked all PPEC members for their excellent work and contributions on work completed by PPEC on strategic commissioning. It is important that engagement is truly integrated into all work at system, place and neighbourhood levels. Sue Clague has offered to have 1:1 conversations with members of PPEC to understand their role and how they feel their contributions would help within the new system structure. Additionally, Sue confirmed to PPEC members that this item will continue to be on the agenda for all meetings until the end of June 2022.</p> <p>Action: Prema, Sue and Jasmin set up 1:1 meetings or group meetings with PPEC members to offer support in the transition into the new structure and where they would fit in.</p> <p>Action: Include the Transition item on future agendas until the end of June.</p>
<p>NN/18/02/22</p>	<p>Reshaping Health Services in Nottinghamshire/TNUH</p>
	<p>Katie Swinburn, Engagement Manager for Nottingham and Nottinghamshire CCG shared a presentation updating members around the programme and the next stage of pre-engagement.</p> <p>Katie Swinburn shared a presentation highlighting the main areas of Reshaping Health Services in Nottinghamshire updates which included the CCGs Statutory Duty around engagement, the guiding principles and provided an update on the programme so far from the last round of pre-engagement in November/December 2020. The main points outlined included engaging with 650 members of the public and patients to gather feedback on the new hospital programme informing members that this was mostly positive and supportive with the proposed changes to services.</p> <p>Katie Swinburn informed members on the next round of pre-consultation engagement which is scheduled to begin from the 7 March 2022 and run for 4 weeks ending on the</p>

	<p>1 April 2022 depending on the agreement from Governing Body members when the this programme will be raised at the next meeting on Wednesday 2 March 2022. Katie Swinburn continued to inform members that there would be the opportunity for members of the public and community groups to have conversations and share their views around the latest clinical model proposals.</p> <p>A Stakeholder Reference Group has been re-confined set up and includes one of the PPEC members Roland Malkin who will be the CCG PPEC representative on this group.</p> <p>The next phase of engagement will incorporate the following methods to engage with members of the public and patients.</p> <ul style="list-style-type: none"> • Public engagement events – 3 x public meetings virtually • Targeted engagement events – around Cancer, Elective, Emergency and Maternity Services • Online Survey • Clinical senate update and provide information on feedback from the engagement. • Attendance at community groups to obtain feedback <p>Following on from this phase of engagement there will be an evidence based report pulled together in collaboration with Nottingham University Hospitals (NUH) on 12 April 2022 including analysis of qualitative and quantitative data.</p> <p>Katie Swinburn assured PPEC members that public and patient engagement will be embedded within this piece of work and the Reshaping Health Services programme team will be updating PPEC on 29 March 2022 on the programme of work to date. Members were also asked to share the information with any communities and networks and extend the offer of attending community groups who were meeting and would like to engage within the next round of engagement.</p> <p>Prema Nirgude highlighted that this piece of work will be the biggest change in service that would happen within Nottinghamshire and encouraged members to engage with their community to gather their views.</p> <p>Members were supportive of this programme and made suggestions of condensing public facing documents with less text and more pictures</p> <p>Action: Members to contact engagement team if any groups are meeting and would welcome conversations with the programme team to share their views.</p>
<p>NN/19/02/22</p>	<p>Elective Recovery Update</p>
	<p>Lisa Durant, System Delivery Director; Planned Care, Cancer and Diagnostics accompanied by Jon Higman, Head of Elective Transformation shared a presentation entitled Elective Recovery Update which members had sight of prior to the meeting.</p> <p>Lisa Durant gave an overview on where the elective recovery is at the moment after stepping down from level 4 during the pandemic. Increased winter demands had an impact on the system. Lisa Durant highlighted some of the challenges the elective recovery team had encountered including patients with and without covid, staff</p>

	<p>sickness, urgent cases, and winter pressures which were all contributing factors to the waiting lists. Lisa Durant confirmed that extra capacity was agreed to help with these pressures.</p> <p>Jon Higman summarised the current position of waiting lists and confirmed that this was in line with the national and regional position. However, waiting lists have grown especially in ENT and orthopaedics. Letters have gone out to all patients who are on the waiting lists giving guidance on wellbeing, but awaiting further national guidance on communicating further, but will continue to communicate with patients at 12 week intervals.</p> <p>Plans to reduce waiting lists in the future are in place specifically within elective care, cancer and diagnostic waiting times with specific timelines to work towards ensuring patients on waiting lists are not waiting more than necessary. A delivery plan for tackling covid 19 has been implemented including separating elective care and emergency care, with more flexibility and collaboration across the system. Jon Higman also confirmed that transformation of delivery by expanding diagnostic testing and increasing of capacity would be implemented along with looking at redesigning pathways such as eye care, cardiac and musculoskeletal services. Additionally allowing access for GPs to gain specialists advice by asking for Advice and Guidance from specialists.</p> <p>Lisa Durant summarised that there are challenges and would be grateful for the help of PPEC to get involved around elective hubs which will link in with Tomorrow's NUH at different sites. Lisa Durant confirmed that funding has been applied for but if allocated the funding how can PPEC advise engaging with patients to help put in place the correct model.</p> <p>PPEC members raised questions around different sites across Nottinghamshire having both elective and emergency care. Lisa Durant confirmed that if we were to ringfence capacity it would be easier to deliver the services at one site. Ensuring that digital tools were used within the implementation. A further question was submitted prior to the meeting around involvement in the private sector and finances. Lisa Durant confirmed that finances are confidential but do have some support from the independent sector bringing additional staff and clinics and this will be included going forward. Lisa Durant also mentioned working in collaboration with Health Education England for training of staff and highlighted the workforce gap with diagnostic and elective capacity. Lisa Durant suggested a more in depth discussion on specific subjects and invited PPEC members to highlight areas of interest.</p> <p>Action: PPEC members to suggest possible subjects. Action: Lisa Durant to inform PPEC members on any updates around communication to patients.</p>
NN/20/02/22	Items for information
	<p>A number of papers were circulated to PPEC members prior to the meeting for information, which included:-</p> <ul style="list-style-type: none"> • Health and Wellbeing Strategies • Communicating Changes in General Practice to Patients Checklist

	<p>Health and wellbeing Strategies, members felt that their voice was not hear and the paper did not provide general outputs and missed some important priorities. The strategy will be taken to the Health and Wellbeing Board next month for sign off with a view to implementation at a community and Public Health level.</p> <p>Helen Miller raised a question prior to the meeting that Healthwatch were involved in around Communicating Changes in General Practice and stated that this was a good example of listening to feedback and working collaboratively and would like to share this work on their website. Katie Swinburn agreed and would also include in the Engagement Toolkit to show what good engagement looks like.</p>
NN/21/02/22	Governing Body and Committee Feedback
	<p>Sue Clague updated members from the previous Governing Body meeting with information around:</p> <ul style="list-style-type: none"> • Covid updates • Issuing of 22/23 operational guidance and Executives are working on an operational plan • Signed off arrangements for incorporating Bassetlaw into the ICS • Finance report significant pressures • Maternity concerns at Nottingham University Hospitals. <p>Key messages from PPEC to highlight at the next Governing Body meeting on 6 April 2022 were;-</p> <ul style="list-style-type: none"> • Concerns about how patient engagement will be truly embedded within new plans at each level of the system. • Tomorrow's NUH engagement plans were supported by members • Update on Elective Recovery with more specifics around patient safety and expectations needed on the elective recovery plan.
NN/22/02/22	Any Other Business
NN/23/02/22	Date of Next Virtual Meeting
	The next PPEC meeting will be held virtually on Tuesday 29 March 2022 from 2.30 pm to 4 pm.

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Quality and Performance Committee
Ratified minutes of the meeting held on
27/01/2022 9:30-11:00
MS Teams Meeting

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Jon Towler	Non-Executive Director
Stuart Poyner	Chief Finance Officer
Lisa Durant	Director of Commissioning - Mid Nottinghamshire
Hazel Buchanan	Associate Director of Strategic Programmes & EPRR
Dr Manik Arora	GP Representative
Dr Hilary Lovelock	GP Representative
Mindy Bassi	Chief Pharmacist
Caroline Nolan	System Delivery Director - Urgent Care
Danni Burnett	Deputy Chief Nurse
Maxine Bunn	Associate Director of Commissioning

In attendance:

Louise Espley	Corporate Governance Officer (minutes)
Ryan Alsop	Lead Nurse for Nursing Home and Home Care Quality Assurance (for item 8 QP 21 148)
Rhonda Christian	Assistant Director, Nursing and Safeguarding (for item 11 QP 21 151)
Sue Cordon	Director of Clinical Governance, Grant Thornton (for item 10 QP 21 150)
Sian Gascoigne	Head of Corporate Assurance

Apologies:

Sue Clague	Non-Executive Director
Rosa Waddingham	Chief Nurse

Cumulative Record of Members' Attendance (2021/22)

Name	Possible	Actual	Name	Possible	Actual
Dr Manik Arora	09	07	Eleri de Gilbert	09	09
Mindy Bassi	09	05	Andy Hall*	06	06
Hazel Buchanan	09	08	Dr Hilary Lovelock	09	07
Maxine Bunn	09	07	Caroline Nolan	09	07

Danni Burnett	09	08	Stuart Poynor	09	07
Lisa Durant	09	09	Dr Richard Stratton*	06	04
Sue Clague	09	07	Jon Towler	09	07
Rosa Waddingham	09	08	Sarah Bray*	03	02

* Dr Stratton left 24/09/2021

* Andy Hall left 25/10/2021

* Sarah Bray joined 28/10/2021

Introductory Items

QP 21 141 Welcome and Apologies

Eleri de Gilbert welcomed members and attendees to the Quality and Performance Committee meeting which was held on MS Teams due to the current Covid-19 situation.

QP 21 142 Confirmation of Quoracy

The meeting was confirmed as quorate.

QP 21 143 Declaration of interest for any item on the shared agenda

No declarations of interest had been identified ahead of the meeting.

The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

QP 21 144 Management of any real or perceived conflicts of interest

No management action required.

QP 21 145 Minutes from the meeting held on 25 November 2021

The minutes were agreed as an accurate record of proceedings.

QP 21 146 Action log and matters arising from the meeting held on 25 November 2021

The action log includes two actions with future dates for completion. Other actions were updated on the action log or addressed as part of the agenda.

An update was provided in relation to the development of outcome measures for community services. There are currently no community metrics as part of the national quality requirement contractually. Work is in progress locally to determine some outcome measures.

It was suggested that alongside the work with the analytics team, the Community Transformation Programme and the Quality team the CCG links with Public Health who are submitting a research bid for funding to look at health inequalities and population health outcomes.

An update will be provided to the Committee in February 2022.

There were no further matters arising.

QP 21 147 Actions arising from the Governing Body meeting held on 01 December 2021.

There were no actions arising for the attention of the Committee.

Quality and Performance

QP 21 148 Deep Dive – Care Homes and Home Care

Ryan Alsop was in attendance for this item.

Ryal Alsop delivered a detailed presentation, highlighting the following points:

- a) The presentation provided the context for Care Homes and Home Care (CHHC) along with information about current operational pressures and challenges.
- b) There are 356 Care Homes and 198 Home Care providers and community support and enablement services across the system, including Bassetlaw.
- c) Four Nursing Homes are currently under enhanced surveillance and two Nursing Homes have a suspension in place.
- d) A recent procurement has taken place in relation to adult Home Care. The new contract will be in place from 01 April 2022 and will increase capacity and efficiency. A similar procurement exercise will follow for Home Care services for children.
- e) The presentation and supporting information provided information about the current market position, quality assurance, safeguarding and the work of the Care Home and Home Care quality assurance team. This highlighted the challenges that had been faced as a result of the Covid-19 pandemic and challenges related to the nursing workforce. Members were informed of several initiatives in place to attract nurses to the sector and the inclusion of CHHC in offers of system mutual aid.
- f) In respect of some providers there are concerns related to poor managerial oversight, clinical oversight, and workforce pressures. These challenges often translate to issues with care planning, risk assessment and quality of care. In addressing such concerns, the workforce oversight group is providing a focus on training and establishing competency frameworks for nursing staff in Care Homes.
- g) In terms of residential homes, there are two providers: Kisimul group and Heathcotes Enright View. The Kisimul group service in Nottinghamshire has recently received a good rating from the CQC having previously been rated inadequate. Heathcotes Enright View is subject to a service improvement notice. The CCG quality team are supporting colleagues from Nottinghamshire County Council to undertake quality monitoring visits and providing specialist advice.
- h) The CCG team includes three Quality Officers an Enhanced Health and Care Home Project Lead, Quality Manager and a Senior Integrated Commissioning Manager. The team have undertaken over 100 face to face quality visits to providers during 2021.
- i) The quality assurance approach and system matrix working arrangements were shared. A joint quality assurance framework will be developed in 2022.
- j) A positive impact from having to find new ways of working during the pandemic is improved partnership working. A daily task force meeting is in place, issues identified are escalated as necessary to the Operational Oversight Group.

- k) The Enhanced Health in Care Homes framework, an element of the Ageing Well Programme was detailed in the presentation alongside a progress update.

The following points were raised in discussion:

- l) Members thanked the team for the detailed presentation which clearly set out both the challenges and significant improvements within the Home Care and Care Home sector. Workforce was highlighted as a particular challenge and the scale of the risk was discussed. Members were informed that some providers have de-registered nursing provision. Work is underway to provide different models of working e.g. virtual nursing oversight and a buddy system for nurses in addition to recruitment and retention initiatives.
- m) It was noted that the workforce issues are reflected in primary care and discussion focused on international recruitment opportunities and differential pay between sectors.
- n) The financial resilience of providers was discussed with members assured that good relationships are in place with providers who show a willingness to openly report issues and pressures.
- o) A question was asked about whether the Home Care and Care Home sector is part of the strategic workforce planning initiative. There was a view that there is a level of inclusion, but there is an opportunity for this to be developed further.
- p) Discussion followed with regards to ensuring that all CHHC providers are using the IT systems to support their work and reporting. It was felt that greater engagement via the Primary Care Networks will help address performance across the spectrum.
- q) In response to a question, it was confirmed that in respect of CHHC the CCG is working closely with Bassetlaw.
- r) It was noted that the ICS as a system would need to consider its future role around market management for this sector.
- s) Thanks were extended to the team for their work, particularly during the pandemic. It was noted that staff in this sector are experiencing significant levels of stress and burnout.

The Quality and Performance Committee:

- **NOTED** the current issues and challenges within the care sector and the CCG contribution to quality assurance, service improvement and system working.

Ryan Alsop left the meeting.

Hazel Buchanan left the meeting for a period during this item.

QP 21 149

NUH and NUH Maternity confidential update

Danni Burnett presented the item, highlighting the following points:

- a) A comprehensive bundle of information was shared with members to demonstrate the oversight arrangements in place. Initial meetings of the QAG and sub-groups have taken place since the refresh of system assurance meetings.
- b) The action plan in response to the section 29a breach was shared with the CCG yesterday. An update on the five specific areas in the report was

presented at a meeting held by NUH on 26 January 2022. The action plan will be submitted to the CQC later this week and has been presented to NHSE/I.

- c) The CCG are keen to see a focus on turning action lists into organisation wide improvement. The CCG is yet to see NUH's overall vision and the instability at Executive level is considered a contributing factor. On a positive note, there is evidence of a more in-depth level of thinking taking place at NUH.
- d) Evidence of the evolving infrastructure is evident. An Interim Corporate Governance Director is working closely with the senior team to refresh the approach to quality and risk.
- e) Concern remains at the overall pace and impact of change. All work streams, especially those related to culture need to be evident and embedded throughout NUH.
- f) The quality insight visit planned for November 2021 was postponed due to Covid-19 measures and has been re-scheduled for 08 March 2022.
- g) Three high profile inquests will take place between January and March 2022 which are likely to attract attention from the media and Health and Scrutiny Committees.
- h) A significant amount of work to managing operational pressures related to the Emergency Department is underway. The Emergency Care Improvement Support Team (ECIST) are working with NUH in this area.
- i) NUH has been successful in securing some digital funding for maternity services.
- j) Operational pressures remain in maternity services with circa 300 women on the virtual Covid ward. The drive to improve the uptake of Covid-19 vaccinations continues.

The following points were raised in discussion:

- k) Members noted the improvements and progress made since the last report to the Committee but remained concerned that the necessary level of assurance around pace and scale of improvement is not evident. Members agreed the actions planned for quarter four, described in the report, were appropriate.
- l) Members felt that the absence of a stable leadership team at NUH is a key factor driving the lack of assurance. The appointment of a new Chair should now result in some progress on this. In addition, there is a need to see action lists becoming focused on wider improvement with a clear articulation of what good will look like for NUH.
- m) Discussion followed regarding the impact of mandatory Covid-19 vaccinations on midwifery staffing. Targeted work with specific staff groups is underway and more is being done to understand the workforce impact both locally and nationally.
- n) Members noted the likelihood of further media interest related to inquests.
- o) Members were assured by the involvement of the Emergency Care Improvement Support Team (ECIST).

The Quality and Performance Committee:

- **NOTED** the update and upcoming activities.

QP 21 150 External review of Quality Assurance

Sue Cordon joined the meeting for this item.

The CCG commissioned the review to assess if the CCG's current quality assurance model is fit for purpose in the current climate and able to develop into a model fit for the future operating environment. This is particularly relevant given the CCG has seen several NHS Providers fall short of meeting or maintaining required standards to ensure high quality care.

Sue Cordon, Director of Clinical Governance from Grant Thornton presented the item and highlighted the following points:

- a) Key lines of enquiry were developed and explored via structured interviews with staff, Governing Body members and the ICS Chair. The report provides a positive view of governance arrangements and highlights significant work undertaken during a very challenging time. The CCG was commended for its proactive development of governance arrangements during the Covid-19 pandemic.
- b) The design of systems and processes has evolved since the six CCGs came together as one and is now looking to the future development of the ICS. The CCG is proactive and demonstrates maturity in terms of its approach to the oversight of quality in commissioned services and in preparation for ICS requirements.
- c) The design and operation of the CCG system for the oversight of quality is good and it is clear to see that changes have been made with a focus on the future.
- d) The leadership of the quality directorate is fundamentally good and robust. The senior team has worked hard to ensure clear and consistent leadership. The pace of change has been challenging for some team members particularly given the impact of the pandemic and the implementation of home working.
- e) The level of interaction with providers is strong and offers robust challenge where necessary, with appropriate enhanced surveillance arrangements in place with the most challenged providers.
- f) Evidence provided assurance that relationships with providers is mature and there is a willingness to work at system level to offer support e.g. SFH working with NUH around ambulance diverts and maternity services.
- g) There is evidence of perseverance in respect of the most challenged providers. The CCG has worked hard to ensure it is invited to the correct meetings and forums to scrutinise assurance.
- h) In developing systems, the quality assurance improvement group demonstrated a proactive approach and has started the process of sharing information system wide although the participation of all providers is needed.
- i) The CCG has a good reputation with regulatory bodies and external stakeholders.
- j) From observation of the Governing Body and Quality and Performance Committee the conclusion is that internal governance is strong with high performing Committees that demonstrate appropriate challenge.
- k) The quality of reports and minutes has improved significantly when compared to three/four years ago.
- l) The report includes 12 recommendations all of which have been accepted by the CCG.

The following points were made in discussion:

- m) Members thanked Sue Cordon for the full and comprehensive report and extended thanks to all who provided contributions to the review. The report provides assurance to the Committee in terms of current ways of working and planning for governance in the system space. Members welcomed the fair, helpful and constructive recommendations included in the report. An action plan to address the recommendations is currently going through the quality team assurance process.
- n) In response to a question about the move to system governance Sue Cordon confirmed that she is not aware of any areas that have progressed to a culture of system assurance. Her view is that Nottingham and Nottinghamshire are further ahead in its thinking than many other areas.
- o) Members requested the report be shared with the Governing Body and Kathy McClean.

Sue Cordon left the meeting.

The Quality and Performance Committee:

- **NOTED** the report and recommendations.

ACTION:

- Quality Assurance report to be shared with the Governing Body and ICB Chair.

QP 21 151

Safeguarding Annual report

Rhonda Christian presented the item and highlighted the following points:

- a) The annual report covers the period April 2020 to March 2021. The purpose of the report is to provide assurance to NHS Nottingham and Nottinghamshire Clinical Commissioning Group (NNCCG) that the CCG has discharged its statutory responsibility to safeguard the welfare of children and adults.
- b) During the period 2020-2021 six CCGs became one CCG covering the Nottingham and Nottinghamshire area.
- c) In August 2020 the Health MASH Team took their place as key partners in the co-ordination of the initial response to safeguarding concerns. This has led to an improvement in compliance with statutory guidance. During 2021/22 there has been a focus on improving the efficiency of the MASH health team.
- d) Safeguarding functions were maintained throughout the pandemic despite teams being diverted to support the emergency response and the move to home working.
- e) Remote learning was been put in place for Primary Care leads as a response to the pandemic, this has proved to be a positive initiative that will continue. Remote GP Leads meeting have also been a successful initiative with an increase in attendance by 50%.
- f) Looking ahead to 2022, there will be a focus on the outcomes of recent safeguarding cases that have received national attention.
- g) Work is underway to review 'working together' requirements and to ensure the recommendations of the Wood review are implemented.
- h) In addition, a review of the health MASH's fitness for purpose will take place.
- i) The team continue to support the vaccination programme, specifically in relation to best interest decisions.

The following points were made in discussion:

- j) Members thanked Rhonda Christian and the team for the comprehensive report covering 2020/21 and the information regarding priorities for 2021/22.
- k) Committee members had previously expressed concerns regarding the potential backlog of safeguarding cases because of the pandemic. It was confirmed that the MASH in the County has reported an increase in cases, although this is not replicated in the City. Work is underway to assess referrals in more detail to understand the actual position.

The Quality and Performance Committee:

- **NOTED** the CCG Safeguarding Annual report for 2020/21.

Corporate Assurance

QP 21 162

Risk report

Sian Gascoigne presented the item and highlighted the following points:

- a) There are ten risks on the risk register, the same number as presented in November 2021. Five risks are rated red.
- b) Members were asked to approve the archiving of risk 174 (emergency response to a mass casualty event). A major incident planning event had taken place during December 2021; the exercise demonstrated that local providers have appropriate plans in place to be able to respond to a mass casualty event. This included taking into consideration modeling around the impact of COVID numbers.
- c) Members were asked to confirm whether risk 156, related to NUH maternity services should remain at a score of 25.

The following points were made in discussion:

- d) Members approved the archiving of RR 174.
- e) Members confirmed that the score of 25 remains appropriate in respect of risk 156 as significant gaps in assurance remain.

The Quality and Performance Committee:

- **COMMENTED** on the risks shown within this paper (including the high/**red** risks) and those at **Appendix A**
- **DID NOT HIGHLIGHT** any new risks.
- **APPROVED** the archiving of RR 174

Closing Items

QP 21 153

Any other business

Danni Burnett highlighted that a request from NUH had been received for a letter of support in respect of an increase in neonatal beds capacity. Members noted that a separate request had been received from NUH related to a letter of support in relation to car parking. The CCG governance process for handling such requests will be confirmed.

No further business was raised.

QP 21 154

Key messages to escalate to the Governing Body

The Committee:

- **RECEIVED** a deep dive report into Care Homes and the Home Care sector (356 Care Homes and 198 Home Care providers) which provided a good amount of assurance in challenging times. There will continue to be a focus on strengthening relationships between providers and the wider system, together with a focus on market management.
- **RECEIVED** an update on quality assurance and oversight of services provided by Nottingham University Hospitals NHS Trust (NUH). The suite of documents presented detailed the evidence presented by NUH as part of the refreshed oversight framework established during November and December 2021. The Committee noted that some progress is evident, particularly around leadership and culture but significant concern remains given operational and workforce pressures and recent/planned changes at Executive level. With respect to maternity services, the Committee agreed to maintain the risk score at 25 at this time, given that despite a lot of good work and action plans the required level of assurance was not yet available.
- **RECEIVED** an external report on existing Quality Assurance processes from Grant Thornton. The review had been commissioned to assess if the CCG's current quality assurance model is fit for purpose now and able to develop into a model fit for the future operating environment.

QP 21 155

Date of next meeting:

24/02/2022 via MS Teams meeting

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Quality and Performance Committee

Unratified minutes of the meeting held on

24/02/2022 9:00-12:00

MS Teams Meeting

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Jon Towler	Non-Executive Director (until 10.50)
Sue Clague	Non-Executive Director
Rosa Waddingham	Chief Nurse
Lisa Durant	Director of Commissioning - Mid Nottinghamshire
Hazel Buchanan	Associate Director of Strategic Programmes
Dr Manik Arora	GP Representative
Dr Hilary Lovelock	GP Representative
Sarah Bray	Associate Director of System Assurance
Caroline Nolan	System Delivery Director - Urgent Care
Danni Burnett	Deputy Chief Nurse
Maxine Bunn	Associate Director of Commissioning

In attendance:

Louise Espley	Corporate Governance Officer (minutes)
Simon Castle	Head of Cancer & End of life Care (for item QP 21 164)
Jon Highman	Head of Elective and Outpatient Transformation (for item QP 21 164)
Coral Osborn	Associate Chief Pharmacist (for item QP 21 166)
Sian Gascoigne	Head of Corporate Assurance

Apologies:

Stuart Poynor	Chief Finance Officer
Mindy Bassi	Chief Pharmacist

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Dr Manik Arora	10	08	Eleri de Gilbert	10	10
Mindy Bassi	10	05	Andy Hall*	06	06
Hazel Buchanan	10	09	Dr Hilary Lovelock	10	08
Maxine Bunn	10	08	Caroline Nolan	10	08
Danni Burnett	10	09	Stuart Poynor	10	07

Lisa Durant	10	10	Dr Richard Stratton*	06	04
Sue Clague	10	08	Jon Towler	10	08
Rosa Waddingham	10	09	Sarah Bray*	04	03

* Dr Stratton left 24/09/2021

* Andy Hall left 25/10/2021

* Sarah Bray joined 28/10/2021

Introductory Items

- QP 21 156 Welcome and Apologies**
- Eleri de Gilbert welcomed members and attendees to the Quality and Performance Committee meeting which was held on MS Teams due to the current Covid-19 situation.
- QP 21 157 Confirmation of Quoracy**
- The meeting was confirmed as quorate.
- QP 21 158 Declaration of interest for any item on the shared agenda**
- No declarations of interest had been identified ahead of the meeting.
- The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.
- QP 21 159 Management of any real or perceived conflicts of interest**
- No management action required.
- QP 21 160 Minutes from the meeting held on 27 January 2022**
- The minutes were agreed as an accurate record of proceedings.
- QP 21 161 Action log and matters arising from the meeting held on 27 January 2022**
- The action log detailed three closed actions and two actions for future completion. A date for a report on the ReSPECT audit findings will be sought.
- There were no further matters arising.
- QP 21 162 Actions arising from the Governing Body meeting held on 02 February 2022.**
- The Governing Body requested the Integrated Performance Report be developed to include forecast projections for the recovery of services and performance against those projections. In addition, the Governing Body asked the Committee to review, in detail performance in respect of Cancer services and elective waiting times. Both matters were addressed on the agenda at QP 21 163 and QP 21 164 respectively.

Quality and Performance

QP 21 163

Integrated Performance Report

Sarah Bray presented the item, highlighting the following points:

- a) The format of the report has been refined in order to highlight system pressures. Reports on planned care and cancer will be addressed at QP 21 164.
- b) The planned care section of the report has been re-drafted to include the forecast position. Waiting lists continue to increase, 52-week waits are stabilising but 104-week waits remain of concern.
- c) Initiatives designed to lead to system recovery and increased capacity were described. This includes use of the independent sector and insourcing. The aim being to create ring-fenced capacity for elective activity.
- d) Monitoring of performance against Cancer standards will resume from April 2022.
- e) A key driver to the deteriorating performance in elective and cancer care relates to acute capacity constraints arising from pressures across the wider system, primarily the ability to discharge patients following an acute episode of care into alternative appropriate settings. A specific section outlining the current position and planned mitigations for 'Medically Safe for Transfer' is included in the report.
- f) This position is having an impact on urgent care where a significant increase in 12-hour trolley waits and increasing numbers of delayed ambulance transfers are reported.
- g) Mental Health services continue to be subject to increasing demand. This is impacting on the performance and delivery of mental health services. IAPT recovery is moving towards non-delivery of the standard from March 2022.
- h) Investment has been identified to ensure sustainable services are in place for Children and Young People services.
- i) Increased lengths of stay for older adults in the care of mental health services are occurring as a result of delayed discharges. Work is underway to align the health and social care response across acute and mental health services. An event is planned to give particular focus to the mental health discharge processes.

The following points were raised in discussion:

- j) In response to a question about staff absences due to Covid-19 the position is reported as improving slowly although an impact on bed capacity is still being experienced.
- k) In terms of performance monitoring in primary care a scoping exercise is underway to review the information currently available and to assess what is required in the future. Joe Lunn and Sarah Bray will progress the development of a framework for primary care performance monitoring as part of the system performance arrangements.
- l) Further information was requested about services for children and young people with eating disorders. Maxine Bunn informed members that investment has been agreed and plans are being progressed. The key risk relates to securing the necessary workforce to ensure sustainability of services.
- m) Support in place for staff who have been working under immense pressure for a prolonged period of time was discussed.

- n) Workforce pressures continue to be a key risk across all sectors. An ICS workforce strategy is looking at system wide solutions.
- o) Assurance was sought that providers continue to employ best practice standards. In addition, the need to prevent deterioration in social and health inequalities as waiting lists are managed was considered an important outcome measure. The complexity of this was appreciated. The Chief Nurse suggested the Clinical Executive Group (CEG) and Elective Care Group will work together to do some of this nuanced work that goes beyond clinical prioritisation.

The Quality and Performance Committee:

- **NOTED** the integrated performance report in its revised format.

QP 21 164

104 week waits and cancer performance

Simon Castle and Jon Higman joined the meeting for this item.

Lisa Durant, Simon Castle and Jon Higman delivered a presentation, highlighting the following points:

104 week waits:

- a) A detailed presentation was delivered addressing; the national and local context, current 104 week wait trajectory, governance, current waiting list profiles, planning requirements for elective recovery and actions to increase capacity.
- b) The trajectory suggests there will be 203 patients at NUH waiting over 104 weeks by the end of March 2022. A plan is in place to treat those patients by the end of quarter one.
- c) Additional capacity has been agreed with the independent sector and mutual aid and insourcing is in place to increase elective activity.
- d) The system is performing comparatively well when considered against the national and regional position for treatment provided within the 18 weeks Referral to Treatment Target (RTT).
- e) Data was presented detailing the profile and length of waits by speciality. Referral volumes were included to provide context.
- f) NHS delivery plan targets in respect of elective care waiting times for 2022/23 include, by July 2022 no-one will wait longer than two years, waits of over 18 months to be eliminated by April 2023, waits of longer than a year for elective care to be eliminated by March 2025 and 30% more elective activity to be delivered by 2024/25.
- g) The elective recovery plan was presented along with plans to increase elective capacity. The system has developed outline plans and submitted bids to establish an elective hub in Nottinghamshire.
- h) The Getting it Right Frist Time (GIRFT) programme is being used to maximise productivity opportunities within existing services which will be reflected in the elective hub model.

Cancer:

- i) The presentation on Cancer recovery and performance included, the national and regional context, the local picture, the impact of Covid-19 on diagnosis and treatment numbers and actions to address performance and the diagnosis/treatment gap.

- j) Referral numbers dropped sharply at the beginning of the pandemic but have recovered to pre Covid levels.
- k) The numbers of patients treated is recovering to pre Covid levels although demand is now higher.
- l) Nottingham and Nottinghamshire ranks in the top quartile in terms of cancer diagnosis and treatment.
- m) The presentation described work underway to find 'hidden' patients who may have cancer and to address overall backlogs.
- n) Data was provided to detail referrals, first treatments, backlogs and performance against the 31 day and 62-day cancer standards.
- o) Planning requirements for 2022/23 include, returning the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023 and by March 2024 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- p) In terms of finding the hidden patients there will be a focus on cancer pathways in which referrals have remained low.

The following points were raised in discussion:

- q) Members thanked the team for the detailed and comprehensive reports which provide significant assurance in terms of understanding the scale of the task and the system wide approach to recovery. Concern remains regarding the scale of restoration required and the potential for harm to patients as a result of long waits and delays in treatment. In response, the robust prioritisation process was described. Cancer patients are regularly contacted by a named Clinical Nurse Specialist to discuss treatment plans. The patient safety specialist group tracks harms and is working to put measures in place to identify hidden harms and those hidden to services.
- r) The importance of sharing learning across the whole system was stressed. There is demonstrable evidence that recovery plans are system focused.
- s) In respect of cancer services, the data suggests that diagnosis is taking place in a timely way but that delays occur in commencing treatment. It was also suggested that fluid pathways need to be in place for patients who need to transfer between cancer pathways. The instigation of rapid diagnostic pathways aims to address this issue. They will prevent repeated referrals back to the GP.
- t) In terms of waiting list recovery, capacity and demand work is looking at projections over the next five years to ensure that additional capacity is future proof.
- u) The variation in performance in respect of palliative and end of life care across localities was noted, particularly the way in which health inequalities influence this. Development of a health inequalities dashboard is underway to enable targeted engagement with hard to reach communities.

The Quality and Performance Committee:

- **NOTED** the content of the paper and next steps for assurance purposes.

QP 21 165**Nursing and Quality quarterly report**

Danni Burnett presented the item and highlighted the following points:

- a) Part one of the report addresses operational challenges as discussed earlier in the meeting and highlights the input of the Quality team. Outbreak management was a key focus during November and December 2021.
- b) Following the focus on the Care Sector in January 2022 this report continues the narrative and highlights work with the CAHMS provider collaborative.
- c) Part two of the report provides an update on actions from quarter two and details of serious incident reporting for quarter three. Backlogs in reviewing serious incidents persist. The Quality team are working with providers to ensure immediate learning is harnessed. Numbers of serious incidents reported are higher than last year although this is not necessarily indicative of a worsening position. Pressure ulcers were the most frequently reported incidents in quarter three followed by treatment delays, slips, trips and falls and sub optimal care (particularly in the Emergency Department).
- d) Three providers remain under enhanced surveillance; NUH, Nottinghamshire Healthcare and Mediscan. National Quality Board recommendations are followed in terms of regulatory oversight.
- e) NUH has implemented refreshed oversight arrangements and continue to work with NHSE/I. A Board to Board meeting has taken place with the national team.
- f) Feedback on the section 29a notice action plan is awaited from the CQC. The notice is likely to remain in place for now.
- g) NUH Maternity services report some positive progress although limited assurance remains in respect of workforce and culture.
- h) A detailed review of NUH performance will be presented to the Committee in March 2022.
- i) The report includes an update on Nottinghamshire Healthcare. Issues related to outbreaks and compliance with Infection Prevention and Control procedures alongside staffing challenges featured in quarter three. A number of services remain under close scrutiny. A CQC report following a visit to medium secure services in early February 2022 is awaited.
- j) All Nottingham and Nottinghamshire patients identified as affected by the suspension of Mediscan services in quarter two have now been followed up. No harms have been noted although the service will remain on 'enhanced' surveillance until the end of quarter four.
- k) Quality insight visits planned for quarter three were delayed due to the level four response to the Omicron wave and have been rescheduled for quarter four.
- l) Work continues with the SAIU to produce a quality dashboard and quality risk profiles for all providers by the end of quarter four.
- m) In primary care, two practices received a 'good' CQC rating. Three practices are under enhanced surveillance with support and improvement plans in place.
- n) Four Nursing Homes are under enhanced surveillance and there is one suspension, this represents significant improvement.
- o) Part three of the report reports the position against statutory responsibilities. There are eleven ongoing statutory safeguarding reviews. Achieving the Initial health assessments target remains challenging. This reflects the position nationally.
- p) Part four of the report addresses quality and transformation and includes an update on local neonatal and maternity services programmes. Trusts have been requested to complete a return by the 15 April 2022 to show their current position in respect of Ockenden and Kirkup.
- q) Learning disabilities and autism are not on track to meet the inpatient trajectory. Actions are in place to achieve the 75% target for annual health checks.

The following points were made in discussion:

- r) Members agreed that the March 2022 will focus on NUH and mental health services followed by a deep dive related to NHT once the CQC report is available.

The Quality and Performance Committee:

- **RECEIVED** the report and supported the actions outlined.

Jon Towler left the meeting at 10.50

QP 21 166

Safe Management of Controlled Drugs Annual report 2020/21

Coral Osborn was in attendance for this item.

Coral Osborn delivered a presentation highlighting the following points:

- a) Throughout 2020/21 the CCG has continued to deliver its statutory duties related to Controlled Drugs (CD) through the work of the CCG Medicines Optimisation team. These include analysis of CD prescribing data, supporting CD investigations, reporting incidents and ensuring safety lessons are learnt.
- b) There remains a focus on the governance related to the prescribing of controlled drugs, with a focus on high doses, high quantities and long periods of time.
- c) The team has had a key role in the Covid-19 response in respect of producing guidelines at critical pace for treatment of Covid-19 symptoms. The MO team worked with clinicians across the ICS to develop end of life guidelines (EoL) which predominantly included CD medication. A specialist medicines optimisation cell was established operating 12 hours a day, 7 days a week.
- d) The CCG also responded to the national request to adapt and adopt national guidance around the re-use of CD medication in care homes. This was to ensure access to CD medications was sustained when the local health system was under immense pressure due to large supplies being required in secondary care.
- e) Strong links with partners remain and are important in terms of information sharing and training.
- f) The team has worked with GP practices to review patients with ambiguous directions and high doses of controlled drugs.
- g) Work for 21/22 is focused on; increased analysis of the prescribing of schedule 4 and 5 medications, increased analysis of the CD prescribing by non-medical prescribers and continuing the focus on pregabalin, gabapentin and temazepam prescribing.

The following points were made in discussion:

- h) Members thanked the team for their work, particularly during the early days of the pandemic. The work in Care Homes at this time has changed attitudes and embedded positive change for the long term.
- i) In responding to a question about the 2021/22 work programme, members were informed that achievement of the plan has been adversely affected by the ongoing role in the Covid-19 vaccination programme.

- j) The complexity and difficulty in addressing the prescribing of pregabalin, gabapentin and temazepam was acknowledged. It was felt that it will take time to achieve change and will require the input from specialist pain teams, psychological services and social prescribers. Long waits for planned care that some patients are experiencing is reflected in the increase in opiate prescribing.

The Quality and Performance Committee:

- **NOTED** the management of controlled drugs work undertaken throughout 2020-2021 co-ordinated by the CCG MO team, in addition to supporting the Covid-19 response.
- **RECOGNISED** the challenges described in implementing controlled drugs work across the ICS.

*Rosa Waddingham left the meeting at 11:15.
Coral Osborn left the meeting.*

Corporate Assurance

QP 21 167

Risk report

Sian Gascoigne presented the item and highlighted the following points:

- a) There are nine risks on the risk register, a reduction of one risk since the report to the Committee in January 2022. Five risks are rated red and were detailed in the paper, two relate to NUH and will be reviewed as part of the deep dive by the Committee in March 2022, the NHT risk will be reviewed in more detail following publication of the CQC report.
- b) Risk 171 links to public confidence and is under review with the Accountable Officer.
- c) Members were asked to consider Risk 129 (generic risk linked to increased waiting lists) following the detailed reports received on waiting times and performance.
- d) Following discussions with the Chief Nurse it is suggested that action is taken to reword the narrative of risk 004 to move it away from an EMAS quality risk to one which reflects the wider urgent care pressures.

The following points were made in discussion:

- e) Members agreed it is timely to review the narrative and score of risk 129 as there is more clarity regarding the consequences of the pandemic on mental and physical health.

ACTION:

- Sian Gascoigne and Lisa Durant will review the wording and score of risk 129.

The Quality and Performance Committee:

- **COMMENTED** on the risks shown within this paper (including the high/**red** risks) and those at **Appendix A**
- **DID NOT HIGHLIGHT** any new risks but requested a review of risk 129.
- **APPROVED** the proposal to review the risk narrative and score of RR 004.

Closing Items

QP 21 168

Any other business

The Chair expressed sincere thanks to Hilary Lovelock for her input, energy and insights into the work of the Committee. Her challenge and wise counsel will be missed. Members wished Hilary well in her retirement.

No further business was raised.

QP 21 169

Key messages to escalate to the Governing Body

The Committee:

- **RECEIVED** a detailed assurance report in respect of 104 week waits and Cancer performance. The report included plans for recovery, investment and detailed the associated risks.

QP 21 170

Date of next meeting:

24/03/2022 via MS Teams meeting

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Finance and Resources Committee**

Un-ratified minutes of the meeting held on
26/01/2022 09:00-10:00
MS Teams Meeting

Members present:

Shaun Beebe	Non-Executive Director (Chair)
Lucy Branson	Associate Director of Governance
Maxine Bunn	Associate Director of Commissioning, Contracting and Performance - Mental Health and Community (joined at 9:30)
Michael Cawley	Operational Director of Finance
Lisa Durant	System Delivery Director – Planned Care, Cancer and Diagnostics
Andrew Morton	Operational Director of Finance
Caroline Nolan	System Delivery Director (Greater Nottingham)
Stuart Poynor	Chief Finance Officer
Maria Principe	Director of System Analytics and Intelligence Unit
Jonathon Rycroft	Associate Director of Financial Recovery (Operations)
Dr Stephen Shortt	Joint Clinical Leader
Sue Sunderland	Non-Executive Director
Jon Towler	Non-Executive Director

In attendance:

Siân Gascoigne	Head of Corporate Assurance
Marcus Pratt	Programme Director – Finance and System Efficiency
Shannon Wilkie	Corporate Governance Officer (Minutes)

Apologies:

Amanda Sullivan	Accountable Officer
Dr James Hopkinson	Joint Clinical Leader

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Shaun Beebe	09	08	Caroline Nolan	09	08
Lucy Branson	09	09	Stuart Poynor	09	07
Maxine Bunn	09	08	Jonathan Rycroft	09	08
Michael Cawley	09	09	Stephen Shortt	09	08
Lisa Durant	09	09	Amanda Sullivan	09	07
Andy Hall	06	06	Sue Sunderland	09	08
James Hopkinson	09	05	Jon Towler	09	07
Andrew Morton	09	07	Maria Principe	03	01

Introductory Items

- FR 21 130** **Welcome and Apologies**
Shaun Beebe welcomed members to the Finance and Resources Committee meeting, which was held on MS Teams due to the current COVID-19 situation.
There were apologies from Amanda Sullivan and Dr James Hopkinson.
- FR 21 131** **Confirmation of Quoracy**
The meeting was confirmed as quorate.
- FR 21 132** **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.
- FR 21 133** **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.
- FR 21 134** **Minutes from the meeting held on 24 November 2021**
The minutes were agreed as a correct record.
- FR 21 135** **Action log and matters arising from the meeting held on 24 November 2021**
All actions on the action log were marked as completed.

Financial Position and Contract Management

- FR 21 136** **CCG Finance Report**
Michael Cawley and Stuart Poynor presented the item and highlighted the following points:
- a) The report presents a forecast breakeven position for the financial year.
 - b) Unlike 2020/21, the financial plan does not reset at month seven and instead the CCG reports on the year to date (YTD) financial position.
 - c) The main area of pressure, as in previous months, is Continuing Healthcare Costs (CHC) with overspends of £2.8M YTD.
 - d) Financial pressures are mainly mitigated using non recurrent measures.
 - e) The forecast outturn for the year is breakeven in line with the reported H1 position plus the final H2 plan.
 - f) The CCG capital plan is expected to under deliver by circa £0.5M due to delays on the primary care estates schemes because of COVID-19 pressures linked to supply chain difficulties.

- g) The latest performance on ERF shows the CCG has exceeded its NHSEI/ 2019/20 IS expenditure baseline in Month 7 and received income of £0.3m. No additional Elective Recovery Fund (ERF) income for M8 and M9 is included as the required IS activity thresholds to trigger an additional payment have not been reached. No further additional ERF income is expected for the remainder of the year.
- h) The overall forecast for the financial year is an income and expenditure breakeven position in line with the breakeven H2 financial plan together with the H1 reported breakeven position.
- i) A brief financial update was provided in respect of the COVID-19 Vaccination Programme which is now in 'Phase three'. The full finance report is submitted to Programme's Vaccination Oversight Board. It covers vaccination activity carried out at Hospital and Vaccination Centres only. The costs of which are reimbursed by NHSEI. Vaccinations carried out by Community Pharmacies and Primary Care Networks (PCNs) are under a separate contractual arrangement with NHSEI and are paid a tariff for the activity carried out. They do not form part of the Programme's reported financial results.
- j) In respect of Phase 1 and 2 of the Programme, it has been confirmed that the previously reported forecast deficit will be reimbursed through funds provided via NHSEI.

The following points were made in discussion:

- k) Members discussed underspend for the primary care capital allocation and were disappointed with the position. It was explained that the CCG is not able to use capital resources earmarked to it from NHSEI for other purposes. The current position has been reported back to NHSEI who are responsible for managing the overall capital resource position regionally. For 22/23, plans would be submitted (via a Project Initiation Document (PID) bid process) which would incorporate those primary care areas that had slipped this year.
- l) Members noted the 11% vacancy factor that the CCG is carrying and queried whether this should be addressed through the ongoing workforce development work; specifically, whether the CCG could improve efficiency. Members received assurance that vacancies are reviewed at the weekly Executive meetings and that the CCG does not actively hold vacancies where there is an operational issue. Some areas, such as the Finance Team, have held more vacancies during the pandemic because of changes to the way the team works. It was agreed that a detailed staffing and sickness report would be scheduled for the March 2022 Committee meeting.

The Committee:

- **NOTED** the report and **APPROVED** the report for onward submission to the Governing Body.

Action:

A detailed workforce report to be presented to the Committee at the March 2022 meeting.

Maxine Bunn joined the meeting during this item.

Andrew Morton presented the report. The following points were raised:

- a) The planning guidance for 2022/23 was received on 24 December 2021 and finance colleagues are working through this. The guidance recognises the uncertainty around COVID-19 variants and the consequent demands on the NHS.
- b) The planning timetable will be extended to the end of April 2022 with plans due in mid-March. The technical guidance and templates were released on 10 January 2022.
- c) A new target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and ICBs to be established.
- d) The guidance sets out ten priorities for the NHS over the coming financial year; these focus mainly on COVID-19 returning to a low level and will be under review by NHSE/I as the pandemic evolves.
- e) There will be an effort to move away from the simplified financial and contracting arrangements which have been in place through the pandemic. The financial framework will continue to support system collaboration.
- f) Allocations will be based on H2 of 2021/22 and will take a 'glide path' approach which will begin to bring systems gradually towards their fair share arrangement of NHS resources.
- g) COVID-19 allocations will remain, although with the assumption COVID-19 will be less prevalent. This could mean the CCG receives only 47% of previous allocations.
- h) £2.3BN has been allocated for national recovery from COVID-19. This will be allocated based on requirement and also achievement.
- i) Discharge funding will no longer be in place from April 2022. Work is ongoing to measure the impact of this on the CCG.
- j) Business rules will remain similar to the current arrangements with an expectation that overspend will be repaid in future years. Surplus is expected on a cumulative basis.
- k) It is expected that providers with allowed deficits will have debt written off once the ICB is established, though this has not been confirmed.
- l) Work is underway to reaffirm the system developed localised contract framework.
- m) A total of £6.5M non recurrent savings opportunities have been identified. This is the outcome of the assessment of CCG savings that are delivered recurrently, through non recurrent means.
- n) It was noted that the guidance described challenging national ambitions around elective recovery and finance colleagues would be presenting to Executive and Governing Body colleagues to explain these.

The following points were made in discussion:

- o) Members noted that the guidance did not focus on resolving the underlying system deficit. It was explained that it is likely this scrutiny will come once the ICB is established and 2022/23 is being treated as a bridge year from

emergency financial arrangements to business as usual.

- p) Members discussed the focus on COVID-19 recovery and noted that in order to resolve the underlying system deficit a medium term plan would need to be developed, rather than focusing on one financial year.

The Committee:

- **RECEIVED** for information and assurance the update on 2022/23 planning and the current position on savings.

FR 21 138

System Financial Update

Marcus Pratt was in attendance to present the report. The following points were raised:

- a) At month nine, the system is declaring a forecast 2021/22 deficit of £20.6M. This is driven by a shortfall in ERF income and increasing costs due to the operational response to the Omicron wave. This has manifested as a £9.9M deficit at Nottingham University Hospitals and £10.7m at Sherwood Forest Hospitals.
- b) The main driver of the deficit is a shortfall in planned ERF income due to reduced elective activity. This is due to COVID-19 leading to greater pressure on the urgent care pathway and also contributing to high levels of staff absence.
- c) Planned ERF in H2 across all organisations in Nottinghamshire was £17.2M. £1.2M has been accrued in October and November 2021 but the most likely scenario suggests that no more will be achieved for the remaining months of 2021/22. The CCG formally notified NHSE of this expectation in the M9 position.

The following points were made in discussion:

- d) Members discussed the importance of transparent reporting in order to tell a story, year on year, of an organisations financial journey.
- e) Members reflected on the population health statistics within Nottinghamshire and the impact this has on the systems financial performance. Previous year's allocations have broadly reflected population need. This is reflected in the system glide path target of 0.3% which is lower than surrounding areas. Members noted this was likely to be reviewed in 2023/24.
- f) Members noted that in comparison to surrounding areas, Nottinghamshire had maintained a higher level of elective activity but unfortunately not enough to trigger ERF.

The Committee:

- **NOTED** the financial position at month nine.

FR 21 139

Cross Provider Report:

Maria Principe presented the report. The following points were raised:

- a) The report uses 2019/20 as a baseline. This baseline, plus the turbulent period the NHS has faced during the pandemic, makes it difficult to identify trends in activity or performance.
- b) The report summarised the volume of activity delivered against the CCGs agreed H1 and H2 plans for both elective and non-elective pathways. A

summary of the key programme areas of spend was also provided.

The following points were made in discussion:

- c) Members discussed identifying a possible change in the threshold for referrals, as patients are now presenting more and the reluctance to attend healthcare settings has subsided. Because of this, excess growth in elective activity is to be expected.
- d) It was explained that work is underway to develop the Cross Provider Report, to provide more detailed intelligence of trends.

The Committee:

- **NOTED** the report and the actions taken to manage the key acute contracts.

Risk Management

FR 21 140

Risk Report

Siân Gascoigne presented the item and highlighted the following points:

- a) There were eight risks pertaining to the Committee's responsibilities, three of which are scored 'high' all of which were in line with discussions held during the meeting.
- b) Given work that has been undertaken around the NHIS IT equipment replacement programme, it was proposed that risk **RR 132** (*Failure of CCG IT System/Hardware*) be archived.

The following points were made in discussion:

- c) Members agreed to archive risk **RR 132**.

The Committee:

- **COMMENTED** on the risk report **HIGHLIGHTING** risks discussed throughout the course of the meeting.
- **APPROVED** the archiving of risk **RR 132**.

Closing Items

FR 21 141

Any other business

No other business was raised.

FR 21 142

Key messages to escalate to the Governing Body

The Committee did not agree any key messages to escalate to the Governing Body.

FR 21 143

Date of next meeting: 23/02/2022.

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Finance and Resources Committee**

Ratified minutes of the meeting held on
23/02/2022 09:00-10:50
MS Teams Meeting

Members present:

Shaun Beebe	Non-Executive Director (Chair)
Maxine Bunn	Associate Director of Commissioning, Contracting and Performance - Mental Health and Community (joined at 9:30)
Michael Cawley	Operational Director of Finance
Lisa Durant	System Delivery Director – Planned Care, Cancer and Diagnostics
Dr James Hopkinson	Joint Clinical Leader
Caroline Nolan	System Delivery Director (Greater Nottingham)
Stuart Poynor	Chief Finance Officer
Jack Rodber	Deputy Director – ICS System Analytics and Intelligence Unit (deputising for Maria Principe)
Dr Stephen Shortt	Joint Clinical Leader
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
Marcus Pratt	Programme Director – Finance and System Efficiency (items FR 21 152 and FR 21 153)
Mark Sheppard	Associate Director of Acute Contracting (item 21 155)

Apologies:

Lucy Branson	Associate Director of Governance
Andrew Morton	Operational Director of Finance
Maria Principe	Director of System Analytics and Intelligence Unit
Jonathan Rycroft	Associate Director of Financial Recovery (Operations)
Amanda Sullivan	Accountable Officer

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Shaun Beebe	10	09	Caroline Nolan	10	09
Lucy Branson	10	09	Stuart Poynor	10	08
Maxine Bunn	10	09	Jonathan Rycroft	10	08
Michael Cawley	10	10	Stephen Shortt	10	09

Lisa Durant	10	10	Amanda Sullivan	10	07
Andy Hall	06	06	Sue Sunderland	10	09
James Hopkinson	10	06	Jon Towler	10	08
Andrew Morton	10	07	Maria Principe	03	01

Introductory Items

FR 21 144 Welcome and Apologies

Shaun Beebe welcomed members to the Finance and Resources Committee meeting, which was held on MS Teams due to the current COVID-19 situation.

The apologies were noted above.

FR 21 145 Confirmation of Quoracy

The meeting was confirmed as quorate.

FR 21 146 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.

FR 21 147 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.

FR 21 148 Minutes from the meeting held on 23 January 2022

The minutes were agreed as a correct record.

FR 21 149 Action log and matters arising from the meeting held on 23 January 2022

There was one action on-going action, with a target completion date of 23 March 2023.

Committee Business

FR 21 150 Finance and Resources Committee Terms of Reference

Shaun Beebe presented the item and highlighted the following points:

- a) At the meeting of the Governing Body held on 2 February 2022, an amendment to the Finance and Resource Committee Terms of Reference was agreed.
- b) The amendment enables the Committee to make urgent decisions in line with its responsibilities for making decisions on procurement approaches and contract awards for non-healthcare contracts. As the Committee's last meeting will be in May 2022, this will ensure an appropriate route for any such decisions required following this and up until the disestablishment of the CCG.
- c) No further points were raised in discussion.

The Committee:

- **NOTED** the amendment to the Terms of Reference

Financial Position and Contract Management

FR 21 151

CCG Finance Report

Michael Cawley presented the item and highlighted the following points:

- a) The CCG remains under a temporary financial regime and is reporting a breakeven position as at month ten, in line with H2 plan approved by NHS England/Improvement (NHSEI) in November.
- b) The greatest area of pressure, as in previous months, is Continuing Healthcare Costs (CHC) with overspends of £2.87 million, year to date.
- c) The CCG continues to carry an elective recovery fund (ERF) overspend, however no further ERF income is expected for the remainder of the year.
- d) Mental health spend is also a pressure, primarily due to section 117 packages and associated costs, with a year to date overspend of £0.85 million and a forecast outturn overspend of £0.81 million.
- e) The CCG capital plan is expected to under deliver by circa £1.1 million, a further £0.6 million reduction from month nine, due to delays in NHSEI regional-led Learning Disabilities Programme (Mansfield Supported Living Scheme).
- f) It has been confirmed that the NHSEI slippage associated with regional Learning Disability (LD) schemes will not impact on the CCG's 2022/23 position and these will no longer be shown as coming from the CCG's financial envelope.
- g) Actions are being taken to mitigate the financial risks associated with the CCG's overspend, principally via the primary care reserves, assumed allocations and balance sheet measures.
- h) There is a potential upside risk estimated at c.£3.4 million. However, that risk is expected to be managed so long as the CCG does not receive any additional unexpected allocations between the current reporting period and the year-end period.

The following points were made in discussion:

- i) Members welcomed the helpful update regarding the regional LD schemes.
- j) Members discussed the importance of accurate reporting of the financial position and associated risks and received assurance that finance colleagues were focused on maintaining the reported forecast break even position and risk mitigation.

The Committee:

- **NOTED** the report and **APPROVED** the report for onward submission to the Governing Body.

FR 21 152 2022/23 Planning Update

Marcus Pratt presented the report. The following points were raised:

- a) The planning guidance for 2022/23 was received on 24 December 2021 and all commissioned organisations had been asked to submit their initial plans for review and consolidation. These will be submitted to the Executive Group week commencing 28 February 2022 for scrutiny and identification of next steps.
- b) The deadline for submitting the draft plan is 17 March 2022, with final plans requiring submission by 22 April 2022.
- c) Next steps include a top down review of the current position, consideration of the financial implications, identification of key challenges and establishment of a framework for identified mitigations.
- d) The starting point for the Nottingham and Nottinghamshire Integrated Care System (ICS) is a £23.5 million deficit.
- e) The funds available to system partners are approximately 1.4% higher than in 2021/22 but with national inflation assumptions at 2.8% this represents a real term reduction in funding.
- f) In addition, the elective recovery funding embedded in the planning assumptions are based on the achievement of 104% of the 2019/20 baseline.

Maxine Bunn joined the meeting at 9.30am

- g) For the CCG to achieve a balanced position costs needs to be taken out of its position which is a significant financial challenge. Six areas have been identified for further scrutiny, including Covid costs and non-clinically essential investment.
- h) This year transformation within the planning guidance is prescriptive with a focus on longer term prevention and streamlining the urgent care pathway. The impact of this will be fully embedded with the plans.
- i) Alongside cash releasing efficiencies, returning productivity to pre-pandemic levels is a key area of focus and will likely require increasing activity using existing resources.
- j) A fully risk mitigated financial plan will not be in place at the point the final plans are submitted in April. As such, a view will be taken as to whether the CCG can submit a compliant plan based on the level of risk embedded within it.
- k) A number of next steps have been identified which will contribute to the submission of a compliant plan, including the exploration of new ways of working using emerging architecture and networks which was incorporated following the Chief Executive Officer's meeting on 8 February 2022.
- l) A number of risks have emerged through the planning process, with the revenue financial gap recognised as the biggest risk over the coming weeks.

The following points were made in discussion:

- m) Members discussed the 2.8% national inflation assumption and were advised that it was likely to increase.
- n) Members noted the challenging financial position and considered the contributing factors. It was agreed that a further, more detailed update, would be received at the March meeting.
- o) Discussion took place regarding the system wide approach to implementing new ways of working, risk sharing and the empowerment of place-based partnerships to deliver transformational change. Assurance was received that whilst transformation had been impacted by the pandemic and winter pressures, a prescriptive approach to transformation within the planning guidance would help to build pace.
- p) Members recognised the need for clear internal communication regarding the challenging financial position, the financial envelope that the CCG is working within, and the need to clearly identify return on investment and measure efficiencies when presenting business cases and contracts. It was agreed that Michael Cawley and Andrew Morton would prepare a briefing for staff and Mark Sheppard would enact the process through the Service Change Group.
- q) Additionally, it was agreed that Stuart Poynor would brief Stephen Jackson, Chair Designate of the Integrated Care Board's Finance, Performance and Digital Committee, on the current financial position and the challenges that are arising as part of financial planning for 2022/23.
- r) It was noted that the March meeting would take place following the submission deadline for the draft financial plan. As such, it was agreed that Marcus Pratt would prepare a briefing document summarising the draft financial plan for circulation to members of the Committee prior to submission deadline date of 17 March 2022.
- s) Members discussed the risk associated with the current financial position and the challenges arising as part of the financial planning process for 2022/23. Assurance was received that the Head of Corporate Assurance was already in the process of articulating a risk for inclusion on the risk register in relation to this.

Actions:

- **Michael Cawley and Andrew Morton to prepare a briefing for staff to communicate that finance colleagues are working on an overcommitted financial envelope and will therefore need to ensure that all contracts and contract extensions deliver value for money and efficiencies and clearly identify a return on investment. Mark Sheppard to enact this process through the Service Change group.**
- **Marcus Pratt to prepare a briefing document summarising the draft financial plan for circulation to members of the Committee prior to submission deadline date of 17 March 2022.**
- **Stuart Poynor to brief Stephen Jackson, Chair Designate of the Integrated Care Board's Finance, Performance and Digital Committee,**

on the current financial position and the challenges that are arising as part of financial planning for 2022/23.

The Committee:

- **RECEIVED** for information and assurance the update on 2022/23 planning and the current position on savings.

FR 21 153

System Financial Update

Marcus Pratt was in attendance to present the report. The following points were raised:

- a) At month ten, the system is declaring a forecast 2021/22 deficit of £23.2 million.
- b) The main driver of the deficit is a shortfall in planned ERF income due to reduced elective activity. This is due to COVID-19 leading to greater pressure on the urgent care pathway and contributing to high levels of staff absence.
- c) The planned ERF in H2 across all organisations in Nottinghamshire was £17.2 million, however, during the period October 2021 to January 2022 only £1 million ERF income was received, £9.9 million adverse to plan.
- d) There is concern at a national level over the amount of capital spend to date and the ability to spend up to forecast levels in the remaining two months of the year.
- e) The ICS capital envelope is now expected to be underspent by £2.5 million due to slippage on Nottinghamshire Healthcare NHS Foundation Trust's (NHFT) Sherwood Oaks scheme.

Marcus Pratt and Caroline Nolan left the meeting at this point.

The following points were made in discussion:

- f) Discussion took place regarding the reasons behind the system's reliance on the ERF. It was noted that these are historic in nature, dating back to the 2019/20 outturn position when the CCGs' exhausted every area of flexibility to implement non recurrent solutions to meet their control totals. [One of the unintended consequences of this approach, following the introduction of the temporary financial regime, was that the regime did not recognise such non-recurrent solutions when calculating allocations to be given out to systems. (The regime instead assumes that all solutions to meet control totals are recurrent which means that the allocations received under the temporary financial regime were lower than they would otherwise have been)].
- g) Members considered the challenges to productivity and noted that across the system patients continued to be treated according to clinical priority.

The Committee:

- **NOTED** the financial position at month ten.

FR 21 154

Cross Provider Report:

Jack Rodber presented the report. The following points were raised:

- a) The report summarised the volume of activity delivered against the CCGs agreed H1 and H2 plans for both elective and non-elective pathways.
- b) Elective demand continued to grow over the few months running up to December 2021 and both routine and two week wait referrals were higher than the 2019/20 baseline.
- c) Outpatient and elective inpatient activity is lower than the same 2019/20 period. This could point to a future risk associated with demand not keeping pace with activity.

Mark Sheppard joined the meeting at this point.

The following points were made in discussion:

- d) Members recognised the potential risk relating to demand not keeping pace with activity, the impact of the pandemic on the demand pattern and emphasised the need to ensure all options, including non-referral, were explored.
- e) Further to this, the importance of working with primary and secondary care clinicians to achieve a true understanding of the referrals situation at a granular level was noted. To ensure the Committee was sighted on this it was agreed that Jack Rodber would conduct a one-off analysis on demand and activity trends (not just the provider report) which would be received at the March meeting.
- f) Members considered the impact of the pandemic on demand and activity moving forwards and recognised that an increase of patients presenting with greater complexity of illnesses could be a cause of the elevated two week wait levels.

Action:

- **Jack Rodber to complete a one-off analysis of demand and activity trends (not just the provider report) to quantify the referrals situation at a granular level, in the context of the pandemic.**

The Committee:

- **NOTED** the report and the actions taken to manage the key acute contracts.

FR 21 155

Contract Negotiations

Mark Shepherd and Maxine Bunn presented this item. The following points were raised:

- a) For the last two years locally signed contracts with acute providers have not been required due to the pandemic and NHSEI establishing a different contracting and payment methodology.
- b) For the H2 period of 2021/22 the CCG has had contracts in place with its Independent Sector (IS) providers.
- c) Signed contracts will need to be in place with all providers from 1 April 2022 to cover the contract year 2022/23.

- d) The NHS Standard Contract remains the document to be used for the above purposes. This has been revised and removed the need to include the Service Conditions and General Conditions in the contract. These will remain live documents owned by NHSEI and the commissioner and provider will be responsible for having oversight of any changes during the life of the contract. Furthermore, CQUIN requirements and national performance requirements will be removed from the contract particulars and placed in the Service Conditions.
- e) The national indication is that payment should be made on an Aligned Incentive model, if applied as written this would be tariff based and have a fixed and variable element.
- f) It is felt that the Nottingham and Nottinghamshire system has moved beyond an Aligned Incentive model. As such conversations are taking place with colleagues at Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust and NFHT to agree a more mature local approach to contract payments.
- g) IS providers will continue to be commissioned to deliver acute services based on national tariff and other smaller contracts will be maintained on the current basis.
- h) The model for elective recovery is developing with further guidance required. However, to ensure that providers are incentivised to over perform and reduce backlogs and waiting lists, the current intention is to separate recovery from the base contract. This will mean that any additional income the system receives for recovery can be utilised in the most appropriate and impactful way.
- i) Work is ongoing to mitigate the risk that the allocations for providers are not agreed by the 1 April. If this was to happen any unagreed contracts would default to national tariff.
- j) Contracts for mental health and community providers will be moving to an allocations-based approach. The planning submissions have been signed off for the mental health contracts and a mental health outcomes framework is under development. A review of the outcomes framework for community providers is currently underway.

The following points were made in discussion:

- k) Assurance was received that the cost associated with Inter Provider Transfers to IS providers will be closely monitored to ensure they are incurred by the correct organisation.
- l) Assurance was received that any changes associated with place-based working would be transacted through the community contract.

The Committee:

- **NOTED** the contracting update for information.

Risk Management

FR 21 156

Risk Report

Siân Gascoigne presented the item and highlighted the following points:

- a) There are seven risks pertaining to the Committee's responsibilities.

- b) It is anticipated that risk RR 151 will be further mitigated following conversation with Mark Sheppard.
- c) A wider financial risk around the financial risk for 2022/23 is due to be articulated in conjunction with finance colleagues.
- d) Following receipt of further assurances regarding the efficiencies and mitigations identified to deliver a balanced financial position the likelihood score of risk RR 172 has been further reduced to a two, resulting in an overall risk score of 8.
- e) No further points were raised in discussion.

The Committee:

- **COMMENTED** on the risk report **HIGHLIGHTING** risks discussed throughout the course of the meeting.

Closing Items

- | | |
|------------------|--|
| FR 21 157 | Any other business
No other business was raised. |
| FR 21 158 | Key messages to escalate to the Governing Body
The Committee did not agree any key messages to escalate to the Governing Body. |
| FR 21 159 | Date of next meeting: 23/03/2022. |



**NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Primary Care Commissioning Committee (Public Session)
Ratified minutes of the meeting held on
19/01/2022 09:00-09:45
MS Teams Meeting**

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Shaun Beebe	Non-Executive Director
Helen Griffiths	Associate Director of Primary Care Networks
Joe Lunn	Associate Director of Primary Care
Sue Sunderland	Non-Executive Director
Danielle Burnett	Deputy Chief Nurse
Michael Cawley	Operational Director of Finance
Dr Ian Trimble	Independent GP Advisor

In attendance:

Lynette Daws	Head of Primary Care
Esther Gaskill	Head of Quality
Sian Gascoigne	Head of Corporate Assurance
Shannon Wilkie	Corporate Governance Officer (minute taker)
Michael Wright	Nottinghamshire Local Medical Committee
Jo Simmonds	Head of Corporate Governance

Apologies:

Lucy Dadge	Chief Commissioning Officer
------------	-----------------------------

Cumulative Record of Members' Attendance (2021/22)

Name	Possible	Actual	Name	Possible	Actual
Shaun Beebe	10	10	Joe Lunn	10	10
Michael Cawley	10	08	Dr Richard Stratton*	10	04
Lucy Dadge	10	09	Sue Sunderland	10	10
Eleri de Gilbert	10	09	Dr Ian Trimble	10	10
Helen Griffiths	10	08	Danielle Burnett	10	09

* Dr Stratton left 24/09/2021

Introductory Items

PCC/21/192 Welcome and Apologies

Eleri de Gilbert welcomed everyone to the public session of the Primary Care Commissioning Committee meeting, which was being held virtually due to the COVID-19 pandemic. Apologies were received from Lucy Dadge.

PCC/21/193 Confirmation of Quoracy

The meeting was confirmed as quorate.

PCC/21/194 Declaration of interest for any item on the shared agenda

There were no identified conflicts of interest.

PCC/21/195 Management of any real or perceived conflicts of interest

No management action was required.

PCC/21/196 Questions from the public

No questions had been received from the public.

PCC/21/197 Minutes from the meeting held on 15 December 2021

The minutes were agreed as an accurate record of proceedings.

PCC/21/198 Action log and matters arising from the meeting held on 15 December 2021

Actions PCC 21 1118 and PCC 21 124 were not yet due.

In relation to action PCC 21 110, a replacement is still being sought for Dr Stratton.

Action PCC 21 183 was on the agenda at item PCC/21/204 for information and was therefore complete.

Action PCC 21 184 was complete and national letters C1487 and C1488 were attached as appendices for information.

There were no matters arising.

Covid-19 Recovery and Planning

PCC/21/199

Covid-19 Practice Level Update: Operational Pressures Escalation Levels (OPEL) reporting

Joe Lunn presented the item and highlighted the following key points:

- a) General Practice continues to progress through the COVID-19 outbreak with practices across all three Localities (South Nottinghamshire, Mid Nottinghamshire and Nottingham City) reporting their Operational Pressures Escalation Levels (OPEL) on a daily basis. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice.
- b) The report provides an overview of OPEL reporting for the five weeks to 31 December 2021. The report also includes the comparator data for the prior reporting period.

- c) 45 of 124 practices reported days where they were at OPEL Level 3 during the five week period (297 days across those practices), 103 practices have reported OPEL Level 2 for the period and 17 practices reported they were consistently OPEL Level 1.
- d) Practices had been asked to begin recording additional staff absence information as part of OPEL reporting, from 29 December 2021 in order to show the impact on staffing due to the Omicron variant of the COVID-19 virus.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL reporting for General Practice for the five-week period to 31 December 2021.
- **NOTED** staff absence reporting for the period 29 December 2021 to 7 January 2022.

PCC/21/200 Primary Care Support to Care Homes

Fiona Callaghan was in attendance to present the item and highlighted the following key points:

- a) The paper requested approval of a two-year direct award for the Primary Care Support to Care Homes service. An extension to the existing contract had been approved at the February 2021 PCCC meeting and there is no further option to extend. The existing contract is due to expire 31 March 2022.
- b) The Prioritisation and Investment Committee recently extended the existing Community Services contracts, and the aim is to align these with the Primary Care Support to Care Homes contracts as both facilitate the delivery of Enhanced Health in Care Homes (EHCH). This work aims to achieve an equitable service provision across Nottingham and Nottinghamshire.
- c) As the original intention was to have achieved community transformation before the contract expiration, there is no alternative offer for Primary Care Support to Care Homes in the South Nottinghamshire area.
- d) The South Nottinghamshire Place Based Partnership will work with the Integrated Care Board (ICB) to enable this contract to be held by the Place Based Partnership, recognising that this is unlikely to be a contract that the ICB will continue to hold.
- e) The budget for the proposed option is recurrent.

The following points were raised in discussion:

- f) Members questioned why an equitable solution for the service in the meantime had not been identified. It was explained that the aim is to align with the existing Community Services contracts. It was noted that there is the ability to implement contract variations should a solution be identified before the two year extension period is over.

- g) Members queried what service provision is in place in Bassetlaw and whether this will be aligned with the Nottinghamshire solution. It was explained that the CCG had reached out to Bassetlaw for an initial conversation on this matter.
- h) Members discussed what the future model would look like. It was noted that in order to provide the best care to patients, it is likely a hybrid approach will be taken to ensure services are not delivered solely in a community setting.
- i) Members were assured that targeted work is ongoing to improve individual services whilst the overarching transformation programme is underway and explained that a two year direct award does not mean that work will cease to improve accessibility, patient outcomes and patient experience in the meantime.
- j) Members felt that the report did not reflect the context of the wider work that is happening. It was agreed that input from commissioning and quality colleagues was needed to help inform decision-making.
- k) Members considered the risks detailed in the report should there be no service provision in place at the contract end date. These include the negative impact on patients and the disruption to ongoing pieces of work which add value to the service, such as implementation of the EHCH framework and the Primary Care Network (PCN) Directed Enhanced Service (DES).
- l) Members supported the proposal however it was agreed that further context and input was needed from commissioning and quality colleagues before a decision could be made. In view of the timeline, it was agreed that wider input would be sought and the paper submitted virtually for approval. The outcome of the decision would be reported back to the Committee at the February 2022 meeting.

The Committee:

- Whilst supporting the proposal in principle **AGREED** further work should take place with commissioning and quality teams before bringing a more detailed proposal for approval. Given timeline it was recognised this may have to be virtually and feeding back to the Committee at the February 2022 meeting.

Financial Management

PCC/21/201 Finance Report – Month Nine

Michael Cawley presented the item and highlighted the following points:

- a) The paper reported the financial position for month nine 2021/22 and has been prepared in the context of the revised financial regime implemented by NHS England/Improvement (NHS/I) in response to the COVID-19 pandemic. Under the H2 regime, the CCG is required to report on the financial year to date position (cumulative from M1 to current month), as opposed to treating the H1 and H2 separately.
- b) The year to date position shows a £2.57 million underspend (2.05% of year to date budget). This is primarily due to the reserves forming part of the position (£2.64 million) offset by small overspends relating to spend associated with Additional Roles (ARRS). The reserves are designed to manage any in-year

unforeseen pressures that may arise on those budgets delegated by the CCG to the Primary Care Commissioning Committee (PCCC). For accounting purposes, the total PCCC reserves position remains reported as part of the overall PCCC position.

- c) The current forecast position is £2.65m overspend (1.59% of total budget). This overspend accounts for forecast spend associated with ARRS (£5.09m) and Winter Access Fund (WAF) (£3.20m) both of which will be funded by NHSEI. The CCG has been advised by NHSEI to present the financial information in this way as part of the national reporting process to secure the relevant funding.

No further points were raised in discussion.

The Committee:

- **NOTED** the contents of the Primary Care Commissioning Finance Report.
- **APPROVED** the Primary Care Commissioning Finance Report for the period ended December 2021.

Risk Management

PCC/21/202 Risk Report

Sian Gascoigne presented the item and highlighted the following points:

- a) There are currently eight risks relating to the Committee’s responsibilities, there has been no change since the previous meeting.
- b) There were no proposed changes to the existing risks and no further risks to be added to the register.

No further points were made in discussion.

The Committee:

- **NOTED** the Risk Report

Information Items

PCC/21/203 Monthly Contract Update.

The Committee received this item for information.

PCC/21/204 Winter Access Fund Update

The Committee received this item for information.

Closing Items

PCC/21/205 Any other business

No further business was raised.

PCC/21/206 Key messages to escalate to the Governing Body

The Committee did not have any messages for escalation to the Governing Body.

PCC/21/207 Date of next meeting:

16/02/2022

MS Teams meeting



**NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Primary Care Commissioning Committee (Public Session)
Ratified minutes of the meeting held on
16/02/2022 09:00-10:30
MS Teams Meeting**

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Shaun Beebe	Non-Executive Director
Helen Griffiths	Associate Director of Primary Care Networks
Joe Lunn	Associate Director of Primary Care
Sue Sunderland	Non-Executive Director
Danielle Burnett	Deputy Chief Nurse
Michael Cawley	Operational Director of Finance
Dr Ian Trimble	Independent GP Advisor
Lucy Dadge	Chief Commissioning Officer

In attendance:

Lynette Daws	Head of Primary Care
Esther Gaskill	Head of Quality
Fiona Callaghan	South Nottinghamshire Locality Director (for item PCC 21 218)
Andrea Brown	Associate Director, Planning and Workforce Transformation (for item PCC 21 220)
Andrew Fearn	Director of Digital Services NUH and SRO Digital Analytics (for item PCC 21 216)
Alexis Farrow	Head of Strategy and Transformation SFH (for item PCC 21 216)
Sian Gascoigne	Head of Corporate Assurance
Sarah Allcock	Primary Care Commissioning Manager (Observing)
Louise Espley	Corporate Governance Officer (minute taker)
Stuart Hague	Nottinghamshire Local Medical Committee

Apologies:

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Shaun Beebe	11	11	Joe Lunn	11	11
Michael Cawley	11	09	Dr Richard Stratton*	06	04
Lucy Dadge	11	10	Sue Sunderland	11	11
Eleri de Gilbert	11	10	Dr Ian Trimble	11	11
Helen Griffiths	11	09	Danielle Burnett	11	10

* Dr Stratton left 24/09/2021

Introductory Items

PCC/21/208 Welcome and Apologies

Eleri de Gilbert welcomed everyone to the public session of the Primary Care Commissioning Committee meeting, which was being held virtually due to the COVID-19 pandemic. Apologies were received from Lucy Dadge.

PCC/21/209 Confirmation of Quoracy

The meeting was confirmed as quorate.

PCC/21/210 Declaration of interest for any item on the shared agenda

The register of interests was provided.

The following conflict of interest was noted:

Item 11. Primary Care Support to Care Homes – South Notts

Helen Griffiths has an interest as the spouse of a practicing GP.

PCC/21/211 Management of any real or perceived conflicts of interest

In terms of management of the conflict Helen Griffiths received the paper and was invited to remain in the meeting but not take part in the discussion or decision in relation to the paper.

PCC/21/212 Questions from the public

No questions had been received from the public.

PCC/21/213 Minutes from the meeting held on 19 January 2022

The minutes were agreed as an accurate record of proceedings.

PCC/21/214 Action log and matters arising from the meeting held on 19 January 2022

The Bull Farm impact assessment will be reported to the Committee in March 2022.

As a reflection of the transitional nature of the CCG, a GP representative will not be identified to replace Dr Stratton on the Committee.

There were no matters arising.

PCC/21/215 Actions arising from the Governing Body meeting held on 02 February 2022

The Governing Body expressed a lot of interest in matters related to primary care at the February 2022 meeting with discussion focused on PCN development and maturity; the development of and engagement in the draft primary care strategy and the importance of a Primary Care IT strategy which did not increase inequalities by omitting the digitally excluded. The Governing Body requested greater visibility of PCN development. A report on the role of PCNs is scheduled for the March 2022 meeting of the ICS Transition and Risk Committee.

The Governing Body has also sought further assurance with regard to the reporting of variations in performance and access in primary care. The Associate Director of Primary

Care will attend the PPEC meeting in April 2022 to discuss the data available and the oversight of delivery in primary care.

Strategy, Planning and Service Transformation

PCC/21/216 Primary Care IT

Andrew Fearn and Alexis Farrow joined the meeting for this item.

Andrew and Alexis were welcomed to the meeting. The PCCC recognises that IT is an essential enabler to the development of primary care. The Committee received the Primary Care IT Strategy in September 2021 and had requested an update on its implementation and progress.

Andrew Fearn and Alexis Farrow provided a verbal update, highlighting the following key points:

- a) There are lots of changes at a national level in respect of Primary Care IT with four bodies involved in IT coming together as one, to create a national digital strategy. The national strategy describes what good looks like and sets expectations for each ICS.
- b) Funding streams for IT have been aligned and there is significant finance available to allow all systems to 'level up' in terms of technology. The aim is to enable information to be shared across all health and care sector boundaries.
- c) Consequently, the strategy presented in September 2021 will be revised. External support has been engaged to support this work and key to its development will be engagement with stakeholders across the system. The resulting primary care IT strategy will align with the overarching ICS strategy. The team is working to a tight timeline to develop the strategy by 30 April 2022.
- d) There is significant work underway to support digital and health literacy skills and a Digital Inclusion Manager at PCN level will take the lead on engagement as this is seen as critical to the development of a meaningful strategy.

The following points were made in discussion:

- e) Members welcomed the update which provided clarity on the position both nationally and locally. Alignment of bodies responsible for IT nationally was considered a positive change alongside the focus on a revised local strategy that has the engagement of stakeholders as a key driver.
- f) Discussion ensued regarding the user based design based approach that will be used in development of the strategy.
- g) The ambition of the new strategy was commended in terms of the focus of investment in primary care. In terms of current IT pressures in primary care, members were encouraged to hear that there is opportunity to access existing and emerging funding to resolve the practical issues faced by primary care.
- h) The importance of PCN engagement in development of the primary care IT strategy was stressed and will be discussed with PCN Clinical Directors.
- i) The Committee will receive an update on development of the strategy in April/May 2022.

The Committee:

- **NOTED** the update.

Andrew Fearn and Alexis Farrow left the meeting.

Commissioning, Procurement and Contract Management

PCC/21/217 The Practice St Albans & Nirmala – Boundary extension application

Joe Lunn presented the item and highlighted the following key points:

- a) The paper details the application from The Practice St Albans & Nirmala to extend their practice boundary. The boundary extension will include Acer Court Care Home (which they are aligned to as part of the Enhanced Health in Care Home DES).
- b) The boundary change also encompasses the geographical area covered by Springfield Medical Centre and reflects the merged practice boundary.
- c) Maps were provided to demonstrate the proposed boundary changes.

The following points were raised in discussion:

- d) Members noted that the Practice merger and Care Home alignment had been subject to discussion and agreement at a previous meeting and approved the resultant boundary change.

The Committee:

- **APPROVED** the application from The Practice St Albans & Nirmala to widen their practice boundary.

PCC/21/218 South Nottinghamshire Primary Care support to Care Homes – preferred option

Fiona Callaghan presented the item and highlighted the following key points:

- a) Following initial presentation of the proposal in January 2022 the report has been revised to include the further detail requested by members. The revised report provided greater clarity regarding the risk of not progressing in the short term and more detail related to the impact on the service.
- b) In terms of the community services contract, work is taking place in the South Nottinghamshire Care Homes Steering Group to determine a Care Homes model for South Nottinghamshire.
- c) The section in the report related to the Community Services review has been strengthened. The ethos of the Community Services transformation work will influence this.
- d) Further detail is included with respect to the NHT contracts.

The following points were raised in discussion:

- e) Members thanked Fiona for the significant amount of work to update the proposal.
- f) It was noted that there are different models of service delivery across Nottingham and Nottinghamshire and Bassetlaw. Further work will take place to develop the most effective model of delivery for the ICS.

The Committee:

- **APPROVED** the direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCNs (via GP Federations) for a two-year period from 01 April 2022 until 31 March 2024.

PCC/21/219 Winter access fund update

Joe Lunn presented the item and highlighted the following key points:

- a) The report details the submission to NHSE/I (on 01 February 2022) against the winter access fund plans. Templates from NHSE/I for submissions have changed significantly for this reporting period (November and December 2021).
- b) The original plan suggested 200k appointments would be available between November 2021 and March 2022 as part of the winter access fund. Despite the diversion of primary care staff to the Covid-19 vaccination programme and higher than anticipated staff absence, 41k appointments have been delivered (to date) as part of the winter access fund.
- c) Staff absence remains a key risk to delivery of the winter access fund plans. Further detail of absence levels is provided in paper PCC 21 223. Absences are stabilising and activity is increasing as a result.
- d) Two financial allocations have been received and spend profiled to March 2022. The CCG anticipates full utilisation of the fund.

The following points were raised in discussion:

- e) Members noted the high level of scrutiny from NHSE/I in respect of the winter access fund.
- f) The impact and outcome of the increase in primary care access was discussed the query being raised was on increased activity and whether this had created additional pressure on secondary care services or are health issues being resolved in primary care. At this stage it was too early to assess the impact on secondary care. There is a focus on general practice that involves testing different ways of delivering services which will be evaluated over the coming months. For example, one PCN is testing a service where there is a home visiting nurse dealing with demand on the day.
- g) NHSE/I has expressed an interest in the CCG's approach and has asked the CCG to share some examples of working differently.
- h) The importance of analysis of the system wide impact of increased access was accepted. It was also noted that the original purpose of the winter access fund was to improve primary care face to face access. As infection prevention and control measures are eased a new normal will emerge regarding the delivery of services.

The Committee:

- **NOTED** the update in relation to the monthly reporting process for "Improving Access for Patients and Supporting General Practice" (Winter Access Fund) and the submission made to NHSE/I on 01 February 2022.

Strategy, Planning and Service Transformation

PCC/21/220 Primary Care Workforce Planning – Quarterly update

Andrea Brown joined the meeting for this item.

Andrea Brown presented the item and highlighted the following key points:

- a) The report provides an update on the approaches and strategies in place to support workforce planning and development in general practice. It includes the

most current reported workforce profile, progress of workforce schemes currently in place and the next steps regarding workforce development.

- b) The methodology for workforce profiles has changed over the last four months. Overall trends remain the same as previously reported. General Practitioner numbers remain static, concern remains with regard to nursing numbers which is reflective of the regional and national position.
- c) The focus since the last update has been to deliver the workforce development programme submitted to NHSE/I. In addition, the Primary Care Workforce Group has kept a watching brief on the potential workforce implications of other areas of work such as the assurance and support work of the Primary Care Team, the emerging expectations of system transformation of primary care as well as the future training needs of general practice staff linked to the enhanced services and recovery initiatives.
- d) Additional roles recruited via PCNs is going well and is positive when benchmarked across the region.
- e) The CCG is working with colleagues from Health Education England (HEE) to look at supply issues and identification of pressure points and their mitigation.
- f) Appendix 2 and 3 of the report relate to retention strategies particularly in respect of General Practitioners. The CCG is on track with exception of two schemes.
- g) Next steps are important in taking the workforce strategy forward. It is important that the opportunity provided by development of the primary care strategy is harnessed to create a strategy that addresses the workforce as a whole and its place in the system. This will help develop a concerted approach to recruitment in addition to retention.
- h) Risks are presented in the report and remain constant. The training hub procurement has enabled a continuation of support to PCN workforce development.

The following points were raised in discussion:

- i) Members thanked Andrea for the candid report highlighting progress and risks. Concern remains regarding the general practice nursing workforce position, both in terms of actual numbers and the age profile of nurses currently working in primary care. It was noted that the position in Nottingham and Nottinghamshire is no different to the regional and national picture. Strategies to support routes of entry to nursing in general practice, apprenticeships, and the creation of career pathways in primary care were discussed.
- j) The importance of alignment of the workforce strategy with the emerging primary care strategy for the ICS was agreed.
- k) The need for accurate workforce data from practices was highlighted. Work is underway with NHS Digital to address this and the Primary Care Team are undertaking validation of data and commencing business continuity discussions with practices where the age profile of staff indicates vacancies are on the horizon.
- l) Members requested that future trend graphs show statistical significance.
- m) PCNs are performing well in terms of regional and national workforce expectations. Further work will focus on joint recruitment and rotational posts as we move to system working. The variation in roles across PCNs was noted and is discussed at the PCN emerging roles group. Population health data will influence role requirements in the future. A workshop is planned in February 2022 where innovative roles will be shared along with the impact they have had.

- n) Members noted that the report is information/data rich and would benefit from additional reference to the aims of the workforce strategy and the progress made in achieving those aims.
- o) The revised workforce strategy will be presented to the Committee in April/May 2022.

The Committee:

- **NOTED** the current workforce position and continued focus on supply, recruitment, and retention strategies.
- **NOTED** the progress and impact made in delivering the workforce development plans for General Practice and PCNs to date.
- **NOTED** the intentions regarding future priorities in the next steps.
- **NOTED** the risk management in place.

Andrea Brown left the meeting.

PCC/21/221 Primary Care Network (PCN) delivery

Lucy Dudge and Helen Griffiths provided a verbal update, highlighting the following key points:

- a) The routine quarterly report on PCN delivery will be presented to the Committee in March 2022.
- b) The ICS Transition and Risk Committee will focus on PCN development at its March 2022 meeting and will receive a report on intentions for PCN development in its broader sense, including Place development, GP sustainability and the development of the Primary Care Strategy.

The following points were raised in discussion:

- c) Members noted the increased focus on PCN development as the move to system wide working progresses.

The Committee:

- **NOTED** the update.

Quality

PCC/21/222 Primary Care Quality Briefing

Esther Gaskill presented the item and highlighted the following key points:

- a) The report includes a summary of the quarter three quality dashboard ratings, primary care quality team activity and CQC ratings.
- b) Primary Care Quality dashboard - One practice achieved an overall 'Green Star' rating. This is a decrease from the previous quarter when three practices achieved a green star rating. The majority of practices achieved an overall 'Green' rating (83 out of 124). This is a decrease of 12 from the previous quarter. 40 practices achieved an overall 'Amber' rating, an increase from the previous quarter when 26 practices were rated amber. No practices received an overall 'Red' rating. The change in performance is attributed to the flu uptake target. Last year saw the highest flu vaccine uptake rates ever achieved, which, combined with this year's COVID-19 booster vaccination programme falling

around the same time as the flu vaccination programme made it particularly challenging for practices to achieve the same uptake level for flu vaccines.

- c) The Primary Care Patient Safety Incidents Report provides a quarterly update on the patient safety incidents within primary care that have been reported to the CCG. During Quarter three, 41 (previous quarter 47) patient safety incidents were received by the CCG relating to primary care. One incident met the national serious incident (SI) framework threshold. The incident was a stage three pressure ulcer. The practice involved identified that there was a missed opportunity to prevent development of the pressure ulcer. The practice identified learning points following this incident.
- d) The CQC's overall rating of practices in Nottingham and Nottinghamshire as of 01 February 2022 is; 18 practices rated 'Outstanding', 102 'Good', with one 'Requires Improvement'. No practices are rated inadequate, and three practices are not yet rated due to recent changes in provider. The CQC has published inspection reports for Bilborough Medical Centre, Broad Oak and JRB Healthcare and all have been rated as 'Good' overall. This is a commendable achievement given the COVID-19 pandemic and the challenges primary care has experienced as a result.
- e) During quarter three the quality team provided enhanced support to a number of practices.

The following points were raised in discussion:

- f) Members commended the three practices that had moved to a good rating following CQC inspections and noted the positive outcomes following intervention by the quality team.

The Committee:

- **NOTED** the Primary Care Quality report for February 2022.

Covid-19 Recovery and Planning

PCC/21/223 Covid-19 Practice Level Update: Operational Pressures Escalation Levels (OPEL) reporting

Joe Lunn presented the item and highlighted the following key points:

- a) General Practice continues to progress through the COVID 19 outbreak with practices, across all three Localities (South Nottinghamshire, Mid Nottinghamshire and Nottingham City), reporting their Operational Pressures Escalation Levels (OPEL) on a daily basis. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice each day.
- b) The report covers the four-week period to 28 January 2022. Overall, the position has slightly improved since January 2022. 37 practices reported days at OPEL level three, 122 practices reported days at OPEL two and two practices reported OPEL level one consistently.
- c) Absence reporting continues and covers the period 10 January 2022 to 04 February 2022. The position is steadily improving across the three localities.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL report to 28 January 2022.
- **NOTED** the staff absence report for the period 10 January 2022 to 4 February 2022.

Financial Management

PCC/21 224 Finance report – month ten

Michael Cawley presented the item and highlighted the following points:

- The paper reported the financial position for month ten 2021/22 and has been prepared in the context of the revised financial regime implemented by NHS England/Improvement (NHS/I) in response to the COVID-19 pandemic. Under the H2 regime, the CCG is required to report on the financial year to date position (cumulative from M1 to current month), as opposed to treating the H1 and H2 separately.
- The year to date position shows a £1.78 million underspend (1.28% of year to date budget). This is primarily due to the reserves for the delegated primary care budget forming part of the position (£2.64 million) offset by small overspends relating to spend associated with Additional Roles (ARRS) that will be reimbursed. [It was separately noted that significant reserves are also being held against the CCG's non-delegated primary care budget as well as those budgets that have been delegated to PCCC].
- The reserves are designed to manage any in-year unforeseen pressures that may arise on those budgets delegated by the CCG to the Primary Care Commissioning Committee (PCCC). For accounting purposes, the total PCCC reserves position remains reported as part of the overall PCCC position.
- The current forecast position is £1.64m overspend (0.98% of total budget). This accounts for a forecast overspend spend associated with ARRS (£4.83m) and WAF (£2.32m) both of which will be funded by NHSE/I. The CCG has been advised by NHSEI to present the financial information in this way as part of the national reporting process to secure the relevant funding.

The following points were raised in discussion.

- It was clarified that in relation to the capital funding for the Mansfield Supported Living Scheme, the slippage with this scheme will not adversely affect the CCG capital funding position in future years.

The Committee:

- **NOTED** the contents of the Primary Care Commissioning Finance Report.
- **APPROVED** the Primary Care Commissioning Finance Report for the period ending January 2022.

Risk Management

PCC/21/225 Risk Report

Sian Gascoigne presented the item and highlighted the following points:

- There are currently eight risks relating to the Committee's responsibilities, the same number of risks as presented in January 2022. Two risks are rated

red/high, RR 160 (risk to staff resilience, exhaustion and burnout) and RR 171 (potential loss of public confidence in primary and secondary health services). Risk RR 171 will be reviewed with the Accountable Officer ahead of the next report to the Committee.

- b) It was proposed that RR 137 (increased risk of Covid-19 infection to clinically vulnerable staff) be archived following a reduction in the risk score to 6.
- c) Risks related to workforce will be reviewed against the mitigations presented as part of the workforce planning update provided at PCC 21 220.

No further points were made in discussion.

The Committee:

- **NOTED** the Risk Report and did not highlight any new risks for inclusion.
- **APPROVED** the recommendation to archive RR 137.

Information Items

- PCC/21/226** **Monthly Contract Update.**
The Committee received this item for information.
- PCC/21/227** **Winter Access Fund – Primary Care Security**
The Committee received this item for information.
- PCC/21/228** **NHS England 2022/23 Priorities and Operational Planning Guidance**
The Committee received this item for information.

Closing Items

- PCC/21/229** **Any other business**
No further business was raised.
- PCC/21/230** **Key messages to escalate to the Governing Body**
The Committee:
- **APPROVED** the boundary extension to The Practice St Albans & Nirmala
 - **APPROVED** the direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCNs (via GP Federations) for a two-year period from 01 April 2022 until 31 March 2024.
 - **RECEIVED** an update on developments related to Primary Care IT and the refresh of the local strategy with a focus on meaningful engagement with PCNs.
 - **RECEIVED** an update on primary care workforce planning. Noting the concerns in respect of nursing in general practice and the importance of alignment of the workforce strategy with the ICS primary care strategy.
- PCC/21/231** **Date of next meeting:**
16/03/2022
MS Teams meeting

Audit and Governance Committee
UNRATIFIED minutes of the meeting held on
13/01/2022, 13:00-14:00
Via MS Teams

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
Christopher Dean	KPMG
Sian Gascoigne	Head of Corporate Assurance
Glynis Onley	Assistant Director, 360 Assurance
Richard Walton	Director, KPMG
Sue Wass	Corporate Governance Officer (minutes)
Kevin Watkins	Client Manager, 360 Assurance

Apologies:

None

Cumulative Record of Members' Attendance (2021/22)					
Name	Possible	Actual	Name	Possible	Actual
Eleri de Gilbert	5	4	Jon Towler	5	5
Sue Sunderland	5	5			

Introductory Items

- AG 21 081 Welcome and apologies**
Sue Sunderland welcomed everyone to the meeting of the Audit and Governance Committee, which was held on MS Teams due to the current Covid-19 situation.
- There were no apologies.
- AG 21 082 Confirmation of quoracy**
The meeting was declared quorate.
- AG 21 083 Declaration of interest for any item on the agenda**
No interests were noted on any item on the agenda.
- Sue Sunderland reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.
- AG 21 084 Management of any real or perceived conflicts of interest**
This item was not required, as no interests were declared.
- AG 21 085 Minutes from the meeting held on 2 November 2021**

The minutes of the meeting held on 2 November were agreed as an accurate record of the discussions held.

- AG 21 086** **Action log and matters arising from meeting held on 2 November 2021**
 Action AG/21/066 was noted as deferred, as it related to the transition, which was now delayed, all other actions were noted as completed.

Information Governance

AG 21 087 **Cyber Security Briefing**

Lucy Branson gave a verbal update and highlighted the following key points:

- a) In December 2021, a software vulnerability was identified that had created considerable concern within the global cybersecurity community.
- b) The vulnerability was found in Log4j - a Java library used to process logs of activity and to log error messages in applications. Log4j is used in web apps, cloud services, and email platforms.
- c) It was embedded into many systems that may have been developed by local and national NHS organisations, as well as systems developed by suppliers and had the potential to allow take-over of a server to provide administrator-level access to networks and systems.
- d) The vulnerability had already been exploited by cyber-attackers internationally, though not yet in the UK.
- e) NHIS was following the national advice from NHS Digital in conjunction with NHS England EPRR Teams and the National Cyber Security Centre to find and patch systems. The programme to address the threat had been named nationally as Operation Sawmill.
- f) Local organisations, including GP practices would need to identify their local information assets and contact their suppliers to ensure where a system or software employs Log4j, that the issue had been addressed by the supplier.
- g) The CCG would use its information asset register to identify with Information Asset Owners, relevant systems maintained by external suppliers which are not managed by NHIS, to seek assurance from those suppliers.

The following points were raised in discussion:

- h) Members queried the potential risk score for the risk. It was noted that the likelihood of an attack was unknown, but systems were at risk until patches had been made. It was likely also that some systems may remain vulnerable to attack due to the difficulty of finding and identifying Log4j.
- i) It was noted that this was a national incident that would be on-going for some time, although the issue was not in the public domain.
- j) The Committee would continue to monitor the risk via the Risk Register.

The Committee:

- **NOTED** the verbal update

ACTION:

- **Lucy Branson to circulate a written briefing.**

Financial Stewardship

AG 21 088 **Transactions Approved Outside Financial Limits**

Michael Cawley presented this item and highlighted the following key points:

- a) Following the initial report at the June meeting; and a request for updated reports to

be brought to the Committee on a quarterly basis, this report covered the period October-December 2021.

- b) During the period 0.89%, or 37, transactions were approved outside of the delegated limits set out in the CCG's Standing Financial Instructions. A further decrease since the last report.
- c) Breaches continued to be primarily the result of financial system limitations.

The following points were raised in discussion:

- d) Members were assured that a focus on reducing the number of transactions approved outside of financial limits had led to a more sustainable position for the CCG. Going forward it was agreed that the Finance Team should consider changing the approval limits of the Director of Procurement and Associate Director of Estates in the ICB's Delegated Financial Limits to mitigate continued breaches caused by their roles. If this was enacted, ongoing assurance by means of sample checks could be introduced and reported to the committee on a less frequent basis.

The Committee:

- **NOTED** the contents of the report.
- **NOTED** the actions taken to minimise the risk of non-compliance with the CCG's Standing Financial Instructions (SFIs).
- **RETROSPECTIVELY APPROVED**, invoice payments and credit notes transacted that are outside an individual officers' Scheme of Delegation.

ACTION:

- **The Finance Team to continue to give thought to changing the approval limits of the Director of Procurement and Associate Director of Estates in the ICB's Delegated Financial Limits to mitigate continued breaches. Subsequently moving to sample checks, but report to the Committee on a less frequent basis**

Internal Audit

AG 21 089

Internal Audit Progress Report

Kevin Watkins presented this item and highlighted the following key points:

- a) Since the last meeting, the stage 2 report for the Head of Internal Audit Opinion, the Continuing Healthcare (CHC); and ICS 2021/22 Operational Planning audits had been issued. The CHC report had given an assurance level of 'significant', and the Stage 2 report had not highlighted any significant concern.
- b) A draft report summarising work completed to date on reviewing the CCG's arrangements for transitioning to the Integrated Care Board had also been circulated to Committee members.
- c) Fieldwork for the review of the Nottinghamshire MASH; and for the Integrity of the General Ledger and Key Financial Systems audit had also been completed.
- d) The terms of reference for the Primary Care Workforce Development review had been agreed and fieldwork had commenced.
- e) 82% of actions had been implemented within the agreed timescales and no actions were outstanding.

The following points were raised in discussion:

- f) Members queried whether the Internal Audit Team was on track to deliver all audits by the end of the financial year. It was noted that the team was confident of completing all audits by March, with the exception of the ICS Transformation and Efficiency Review. As this was a piece of work being undertaken with Derbyshire, it had the potential to slip into 2022/23.

- g) Regarding the operational planning review audit, members queried whether there were any plans to update the five-year strategic plan. It was noted that, given the focus of the past two years had been on the response to the pandemic and on the transition to the ICB, operational issues had taken precedence. Moreover, planning guidance that had been recently issued was noted as being specific only to the coming financial year. It was agreed that this was an issue that the ICB should have as a focus moving forward and Lucy Branson would make enquiries and report to the next Transition and Risk Committee.

The Committee:

- **RECEIVED** the progress report and **NOTED** the key messages and progress being made with the delivery of planned assurances for 2021/22

ACTION:

- **Lucy Branson to report on plans to refresh the five-year strategic plan to the next Transition and Risk Committee**

AG 21 090 Head of Internal Audit Opinion – Stage Two Report

Kevin Watkins presented this item and highlighted the following key points:

- a) The stage two report had been completed and had demonstrated that robust risk management arrangements continued to be in place.

The Committee:

- **NOTED** the Stage Two Head of Internal Audit Opinion report.

Risk Management

AG 21 091 Annual Fraud Risk Assessment

Sian Gascoigne presented this item and highlighted the following key points:

- a) The previous Committee meeting in November had received a report from the CCG's Local Counter Fraud Provider regarding the CCG's approach to meeting the Government Functional 'Standard 013: Counter Fraud Management of counter fraud, bribery and corruption activity'. This report presented the output of the CCG's annual local fraud risk assessment.
- b) A separate fraud risk register was maintained, which contained potential fraud risks, as opposed to 'live' risks. The assessment had outlined a total of 26 potential fraud risks, which had then been cross-referenced against fraud risks previously identified by the CCG to identify any gaps. The gap analysis was then used as a basis for the CCG's annual fraud risk assessment, which was undertaken on the 10 December.
- c) Each risk had been considered to determine if it would present a 'material' risk to the CCG. If so, it was included on the Fraud Risk Register, which also contained the controls and mitigating actions that were in place to address any gaps.

The following points were raised in discussion:

- d) Members noted that a robust process was in place for the management of fraud risks.

The Committee:

- **NOTED** the CCG's fraud risk assessment process; and
- **REVIEWED and COMMENTED** on the output from the annual fraud risk assessment.

AG 21 092 Governing Body Assurance Framework – Q3 Position

Lucy Branson presented this item and highlighted the following key points:

- a) The report presented a detailed and focused review of the strategic risks identified within the CCG's 2021/22 Governing Body Assurance Framework and provided a review of the actions identified to remedy any identified gaps in controls and assurances.
- b) In recognition of 2021/22 being a year of transition (subject to legislation), 11 of the strategic risks were jointly owned by the CCG and the ICS. These 11 strategic risks, which were approved by the ICS Board in July 2021, also formed the basis of the ICS Board Assurance Framework.
- c) An update on the impact of the ICB establishment delay on the Assurance Framework was also contained within the report. The large majority of the 'gaps' identified in the Governing Body Assurance Framework related to the development and embedment of controls and routine assurance reporting for the ICB. As a result of the national deferral, it was unlikely that these actions would be achieved by the originally agreed implementation dates. However there continued to be a robust control environment in place within the CCG. As such, the deferral of actions was unlikely to present the organisation with any increased likelihood of strategic risks materialising.

The following points were raised in discussion:

- d) Members queried whether there were any risks to the CCG continuing to exist into Quarter One. It was noted that work was in train to assess any risks, including the treatment of the Bassetlaw CCG boundary change, and guidance from NHSE/I was awaited. An update would be provided at the next meeting.
- e) Regarding Risk 2, the recovery and transformation of services, members discussed whether a likelihood score of 3 was too low and should be higher given the current difficult operating environment. It was agreed to discuss this with the Chief Commissioning Officer.
- f) Regarding Risk 8, relating to financial governance, members discussed whether a likelihood score of 4 was too high, given the recent clarity on planning arrangements. It was noted that although additional guidance had been received, further work needed to be undertaken and the score would be kept under review.
- g) Action 11.2 relating to the development of Freedom to Speak Up Guardian arrangements was noted as erroneously marked as completed, as the CCG had since been asked to become a pilot site.
- h) Members requested assurance and noted the importance of the development of health inequalities improvement plans being on track to complete during Quarter Four.
- i) Members discussed the need to seek assurance of the upward reporting of risk areas going forward. It was noted that ICB governance was still a work in progress, which would become clearer. This would be subject of an update at the next meeting.

The Committee:

- **SCRUTINISED** and **COMMENTED** on the quarter three position of the Governing Body Assurance Framework: and
- **NOTED** the work in place to remedy any identified gaps in controls and assurances and the impact of the delay of the Integrated Care Board (ICB) establishment on delivery of actions.

AG 21 093 Risk Report

Lucy Branson presented this item and highlighted the following key points:

- a) The report presented the Committee with risks relating to the Committee's responsibilities.

- b) It was proposed to archive RR 018 (staff training compliance), RR 027 (shared drive project) and RR 142 (compliance with Display Screen Equipment (DSE) Regulations 1992). All controls were in place to monitor and report mandatory training compliance for CCG staff; work had now concluded on the transfer of electronic files; and DSE assessments had been completed for all staff.

The Committee:

- **APPROVED** the archiving of risk RR 018 (staff training compliance), RR 027 (shared drive project) and RR 142 (compliance with Display Screen Equipment (DSE) Regulations 1992).

Closing Items

AG 21 094 Any other business

There was no other business.

AG 21 095 Key messages to escalate to the Governing Body

- Assurance that identified gaps in control and assurance regarding the CCG's key strategic risks continued to be monitored and addressed.

AG 21 096 Date of the next meeting:

03/03/2022

Via MS Teams



**UNRATIFIED minutes of the meetings in common of:
NHS Bassetlaw CCG Audit Committee
NHS Nottingham and Nottinghamshire CCG Audit and Governance Committee
held on
13/01/2022, 14:00-15:00
Via MS Teams**

Members present Bassetlaw CCG:

Sue Sunderland Non-Executive Director (Chair)

Members present Nottingham and Nottinghamshire CCG:

Sue Sunderland Non-Executive Director (Chair)
Eleri de Gilbert Non-Executive Director
Jon Towler Non-Executive Director

In attendance Bassetlaw CCG:

Michele Godley Deputy Chief Finance Officer
Cheryl Rollinson Head of Corporate Governance

In attendance Nottingham and Nottinghamshire CCG:

Lucy Branson Associate Director of Governance
Michael Cawley Operational Director of Finance
Andrew Morton Operational Director of Finance
Sue Wass Corporate Governance Officer (minutes)

In attendance:

Christopher Dean KPMG
Glynis Onley Assistant Director, 360 Assurance
Claire Page Client Manager, 360 Assurance
Richard Walton Director, KPMG
Kevin Watkins Client Manager, 360 Assurance

Apologies Bassetlaw CCG:

Sam Senior Non-Executive Director

Apologies Nottingham and Nottinghamshire CCG:

None

Introductory Items

**AG 21 097 / Welcome and apologies
AC22001**

Sue Sunderland welcomed everyone to the meeting in common of the Audit and Governance Committees of Bassetlaw CCG and Nottingham and Nottinghamshire CCG, which was held on MS Teams due to the current Covid-19 situation.

Apologies were noted as above.

**AG 21 098 / Confirmation of quoracy
AC22002**

The meetings were declared quorate for both CCGs.

**AG 21 099 / Declaration of interest for any item on the agenda
AC22003**

No interests were noted on any item on the agenda.

Sue Sunderland reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

**AG 21 100 / Management of any real or perceived conflicts of interest
AC22004**

This item was not required, as no interests were declared.

ICS Transition Arrangements

**AG 21 101 / Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG
AC22005 Close-down**

Lucy Branson presented this item and highlighted the following key points:

- a) The report provided an update on the progress of the CCGs' joint Due Diligence Plan.
- b) The Due Diligence Plan was being delivered jointly by a Task and Finish Group comprising representative of both CCGs and the Group's Terms of Reference had been provided for information.
- c) The Audit Committees' responsibility was for scrutinising the robustness of the process for meeting the requirements of NHSE/I's due diligence checklist as the 'sending' organisations. In addition to ensuring all information concerning the CCGs' staff, assets and liabilities were transferred to the Integrated Care Board, and relevant close down activities, there was an emphasis on the preservation of 'corporate memory'.
- d) The report gave a detailed overview of progress and no significant concerns or risks were reported.
- e) A risk log continued to be maintained. There were a small number of low/medium risks, the most significant being the capacity of operational leads to take forward due diligence requirements; and the alignment of the commissioning policies of the two CCGs.
- f) A revised target date of 1 July 2022 had been agreed for the new statutory arrangements for ICBs to be legally established, subject to the passage of the legislation through Parliament. The national NHSE/I team was currently reviewing the ICB establishment timeline, and an updated version and revised requirements was expected to be published shortly. A further update would be given at the next meeting.

The following points were raised in discussion:

- g) Kevin Watkins noted the role of the Internal Audit function in supporting the due diligence process within the Task and Finish Group, at the ICS Transition and Risk Committee and within the project board establishing the finance ledger. An audit report had recently been circulated providing significant assurance of the robust processes put in place for managing the work.
- h) Members took assurance from this report and the Internal Audit report and thanked all staff involved for their work to date.

The Committees:

- **NOTED** that good progress has been made in delivering the joint Due Diligence Plan to date.
- **NOTED** that work is continuing as scheduled in accordance with the current Due Diligence Plan and that this will only be amended following the national review of the ICB establishment timeline. The revised plan will be presented to the Committees at their meeting in common on 3 March 2022.
- **NOTED** that the CCGs' current Audit Committees will remain in effect until 30 June 2022 (subject to legislation) and will therefore be responsible for overseeing the CCGs' annual accounts and reports process for 2021/22.

External Audit

**AG 21 102 /
AC22006**

External Audit Plans

- **Bassetlaw CCG**
- **Nottingham and Nottinghamshire CCG**

Richard Walton presented this item and highlighted the following key points:

- a) Due to technical issues, it was noted that both reports were in draft.
- b) Both reports were very similar regarding the key risks that had been identified and the planned audit approach.
- c) Focus would be on the following risks: fraudulent expenditure recognition, management override of control, going concern, regularity, primary care commissioning, and IFRS 16 transition.
- d) Both CCGs were showing an increased risk as a going concern, as CCGs would cease to exist during 2022/23. This would require different treatment within the financial statements and audit opinion; however, this was not a significant issue.
- e) IFRS16 was a new risk. Although it was being applied by HM Treasury from 1 April 2022, CCGs were required to start collating reliable data for comparable figures ahead of that date prior to the transfer of services to the new body.
- f) Due to the revised funding arrangements in place for 2021/22, the 2021/22 resource allocation from the H1 and the H2 plan submissions had been utilised as the basis of setting materiality. Nottingham and Nottinghamshire CCG had been increased from to 2% from 1.8% and Bassetlaw CCG remained at 2%.
- g) The key difference in the audit focus for the two CCGs was the treatment of in year expenditure. With regard to Nottingham and Nottinghamshire CCG, due to the underlying deficit, the risk was of management understating expenditure: and regarding Bassetlaw CCG, the risk was of overstating expenditure.
- h) Value for money assessments were currently being undertaken and findings would

be brought to the next meeting.

The following points were raised in discussion:

- i) Members noted a minor error in the Nottingham and Nottinghamshire audit Plan regarding primary care commissioning, which was a new area of focus for the CCG.
- j) Members agreed with the audit approach.

The Committees:

- **NOTED** the reports.

Closing Items

AG 21 103 / Any other business
AC22007

There was no other business.

AG 21 104 / Key messages to escalate to the Governing Bodies
AC22008

- Good assurance received of robust due diligence processes in place for the close down of the CCGs.

AG 21 105 / Date of the next meeting:
AC22009
03/03/2022
Via MS Teams