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

Nottingham and Nottinghamshire Clinical Commissioning Group

# Meeting Agenda (Open Session)

## Governing Body
## Wednesday 02 February 2022 (09:00 – 10:50)
## Virtual meeting via Zoom

| Time | Item | Presenter | Reference |
|---|---|---|---|
| **09:00** | **Introductory Items** | | |
| | 1. Welcome, introductions and apologies | Jon Towler | GB/21/114 – Verbal |
| | 2. Confirmation of quoracy | Jon Towler | GB/21/115 – Verbal |
| | 3. Declarations of interest for any item on the agenda | Jon Towler | GB/21/116 |
| | 4. Management of any real or perceived conflicts of interest | Jon Towler | GB/21/117 |
| | 5. Questions from the public | Jon Towler | GB/21/118 – Verbal |
| | 6. Minutes from the meeting held on 1 December 2021 | Jon Towler | GB/21/119 |
| | 7. Action log from the meeting held on 1 December 2021 | Jon Towler | GB/21/120 |
| **09:10** | **Strategy and Leadership** | | |
| | 8. Accountable Officer Report | Amanda Sullivan | GB/21/121 |
| | 9. Joint Clinical Leaders' Report | Stephen Shortt /James Hopkinson | GB/21/122 – Verbal |
| | 10. Arrangements for ICS Boundary Change and ICB Establishment | Amanda Sullivan / Lucy Branson | GB/21/123 |
| **09:55** | **Commissioning Developments** | | |
| | 11. Primary Care Commissioning Committee Highlight Report – 15 December 2021 and 19 January 2022 | Eleri de Gilbert | GB/21/124 |
| | 12. Patient and Public Engagement Committee Highlight Report – 30 November 2021 and 25 January 2022 | Sue Clague | GB/21/125 |
| **10:10** | **Financial Stewardship and Resources** | | |
| | 13. Finance and Resources Committee Highlight Report – 26 January 2022 | Shaun Beebe | GB/21/126 |
| | 14. 2021/22 Financial Report Month Nine | Stuart Poynor | GB/21/127 |
| **10:25** | **Quality and Performance** | | |
| | 15. Quality and Performance Committee Highlight Report – 27 January 2022 | Eleri de Gilbert | GB/21/128 |

| Time | Item | Presenter | Reference |
|---|---|---|---|
| | 16. Integrated Performance Report | Stuart Poynor | GB/21/129 |
| **10:40** | **Corporate Assurance** | | |
| | 17. Audit and Governance Committee Highlight Report – 13 January 2022 | Sue Sunderland | GB/21/130 |
| | 18. Corporate Risk Report | Lucy Branson | GB/21/131 |
| **10:45** | **Information Items**<br>*The following items are for information and will not be individually presented. Questions will be taken by exception.* | | |
| | 19. Ratified Minutes of CCG committee meetings:<br>a) Patient and Public Engagement Committee –26 October 2021 and 30 November 2021<br>b) Quality and Performance Committee – 25 November 2021<br>c) Finance and Resources Committee – 24 November 2021<br>d) Primary Care Commissioning Committee – 17 November 2021 and 15 December 2021<br>e) Audit and Governance Committee – 2 November 2021 | N/A | GB/21/132 |
| **10:45** | **Closing Items** | | |
| | 22. Any other business | Jon Towler | GB/21/133 – Verbal |
| | 23. Date of the next meeting:<br>06/04/2022<br>To be held virtually | Jon Towler | GB/21/134 – Verbal |

**Confidential Motion:**

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

Register of Declared Interests

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

• This document is extracted, for the purposes of this meeting, from the CCG's full Register of Declared Interests (which is publically available on the CCG's website).
**This document was extracted on 28 January 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 | Non-financial Professional Interests | Non-financial Personal Interests | Indirect Interest | Date From: | Date To: | Action taken to mitigate risk |
|---|---|---|---|---|---|---|---|---|---|---|
| ARORA, Dr Manik | Governing Body GP Representative | Nottingham City GP Alliance 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. |

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| BRANSON, Lucy | Associate Director of Governance | St George's Medical Practice | Registered Patient | | | ✓ | | 01/11/2005 | Present | This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making. |
| CLAGUE, Sue | Non-Executive Director | Victoria and Mapperley Practice | Registered Patient and member of Patient Participation Group | | | ✓ | | 09/01/2016 | Present | This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making. |
| CLAGUE, Sue | Non-Executive Director | University Hospitals of Derby and Burton Hospitals NHS Foundation Trust | Family Member, Non Executive Director | | | | ✓ | 31/10/2015 | 01/09/2021 | Interest expired - no action required |
| DADGE, Lucy | Chief Commissioning Officer | Mid Nottinghamshire and Greater Nottingham Lift Co (public sector) | Director | ✓ | | | | 01/10/2017 | Present | This interest will be kept under review and specific actions determined as required. |
| DADGE, Lucy | Chief Commissioning Officer | Pelham Homes Ltd – Housing provider subsidiary of Nottinghamshire Community Housing Association | Director | ✓ | | | | 01/01/2008 | 30/09/2021 | Interest expired no action 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. |

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| 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. |
| LOVELOCK, Dr Hilary | Governing Body GP Representative | Brierley Park Medical Centre | GP Retainer | ✓ | | | | - | 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 this practice. |
| LOVELOCK, Dr Hilary | Governing Body GP Representative | Primary Integrated Community Services (PICS) Ltd | Shareholder in Primary Integrated Community Services individually <5%. | ✓ | | | | - | Present | To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by PICS. |
| LOVELOCK, Dr Hilary | Governing Body GP Representative | Clinical Research Network | Recruiter to Care-IS, All Heart-You, CANDID research studies, where payment is received per recruited patient | ✓ | | | | - | Present | This interest will be kept under review and specific actions determined as required. |
| OKUBADEJO, Dr Adedeji | Independent Secondary Care Doctor | University Hospitals Birmingham NHS Foundation Trust | Employed as Associate Medical Director and Consultant in Anaesthesia and Pain Management | ✓ | | | | 25/04/2016 | Present | This interest will be kept under review and specific actions determined as required. |
| OKUBADEJO, Dr Adedeji | Independent Secondary Care Doctor | Spire | Independent private clinical anaesthetic practice undertaken in private hospitals in the Birmingham area | ✓ | | | | 17/12/2015 | Present | This interest will be kept under review and specific actions determined as required. |
| OKUBADEJO, Dr Adedeji | Independent Secondary Care Doctor | 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. |

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| 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 | 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 |

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|---|---|---|---|---|---|---|---|---|---|---|
| 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. |
| 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 |

NHS
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## Managing Conflicts of Interest at Meetings

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

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

3. Conflicts of interest include:

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

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

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

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

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

NHS
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**Governing Body (Open Session)**
**UNRATIFIED minutes of the meeting held on**
01/12/2021, 11.30-12.30
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 |
| 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 |
| Sue Wass | Corporate Governance Officer (minutes) |
| Alex Ball | Director of Communication and Engagement |

**Apologies:**

| | |
|---|---|
| Dr Hilary Lovelock | GP Representative, Mid-Nottinghamshire |

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

** Dr Richard Stratton left 24/09/2021*

## Introductory Items

**GB 21 093 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 21 094** **Confirmation of Quoracy**
The meeting was declared quorate.

**GB 21 095** **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 21 096** **Management of any real or perceived conflicts of interest**
No management action was required.

**GB 21 097** **Questions from the Public**
There were no questions.

**GB 21 098** **Minutes from the meeting held on 06 October 2021**
The minutes were agreed as an accurate record of the discussions held.

**GB 21 099** **Action log from the meeting held on 06 October 2021**
Action GB 21 083 was noted as not yet due.

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

## Strategy and Leadership

**GB 21 100** **Accountable Officer Report**
Amanda Sullivan presented the item and highlighted the following key points:

a) Covid infection rates continued to be monitored closely, with continuing high rates of transmission and hospital admissions. There was a close correlation between vaccination status and the severity of the illness. The pressures on all aspects of the health system remained immense and actions to increase capacity within the system were being undertaken, including asking citizens to use health services wisely.
b) To date 82% of over 18's in the CCG's area had received two doses of the Covid vaccine. The Vaccination Programme continued to roll out phase three of the programme with the administration of booster vaccines. Planning was now underway to upscale the programme following the emergence of the Omicron variant.
c) Flu vaccinations continue to be rolled out at GP surgeries and pharmacies as part of the winter planning process. The winter planning process had been brought forward, understanding the additional stress put on the system due to the continuing response to the pandemic and concern regarding staff wellbeing.
d) The Governing Body was asked to approve the establishment of a Mental Health and Learning Disability Specialist Treatment/Funding Panel to process requests for treatment that could not be met by locally commissioned services. This would ensure a more consistent approach and more robust decision making and would operate in a similar way to the established Individual Funding Requests process.
e) The Governing Body was asked to ratify the approval of the H2 (October-April) Operational Plan, which had required submission to NHS England/Improvement by 16 November 2021. The approval had been made under the urgent decision powers delegated by the Governing Body under Standing Order 4.10.
f) Amanda was pleased to announce that she had been successful in securing the post of Chief Executive Designate of the Nottingham and Nottinghamshire Integrated Care Board (ICB).
g) The Integrated Care System Board had held its last formal meeting on 4 November, pending the establishment of the Integrated Care Board, subject to Royal Assent. Partner meetings would continue to undertake any business required between now

and the end of March.

h) Subject to legislation, the Government had announced that Health Education England would merge with NHS England and NHS Improvement. NHS Digital and NHSX would also be incorporated into NHS England and NHS Improvement, which would add new areas to the Integrated Care Board's portfolio.

The following points were raised in discussion:

i) Members queried whether a separate process was required for mental health and learning disability specialist treatment. It was noted that legal advice had been taken on the matter; and although the expertise of members of the Individual Funding Panel would be used, the applications needed to remain distinct.

j) Members requested an update on progress in the development of Primary Care Networks in the CCG's area and it was agreed to provide an update at the Governing Body's January Development Session.

The Governing Body:

- **RECEIVED** the Accountable Officer's Report for information.
- **APPROVED** the establishment of a Mental Health and Learning Disability Specialist Treatment/Funding Panel.
- **RATIFIED** the ICS 2021/22 H2 NHS Plan for NHS Nottingham and Nottinghamshire CCG, as approved via emergency decision making powers.

**ACTION:**

- **Dr Shortt to lead on an update on Primary Care Network development at the January Development Session.**

**GB 21 101 Joint Clinical Leaders' Report**

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

a) There continued to be significant pressure on GP practices in the continuing drive for recovery of services, increasing the number of face-to-face appointments and responding to the vaccination programmes. The Primary Care Networks had responded well to the roll out of the Covid vaccination programme.

The Governing Body:

- **NOTED** the verbal update.

## Commissioning Developments

**GB 21 102 Primary Care Commissioning Committee Highlight Report – 20 October 2021 and 17 November 2021**

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

a) The Committee had received a report on the utilisation of funds to improve access for patients.

b) A quality report using data from Care Quality Commission inspections demonstrated that despite the significant pressure on GP services, practices were maintaining the quality of their services.

c) The Committee had discussed the results of the annual national patient survey. Although the response rate in the CCG's area was only 36%, GP practices in the CCG's area scored higher than the national average for 'overall experience'. Identified areas for improvement, such as telephony and booking services would be a focus going forward.

The following points were raised in discussion:

d) Members queried whether, due to the pressures, GPs were disengaging from

Primary Care Networks. It was noted that there was a desire to make progress and there had been excellent engagement with the Winter Access Fund process.

e) Members noted that anecdotally, due to the increase in roles within Primary Care Networks, estate was becoming a challenge. It was noted that funding had been secured from NHS England/Improvement to progress a primary care estates strategy and that Primary Care Network engagement would be key to its scoping and development.

The Governing Body:

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

**GB 21 103 Patient and Public Engagement Committee (PPEC) Highlight Report – 26 October 2021**

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

a) Members had welcomed a proposed framework and the development of a co-production strategy for working with communities as part of the transition to the Integrated Care Board. There was strong support for a stronger role for Patient Participation Groups.
b) A presentation on the Community Transformation Programme had provided members with details of the stakeholder engagement undertaken to date and members requested further detail regarding plans for citizen engagement to be undertaken in the New Year.
c) Updates on NHS digital applications, the interpretation and translation service, and plans for elective recovery were welcomed. Members highlighted the need for a single gateway to NHS digital applications to improve accessibility.

The Governing Body:

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

## Financial Stewardship and Resources

**GB 21 104 Finance and Resources Committee Highlight Report – 27 October 2021 and 24 November 2021**

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

a) The Committee had continued to oversee the finalising of the H1 (April-September) financial position and had endorsed the CCG element of the system financial plan for H2 (October-March).
b) An additional Committee meeting had been requested in December to provide assurance on transition arrangements.

The following points were raised in discussion:

c) Members queried whether the Committee continued to oversee organisational development. It was noted that the Committee would continue to oversee organisational development for the CCG for the remainder of the financial year and an update report would be received in January 2022. The ICS Transition and Risk Committee had responsibility for ensuring organisational development requirements were embedded into the governance process of the Integrated Care Board.

The Governing Body:

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

**GB 21 105 2021/22 Financial Report Month Seven**

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

a) The CCG had commenced the year under a temporary financial regime due to the

continuing pandemic, which had split the financial year into two separate reporting periods. The financial year was now being considered as a whole, which required the recovery of the of H1 financial position.

b) The temporary financial regime had impacted on the CCG's underlying financial position and negotiations with regulators had resulted in the receipt of additional transition funds which allowed for a forecast breakeven position. However, there remained risk to this forecast position, notably the delivery of the Elective Recovery Fund.

The Governing Body:

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

## Quality and Performance

**GB 21 106** **Quality and Performance Committee Highlight Report – 28 October 2021 and 25 November 2021**

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

a) The Committee had scrutinised a deep dive report on Nottinghamshire Healthcare NHS Foundation Trust. Although there had been significant improvements and an open and transparent relationship had been established, the Committee had agreed to maintain the risk score pending further new concerns and the need to ensure the sustainability of the improvements made.

b) The Committee had maintained focus on Nottingham University Hospitals NHS Trust's maternity services and wider performance issues. There were signs of improvement, but not at the expected pace that was required, and an Improvement Plan had not yet been finalised. There was significant concern regarding workforce pressures at the Trust from winter pressures in addition to the scale of change required to improve quality and performance.

c) The initial findings of the external review of quality assurance had been shared with the Committee, which confirmed that overall, quality assurance processes were now robust, with confirmation that the Committee was working effectively. The findings of the review would be incorporated into the design of new system quality assurance processes.

The Governing Body:

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

**GB 21 107** **Quality Report**

Rosa Waddingham presented the item and highlighted the following key points:

a) The report brought together the key quality and safety metrics for NHS commissioned services in Nottingham and Nottinghamshire.

b) Significant system pressures were resulting in quality and safety concerns across a range of services and several providers were on 'enhanced surveillance'. All had recovery action plans in place and the CCG had oversight arrangements in place to monitor progress.

c) The CCG continued to work with local authorities to support care home providers to address quality and workforce challenges, including outbreak management.

d) There had been a significant backlog in the Serious Incident reporting process across all providers and a thematic review was underway, which would be incorporated into a system wide patient safety approach within the new organisation.

e) Regarding local maternity services, focus remained on ensuring oversight of the implementation of recommendations from the Ockenden Report.

f) Work to improve adult learning disability and autism inpatient performance continued.

g) NHS England and NHS Improvement had recently set a national priority in response to the Norfolk Safeguarding Adults Review. All children and young people and adults

with a learning disability and autism who were currently in an inpatient setting must undergo a thorough review of their care and support needs by the end of January 2022. All reviews for patients under the CCG's responsibility had been booked.

The Governing Body:

- **NOTED** the Quality Report.

**GB 21 108 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) All providers were highlighting staffing concerns as the pressure of the continued response to the pandemic impacted on the recovery of services.
c) The number of cancer patients waiting more than 62 days for initial treatment had increased and the backlog position remained challenging.
d) Trajectories for the H2 planning period (October-March) had now been incorporated into the report.

The Governing Body:

- **NOTED** the Integrated Performance Report.

## Corporate Assurance

**GB 21 109 Audit and Governance Committee Highlight Report – 2 November 2021**

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 progression of arrangements to comply with the Emergency Preparedness, Resilience and Response (EPRR) core standards; and actions to ensure the safe transfer of staff and property to the new organisation, which was being undertaken as part of a comprehensive CCG closedown and Integrated Care Board establishment due diligence process.
b) The Committee had endorsed the CCG's Information Governance Management Framework and recommended that the Governing Body approved the document.

The Governing Body:

- **NOTED** the Audit and Governance Committee Highlight Report.
- **APPROVED** Information Governance Management Framework.

**GB 21 110 Corporate Risk Report**

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

a) The CCG currently had eleven 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) The risks had relevance to many of the discussions held at this meeting, covering clinical systems, quality issues and the ongoing impact of the pandemic on services.
c) Following the last meeting in October, two risks had been added as a result of discussions: risk RR 171, relating to a potential risk of loss of public confidence in local primary and secondary care health services; and risk RR 172, relating to a potential risk that H2 funding may not be sufficient to address recovery or meet the level of demand for the CCG's population.

The following points were raised in discussion:

d) Members discussed the potential for the new Omicron variant to have a significant impact on workforce pressures. It was agreed that a review of all workforce related risks on the CCG's Corporate Risk Register would be undertaken and reported to the CCG Executive.

The Governing Body:

- **NOTED** the Corporate Risk Register.

**ACTION:**

- **Lucy Branson to lead on a review of all workforce related risks on the CCG's corporate risk register and bring a report to the CCG Executive.**

## For Information

**GB 21 111** **Ratified minutes of Governing Body committee meetings**
The minutes were **NOTED**.

## Closing Items

**GB 21 112** **Any other business**
There was no other business.

**GB 21 113** **Date of the next meeting:**
02 February 2022 to be held virtually.

Nottingham and Nottinghamshire Clinical Commissioning Group

**Governing Body**
**ACTION LOG for the meeting held on 01/12/2021**

| Meeting date | Agenda reference | Agenda item | Action | Lead | Date to be completed | Comment |
|---|---|---|---|---|---|---|
| **ACTIONS OUTSTANDING** | | | | | | |
| - | - | - | *No actions outstanding* | - | - | - |
| **ACTIONS ONGOING / NOT YET DUE** | | | | | | |
| - | - | - | *No actions ongoing* | - | - | - |
| **ACTIONS COMPLETE** | | | | | | |
| 06/10/2021 | GB 21 083 | 2021/22 Financial Report Month Five | To discuss the development of the System Analytics and Intelligence Unit at a future Governing Body Development Session. | Stuart Poynor | - | Added to the plan for shadow ICB operating arrangements during Q1, 2022/23. |
| 01/12/2021 | GB 21 100 | AO report | To lead on an update on Primary Care Network development at the January Development Session. | Dr Shortt | - | Added to the forward plan for the Primary Care Commissioning Committee during Q4, 2021/22. |
| 01/12/2021 | GB 21 110 | Risk Report | To lead on a review of all workforce related risks on the CCG's corporate risk register and bring a report to the CCG Executive. | Lucy Branson | - | Included in the Risk Report at item GB/21/131 |

Nottingham and Nottinghamshire Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Accountable Officer's Report | **Paper Reference:** | **GB 21 121** |
| **Sponsor:** | Amanda Sullivan, Accountable Officer | **Attachments/ Appendices:** | A: CCG Policies to have review dates extended to 31 March 2023 |
| **Presenter:** | Amanda Sullivan, Accountable Officer | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☒ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• 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 | ☒ | Establishment of a Strategic Commissioner | ☒ |
| Financial Management | ☐ | Wider system architecture development (e.g. ICP, PCN development) | ☒ |
| Performance Management | ☒ | Cultural and/or Organisational Development | ☐ |
| Strategic Planning | ☒ | Procurement and/or Contract Management | ☐ |

| **Conflicts of Interest:** |
|---|
| ☒ No conflict identified |

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

| **Risk(s):** |
|---|
| No risks are identified within this report. |

| **Confidentiality:** |
|---|
| ☒No |

| **Recommendation(s):** |
| --- |
| The Governing Body is requested to:<br>**1. RECEIVE** the Accountable Officer's Report for information.<br>**2. APPROVE** 12-month extensions to the review dates for the CCG's policies outlined within Appendix A. |

# Accountable Officer's Report

## COVID-19 Update

### 1. Local Prevalence and Response

As of 26 January, 415 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. Using the latest figures available, November saw 581,070 GP appointments taking place, with 62% being face-to-face and 47% being the same day or 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 2,039,171 vaccinations (first, second, third and boosters) have been administered since the start of the programme. This means that 84.1% per cent of over 18s have now received two doses and 64.4% of over 18s have had a booster dose.

To protect as many people as possible from the Omicron strain, three additional walk-in facilities were opened in Nottingham and Newark offering booster vaccinations. These temporary sites have now closed; however, a range of dedicated sites, GP surgeries and pharmacies throughout the county continue to offer both booked appointments and walk-in facilities for first, second and booster vaccinations.

The programme will continue to focus on working in areas of lower take up to boost vaccination rates.

## CCG Updates and Developments

### 3. Emergency Governance Arrangements

On 13 December 2021, NHS England and NHS Improvement declared a move back to a Level 4 National Incident in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in Covid-19 cases (both Delta and Omicron variants). A letter dated 24 December followed, in which NHS England and NHS Improvement set out several actions designed to reduce the burden of reporting and to release capacity to manage the Covid-19 pandemic. This included requirements relating to governance and meetings.

On 5 January 2022, the Governing Body approved emergency governance arrangements in line with national guidance; namely to continue to hold all meetings virtually unless there is a

specific business reason to meet face-to-face. All CCG Governing Body and other Committee meetings will continue to be held, but with focussed agendas and streamlined papers. The arrangements are being kept under review and any further proposals for revised arrangements will be brought to the Governing Body for consideration and approval. This will include agreement of exit arrangements and a return to 'business as usual' governance.

**4. National 2022/23 Priorities and Operational Planning Guidance**

On 24 December 2021, NHS England and NHS Improvement published their national 2022/23 Priorities and Operational Planning Guidance.

The planning guidance sets out a revised target date of 1 July 2022 for new statutory arrangements to take effect and Integrated Care Boards (ICB) to be legally and operationally established, subject to the passage of the Health and Care Bill through Parliament. It also confirmed that the Integrated Care System (ICS) boundary changes agreed by the Secretary of State for Health and Social Care will come into effect from 1 April 2022 to support the smooth transition from CCGs to ICBs at the implementation date. This is discussed in more detailed in a separate paper on the agenda for today's meeting.

The planning guidance sets out ten ambitious national priorities for 2022/23, which continue to focus on preventing ill-health and tackling health inequalities and build on the priorities introduced in 2021/22. The ten priorities for 2022/23 are:

a) Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

b) Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

c) Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

d) Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

e) Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

f) Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

g) Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways

and measure outcomes with a focus on improving access and health equity for underserved communities.

h) Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

i) Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

j) Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

ICS footprints will represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams will lead the planning process, working with partners across the ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. Draft plans will be submitted on 17 March and the deadline for final plans is 28 April 2022.

## 5. CCG Corporate Policies

The CCG's policies are an integral part of the organisation's system of internal control as they help to ensure compliance with relevant legislation and national guidance; as well as conveying other organisational standards, responsibilities, and expectations.

There are a number of CCG policies that have scheduled review dates of 31 March 2022 or during the months following this in 2022/23. All CCG policies are currently being reviewed as part of developing a suite of policies that will be required for the new Integrated Care Board (subject to legislation). However, given the revised ICB establishment timeline, approval is being sought from the Governing Body to extend the review dates (until March 2023) for the policies listed at **Appendix A**. There are no key changes required for these policies, as they stand, prior to being developed into ICB policies. This will be kept under review with policy authors.

## 6. CCG Governing Body Member to Step Down

Dr Hilary Lovelock, who has been a member of the CCG's Governing Body since April 2020 as GP Representative for Mid Nottinghamshire, is stepping down from her role at the end of March 2022. Hilary has supported the CCGs since their inception in 2011, when she joined NHS Mansfield and Ashfield CCG's Governing Body. I would like to extend my best wishes to Hilary for the future and thank her for her valuable input and insight, not only as a member of the Governing Body and the Prioritisation and Investment and Quality and Performance Committees, but also for her work to develop integrated care teams, primary care networks, and lately her work in the vaccination programme.

## Partner Updates

### 7. Appointment of new Chair at Nottingham University Hospitals Trust

Nick Carver has been appointed as the new Chair of Nottingham University Hospitals NHS Trust and will join the Trust on 1 February 2022. Nick has worked in the NHS for 42 years and has held several senior roles in the NHS in the East of England, West Midlands, West Country, and South Wales. He joined East and North Hertfordshire NHS Trust as Chief Executive in November 2002, retiring in December 2021 having held the role for 19 years. Nick will now lead the process to recruit a new, substantive Chief Executive for the Trust.

### 8. Integrated Care System (ICS) Board Update

When the Nottingham and Nottinghamshire Integrated Care System (ICS) Board last met in November, the Board agreed that it would be its last meeting, as transition plans to new statutory arrangements would see shadow Integrated Care Board (ICB) arrangements start in January 2022, ahead of formal establishment in April 2022.

However, in light of the revised target date for the new statutory arrangements, it has been agreed that ICS Board meetings will be reinstated. This will provide a framework for the ongoing oversight of the ICS Transition Plan and will also facilitate ongoing engagement with key stakeholders across the system and transparency for citizens. To this end, further formal meetings will take place in March and May 2022.

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

### 9. Health and Wellbeing Board Updates

Nottinghamshire County Health and Wellbeing Board

The Nottinghamshire County Health and Wellbeing Board last met on 24 November. The meeting received reports on the Better Care Fund Plan 2021-22, suicide prevention in Nottinghamshire, improving outcomes for survivors of domestic abuse and the local transformation plan for children and young people's emotional and mental health.

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 last met on 26 January. The meeting received a report on suicide prevention in the City; the Nottingham City Safeguarding Adults Annual Report; and updates on the development of the Health and Wellbeing Strategy; and the development of place-based partnerships.

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.

## Recommendation(s)

The Governing Body is requested to:

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

**Appendix A: CCG Policies to have review dates extended to 31 March 2023**

| Policy Title |
|---|
| GOV 001 Risk Management |
| GOV 002 Conflicts of Interest |
| GOV 003 Gifts, Hospitality and Sponsorship |
| GOV 004 Raising Concerns (Whistleblowing) |
| IG 002 Confidentiality and Data Protection |
| IG 004 Internet and Email |
| QUAL 001 Safeguarding (incl. Prevent) |
| QUAL 002 Safeguarding (Managing Allegations) |
| QUAL 003 Mental Capacity Act |
| COM 001 Service Benefit Review |
| COM 004 Service Restrictions |
| HR 002 Capability |
| HR 005 Family Leave |
| HR 007 Leave |
| HR 008 Staff Appraisal |
| HR 009 Acceptable Behaviours |
| HR 011 Flexible Working |
| HR 013 Agency Workers |
| HR 015 Employment Breaks |

Nottingham and Nottinghamshire Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (open session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Arrangements for ICS Boundary Change and ICB Establishment | **Paper Reference:** | **GB 21 123** |
| **Sponsor:**<br>**Presenter:** | Amanda Sullivan, Accountable Officer<br>Amanda Sullivan, Accountable Officer / Lucy Branson, Associate Director of Governance | **Attachments/ Appendices:** | **A:** High-Level Transition Timeline and Shadow Operating Arrangements |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approve | ☒ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

| **Executive Summary** |
|---|
| To allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. However, it has been confirmed that the ICS boundary changes decided by the Secretary of State for Health and Social Care will still come into effect from 1 April 2022 to support the smooth transition from CCGs to ICBs at the implementation date.<br>This paper sets out local arrangements being put in place to ensure the CCG remains legally constituted and able to operate effectively during the extended preparatory period, working in partnership with NHS Bassetlaw CCG colleagues and designate ICB leaders. It also sets out high-level arrangements for shadow ICB operation. |

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

| **Conflicts of Interest:** |
|---|
| ☒ No conflict identified |

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

| **Risk(s):** |
|---|
| None stated |

| **Confidentiality:** |
| --- |
| ☒No |
| **Recommendation(s):** |
| **1.** To **NOTE** the contents of the report. |
| **2.** To **APPROVE** the proposed amendment to the Finance and Resources Committee's Terms of Reference. |

# Arrangements for ICS Boundary Change and ICB Establishment

## Introduction

1. The Health and Care Bill, which intends to put Integrated Care Systems (ICSs) on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies, is currently being considered by Parliament. To allow sufficient time for the remaining parliamentary stages, a revised target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previously stated target date of 1 April 2022.
2. This new target date will provide some extra flexibility in preparing for the new statutory arrangements and in managing the immediate priorities of the pandemic response; however, it is also recognised as important for momentum to be maintained towards the new arrangements. As such, designate ICB leaders have been asked to continue to prepare for the formal establishment of ICBs in line with the guidance previously set out but working to the revised target date.
3. During the extended preparatory period from 1 April 2022 to the point of commencement of the new statutory arrangements, CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business through existing Governing Body and committee arrangements. However, CCG leaders will be required to work closely with designate ICB leaders in key decisions that will affect the future ICB.
4. It has been confirmed that the ICS boundary changes decided by the Secretary of State for Health and Social Care will come into effect from 1 April 2022 to support the smooth transition from CCGs to ICBs at the implementation date.
5. The accounting period for 2022/23 will remain as a 12-month period (a 3-month period for CCGs and a 9-month period for ICBs) and the audit process will be confirmed in due course.
6. The CCG employment commitment arrangements will be extended to reflect the new target date.

## Nottingham and Nottinghamshire ICS Boundary Change

7. The area of Bassetlaw will move from the South Yorkshire and Bassetlaw ICS into the Nottingham and Nottinghamshire ICS on 1 April 2022.
8. The ICS boundary change does not affect NHS Bassetlaw CCG or NHS Nottingham and Nottinghamshire CCG as statutory organisations; however, NHS Bassetlaw CCG will transfer from NHS England's North East and Yorkshire Region to the Midlands Region from this date.
9. During the extended period of operation, the two CCGs will continue to work collaboratively, with increasing operational alignment and formal meetings being held 'in common' between the two CCGs, as appropriate. As a minimum, this will see the two Audit Committees meeting in common throughout the extended period.

**Transition to ICB Establishment**

10. In light of the revised target date for the new statutory arrangements, an exercise has been completed to ensure the CCG remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership. The outcome of this exercise is summarised below, and we are working with Bassetlaw CCG colleagues to enable a consistent approach to be adopted (where relevant):

    a) The Governing Body will have two vacant GP Representative roles from 1 April 2022; however, all other members have confirmed they will continue in post for the extended period, which enables Governing Body quoracy requirements to be met.

    b) An assessment of the GP Representative vacancies on committee quoracy has been completed, and discussions are being held with the CCG's Joint Clinical Leaders to realign the three remaining Governing Body GPs across the committees to provide equitable support.

    c) Additional Governing Body and committee meeting dates are being scheduled, with the final meeting of the Governing Body being held in June 2022 and final meetings of most committees being held in May 2022.

    d) The Audit and Governance Committee is the exception to the above detailed arrangement, as a June meeting date will be required for approval of the Annual Report and Accounts. It should also be noted that an additional meeting of the committee will be needed in May in line with the requirements of the revised Due Diligence timeline.

    e) Minutes from all final meetings will be ratified virtually.

    f) It is proposed that no further CCG development sessions be held.

    g) Should any decisions be required following the final scheduled meetings, then urgent decision-making processes will be utilised. To this end, and in line with its responsibilities for making decisions on procurement approaches and contract awards for non-healthcare contracts, it is proposed that the Finance and Resources Committee's terms of reference be amended to include the following:

    > *On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.*
    >
    > *Where an urgent decision is required a supporting paper will be circulated to Committee members by the secretary to the Committee.*
    >
    > *The Committee members may meet either in person, via telephone conference or communicate by email to take an urgent decision. The quorum, as described in section 6, must be adhered to for urgent decisions.*
    >
    > *A minute of the discussion (including those performed virtually) and decision will be taken by the secretary to the Committee and will be reported to the next meeting of the Committee for formal ratification.*

*ICB Shadow Operation*

11. Work is well underway to define ICB shadow operating arrangements, with a view to these operating incrementally during Q1 of 2022/23 in line with the appointment timeline for the designate ICB Board members and the finalisation of ICB governance arrangements.

12. ICB shadow operating arrangements will incorporate requirements to ensure a safe and effective handover of CCG functions and duties and the preservation of corporate memory. This will include the involvement of ICB designate leaders in key decisions that will affect the future ICB, notably commissioning and contracting, and designate ICB Non-Executive Directors being invited to attend CCG committee meetings.

13. In light of the revised target date for the new statutory arrangements, ICS Partnership Board meetings are being reinstated to provide a framework for oversight of the ICS Transition Plan and 2022/23 Operational Planning requirements; also, to facilitate ongoing engagement with key stakeholders across the system and transparency for our citizens.

14. A high-level plan to support the transition from the existing to new statutory arrangements, including a period of shadow operation is provided at **Appendix A**.

**Recommendations**

15. The Governing Body is asked to:

    a) **NOTE** the contents of the report.

    b) **APPROVE** the proposed amendment to the Finance and Resources Committee's Terms of Reference.

**Lucy Branson**
**Associate Director of Governance**

## Appendix A: High-Level Transition Timeline and Shadow Operating Arrangements

| | CCG Closedown | | | | ICB Establishment | |
|---|---|---|---|---|---|---|
| | | *ICB Shadow Operation* | | | | |
| **CCG Governance** | **Mar 2022** | **Apr 2022** | **May 2022** | **Jun 2022** | **July 2022** | **Aug 2022** |
| Governing Body [1, 2] | | | | | | |
| Prioritisation and Investment Committee [1, 2] | | | | | | |
| Quality and Performance Committee [1] | | | | | | |
| Finance and Resource Committee [1, 2] | | | | | | |
| Primary Care Commissioning Committee [1, 2] | | | | | | |
| Audit and Governance Committee [1, 3] | | | | | | |
| Remuneration and Terms of Service Committee [4] | | | | | | |
| **ICS Governance** | | | | | | |
| ICS Partnership Board | | | | | | |
| ICS Transition and Risk Committee | | | | | | |
| **ICB Board Appointments** *(indicative)* | | | | | | |
| Non-Executive Directors | ✓ | | | | | |
| Executive Directors | ✓ | | | | | |
| Partner Members | | ✓ | | | | |
| **ICB Governance** | | | | | | |
| ICB Board | | D | D | D | | |
| Remuneration Committee | | | | D | | |
| Audit and Risk Committee | | | D | | | |
| Quality, People and Inequalities Committee | | | D | | | |
| Finance, Performance and Digital Committee | | | D | | | |
| Strategic Commissioning Committee | | | D | | | |
| Place-based Committees (Nottm City, South-Notts, Mid-Notts and Bassetlaw) | | | D | | | |
| Executive Leadership Group | | | | | | |
| Clinical and Care Professional Leadership Group | | | | | | |
| **Integrated Care Partnership** | | | | | | |
| Integrated Care Partnership *(to be confirmed)* | | | | | | |

[1] Minutes of the last meeting to be ratified virtually.

[2] Urgent decision-making processes to be utilised if decisions are needed after the last scheduled meeting.

[3] Audit and Governance Committee meeting needed in June to sign off the CCG's Annual Report and Accounts 2021/22.

[4] Meeting to be scheduled if needed.

| | |
|---|---|
| | CCG/ ICS Final Meetings (including handover arrangements). Meetings will include designate ICB leaders, in particular in key decisions that will affect the future ICB. |
| D | Development Sessions/ induction activities |
| | ICB/ ICP Shadow Meetings |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Highlight report from the (virtual) meeting of the CCG's Primary Care Commissioning Committee | **Paper Reference:** | **GB 21 124** |
| **Chair of the meeting:** | Eleri de Gilbert – Non Executive Director | **Attachments/ Appendices:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Summary of the Meetings**

The Primary Care Commissioning Committee (PCCC) met on the 15 December 2021 and 19 January 2022. Due to the current Coronavirus (Covid-19) situation, the meetings were held virtually.

At the December meeting, the Committee:

- **RECEIVED** routine reports in relation to; Primary Care Contracting, finance and OPEL reporting.
- **RECEIVED** the risk report which included two new risks, RR 169 and RR 171. RR 169 reflects the potential risk that Primary Care Networks (PCNs), PCN Clinical Directors and/or GP Member Practices may become disengaged due to the increasing expectations of PCNs. RR 171 articulates the risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports related to access and waiting times.

At the January meeting, the Committee:

- **CONSIDERED** essential business only due to the implementation of emergency governance arrangements.
- **RECEIVED** reports for information only related to; contract performance and the utilisation of the winter access fund.
- **RECEIVED** the monthly OPEL report. 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. Practices had been asked to begin recording additional staff absence information as part of OPEL reporting, from 29 December 2021 to 07 January 2022 in order to show the impact on staffing due to the Omicron variant of the COVID-19 virus.
- **RECEIVED** the risk report. There were eight risks for the attention of the Committee, the same as reported in December 2021. No new risks were identified in January 2022 for the public risk register.

**Key messages for the Governing Body**

The Committee:

- **RECEIVED** an update on the Springfield Medical Centre merger in December 2021. This item was subject to four questions from members of the public related to concerns about the merger being with an Operose practice. The Chair reiterated that Dr and Mrs Mohindra, under their GMS contract, are able to go into partnership with the practice St Albans/Nirmala to secure the continuation of primary medical services for their practice population and allowing them to retire. Under the GMS regulations this does not require approval by the CCG or a procurement process. It was confirmed that the decision to merge was not under review. Indeed the PCCC has supported the merger. The focus of discussion on this occasion was on engagement and the cascade of information to patients and stakeholders. The Committee were **ASSURED** that the engagement undertaken and planned was thorough.
- **RECEIVED** an update on the winter access fund following NHSE/I approval of CCGs plans. Implementation of plans will be monitored through to the end of March 2022.
- **RECEIVED** an update on the temporary GP contract changes to support COVID-19 Vaccination Programme. Letters issued by NHSE/I confirming service arrangements were shared with Members.
- **RECEIVED** the outcome of the Primary Care Network NHSE/I Maturity Matrix review. The outcome demonstrated good progress in PCN development.
- In January 2022, **SUPPORTED** a direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCN's (via GP Federations) for a two year period from 01 April 2022 to 31 March 2024. Discussion with the Commissioning team would follow ahead of finalising the preferred option.

**The ratified minutes of the January 2022 meeting will be received by the Governing Body in April 2022.**

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Nottingham and Nottinghamshire Patient and Public Engagement Committee | **Date:** | 02 February 2022 |
| **Paper Title:** | Highlight report from meetings held on 30 November 2021 and 25 January 2022. | **Paper Reference:** | **GB 21 125** |
| **Chair of the meeting:** | Sue Clague | **Attachments/ Appendices:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• 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 30 November 2021 and 25 January 2022. PPEC members have valued the attendance of Alex Ball and Lucy Dadge representing the Executive Team at those meetings.

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

- Outcomes of engagement undertaken to develop a new service for children and young people to be known as the Holistic Healthy Lifestyle Service (a service for children and young people who are significantly above a healthy weight without having other health issues)
- Framework for ICS transition for involving people and communities with a focus on governance structures
- Primary Care IT Strategy
- Equality, diversity and inclusion training to be delivered through Let's Talk Events
- Update on other key areas of work including:
    - Covid vaccination programme
    - Plans for engagement to inform development of Interpretation & Translation Services
    - Elective recovery plans relating to backlog and waiting list recovery
    - ICS Establishment delay
    - Nottingham & Nottinghamshire Compact
    - Voluntary Sector Alliance PPE Contract Highlight reports
    - Platform One Practice transition of patients

**Key Messages for the Governing Body**

The key messages that PPEC members agreed to share with the Governing Body from its meeting held on 30 November 2021 and 25 January 2022 are:

1. 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 to be known as the Holistic Healthy Lifestyle Service. The thoroughness of the engagement and report was commended. PPEC members were particularly pleased that the engagement had been undertaken

at a stage that it could be used to inform the service specification. In addition, it would be aligned to the development of a new service for adults and that this would support transition arrangements between children and young people and adult services. PPEC members will review this programme of work using the PPEC effectiveness framework to identify any good practice or learning.

2. With regard to the ICS Transition, Working with people and communities, PPEC members received an update following discussion of this at the last ICS Board meeting. PPEC members' discussion focused on citizen engagement at a place and neighbourhood level. There was some concern about the maturity of place and neighbourhood infrastructure to deliver effective citizen engagement. There was strong support for PPG involvement but recognition that not all areas have strong PPGs and that inclusive citizen (not just patient) engagement is necessary to ensure diverse populations have a voice.

3. An update was provided regarding Interpretation & Translation Service in relation to the planned engagement and PPEC members noted a thorough process was planned.

4. 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. However, it was noted that increasing pressures continue across the system in particular challenges regarding flow out of hospital that impacts on the ability to offer elective care to patients.

5. 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.

6. Highlight reports detailing engagement undertaken by the Voluntary Sector Alliance through the CCG commissioning service during quarter 3 were noted by PPEC members.

7. PPEC members made suggestions for areas of health inequalities to include in the programme of Let's Talk Events. Suggestions included mental health, knife crime, Covid recovery, young people and families, young people with care experience and young adults impacted by trauma.

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

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Finance and Resources Committee Highlight report – 23 December 2021 and 26 January 2022. | **Paper Reference:** | **GB 21 126** |
| **Chair of the meeting:** | Shaun Beebe – Non-Executive Director | **Attachments/ Appendices:** | None |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Summary of the Meeting**

The extraordinary Finance and Resources Committee (FRC) meeting scheduled for the 23 December was cancelled in line with the CCGs decision to stand down all meetings (unless related to urgent care) due to the change in status of the system to that of level 4 and the redeployment of staff to the vaccination programme. The scheduled papers for the meeting (including the Finance Report, an update on the CCG's savings plan and the Cross Provider Report) were circulated to members for information.

The FRC met on 26 January, with a focussed agenda, in line with the CCG's agreed emergency governance arrangements.

At this meeting, the Committee:

- **RECIEVED** the finance report for month nine, which showed a forecasted breakeven position for the remainder of the year. The latest position showed a position consistent with previous months. Overspending areas continue to be mitigated by the release of primary care delegated reserves and other non-recurrent measures. The Committee approved the report for onward submission to the Governing Body.
- **RECIEVED** an update on financial planning for 2022/23. The latest planning guidance was received on 24 December 2021. Members were briefed on the key points within the guidance such as an extension of the planning timetable to the end of April 2022 and the new target date of 1 July 2022 for statutory arrangements of the ICB to take effect. The guidance is being taken forward as a system to deliver a plan in line with the required submission dates.
- **RECEIVED** the Cross Provider Report which provided an overview of financial and activity performance for the Nottingham and Nottinghamshire CCG at month nine, with particular focus on the major acute contracts and performance against ERF targets.
- **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;-<br>• The progress of the H2 Plans |

**The ratified minutes of the November 2021 meeting are provided to the Governing Body in the 'Information Items' section of this meeting.**

**The ratified minutes of the January 2022 meeting will be received by the Governing Body on 2 March 2022.**

Nottingham and Nottinghamshire Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (open session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Finance Report Month Nine | **Paper Reference:** | **GB 21 027** |
| **Sponsor:** | Stuart Poynor, Chief Financial Officer | **Attachments/ Appendices:** | - |
| **Presenter:** | Michael Cawley, Operational Director of Finance | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Executive Summary**

The CCG remains under a temporary financial regime due to the continuing COVID situation which splits the financial year into two planning periods H1, April to September and H2, October to March. The financial year is to be reported on the entire twelve-month period. The forecast outturn for the year is breakeven in line with the reported H1 position plus the final H2 plan.

The year-to-date month nine reported position is on plan against the combined H1 and H2 financial plan. Continuing healthcare costs continue to be the main cost pressure for the CCG (£2.8 million overspend year to date, £3.4 million overspend forecast outturn). The CCG continues to carry an elective recovery fund (ERF) overspend as incurred during H1 of circa £2.8 million. Mental health spend also has a pressure, primarily due to section 117 packages and associated costs, with a year to date overspend of £0.8 million and a forecast outturn overspend of £1.2 million.

In line with previous months, the above overspending areas are mitigated by the release of the primary care delegated reserve and non-recurrent measures, which has been described in detail in previous months finance report.

The CCG capital plan of £2.1 million is now expected to undershoot by circa £0.5 million due to delays on the primary care estates schemes as a result of Covid pressures and supply chain difficulties. We are currently discussing with NHSEI about how this is best managed. The GP IT and Mansfield supported living schemes are expected to incur expenditure per respective capital allocations.

The report was discussed and approved by the Finance and resources Committee at its meeting on 26 January 2022.

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

**Conflicts of Interest:**

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

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

**Risk(s):**

None identified.

**Confidentiality:**

☒No
☐Yes
☐The document contains Personal information
☐The CCG is in commercial negotiations or about to enter into a procurement exercise
☐The document includes commercial in confidence information about a third party
☐The document contains information which has been provided to the CCG in confidence by a third party
☐The discussion relates to policy development not yet formalised by the organisation
☐The document has been produced by another public body
☐The document is in draft form

**Recommendation(s):**

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


NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group
Finance report
Month nine 2021/22
1

# Contents

# 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 nine, the year to date position of month one through to month nine will be reported.
- The year to date month nine reported position is a balanced in year income and expenditure position. This represents an on plan position for H2.
- Within this on plan position, there are in month pressures in the areas of CHC £0.300 million, NCA and other acute activity £0.122 million and Mental Health (locked rehab and section 117 packages) £0.408 million. The pressures are offset by underspends on Prescribing £0.853 million, Community contracts £0.076 million, Corporate costs £0.126 million, elective recovery fund (ERF) related independent sector activity £0.370 million and other contracts £0.127 million. A number of allocations have been received which are committed and the reserves position assumes a level of expenditure for these.
- The forecast outturn for the year is breakeven in line with the reported H1 position plus the approved H2 plan. Key pressure areas for the full year forecast are CHC expenditure at £3.4 million over plan, Mental Health expenditure at £1.2 million plan and the previously reported H1 ERF pressure of £3.080 million. These pressure areas are all mitigated to a breakeven position, with underspends forecast on Community, Prescribing, other Primary Care, and balance sheet flexibility.
- The CCG capital forecast for the full year is now expected spend circa £1.6 million, representing a £0.5 million shortfall against the £2.1 million plan. This shortfall is against the primary care estates development plans which have been mainly delayed due to Covid pressures and supply chain difficulties.

# CCG month 9 financial position

The month 9 financial position is set out below (see appendix 1 for the full OCS):

| 21/22 | Month 9 YTD Ledger | | | Off Ledger | | | | |
|---|---|---|---|---|---|---|---|---|
| Programme Area | Budget £'000 | Actual £'000 | Variance £'000 | Cumulative Surplus | Elective Recovery Fund £'000 | Hospital Discharge Programme £'000 | ARRS/WAF £'000 | Total adjusted variance £'000 |
| Acute | 819,500 | 826,421 | (6,920) | | 0 | | | (6,920) |
| Community | 132,762 | 132,448 | 314 | | | | | 314 |
| Mental Health | 151,659 | 152,491 | (832) | | | | | (832) |
| Continuing Healthcare | 91,072 | 93,822 | (2,750) | | | | | (2,750) |
| Primary Care Co-Commissioning | 125,422 | 122,855 | 2,567 | | | | 186 | 2,753 |
| Prescribing | 120,390 | 119,587 | 804 | | | | | 804 |
| Other Primary Care | 30,424 | 28,012 | 2,411 | | | | | 2,411 |
| Other Programme | 62,211 | 66,826 | (4,614) | | | 4,793 | | 179 |
| Total Programme Costs | 1,533,441 | 1,542,462 | (9,021) | | 0 | 4,793 | | (4,041) |
| Running Costs | 13,886 | 13,850 | 36 | | | | | 36 |
| Contingency | 0 | 0 | 0 | | | | | 0 |
| **Total prior to planned surplus/(deficit)** | **1,547,327** | **1,556,312** | **(8,984)** | | **0** | **4,793** | | **(4,005)** |
| Planned Surplus/(Deficit) | 12,952 | 0 | 12,952 | (8,947) | | | | 4,005 |
| **Total reported position** | **1,560,279** | **1,556,312** | **3,967** | | **0** | **4,793** | | **0** |

Note, Positive variance is favourable, negative variance is adverse

- The Acute overspend of £6.9m is due to £2.79m of ERF pressure – see the next slide, and overperformance independent sector budgets in H1 – pre ERF. The pre-ERF over performance was offset against a planned surplus of £4.0m in H1 which moved it to a breakeven position.
- The CHC overspend of £2.75m is due partly from price increase as a result of the Lang Buisson review, but primarily due to an increase in placements primarily 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.
- 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.
- Other programme also contains HDP claims awaiting reimbursement.
- The CCG is reporting a breakeven position for month nine in line with the H2 plan approved by NHSE/I in November.
- The forecast outturn for the year is breakeven in line with the reported H1 position plus the final H2 plan

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

# CCG month 9 position continued

Key variances to plan at month 9:

- Continuing healthcare package costs remain the main pressure for the CCG. The year to date position has deteriorated by £0.300 million in month to give a year-to-date pressure against plan of £2.750 million. This is due to both volume (new CHC patients) and price pressures on the packages
- Prescribing/oxygen costs have improved by £0.853 million in month, and are now £0.804 million under plan, with a full year forecast of £1.161 million. This area of spend remains volatile. Whilst a key under-spending budget, there is flexibility in the overall position should prescribing costs not remain underspent against plan
- No ERF related income or expenditure is assumed in the month nine plan. The year to date ERF pressure reported in month eight is £2.79 million, net of £0.3 million accounted for in month nine, relating to month seven (the £2.79 million is a result of national changes to the threshold for achievement and changes to baseline activity both of which occurred during H1). No further ERF is expected at this time for the remainder of the year due to the threshold level.
- Local Covid costs are on plan
- Covid Vaccination Programme expenditure on dealing with inequalities is included in the month nine position. The CCG can claim for additional funding to cover this specific expenditure up to the forecast level of costs of £0.1 million.
- Delegated primary care costs are £2.654 million below plan. This represents the key mitigating underspend offsetting the year to date ERF pressures. This is primarily due to the release of the H1 reserve of £2.639 million.
- In addition to the primary care and prescribing underspends, there are in month underspends on community contracts £0.076 million and acute independent sector activity (as noted above) £0.370 million. On a year-to-date basis, the key underspending areas are delegated primary care as noted and other primary care as reported in prior months
- The position excludes risks related to potential maternity costs

# Month 9 reporting risks, issues and forecast

Risks/issues.

The key issue was the efficiency target which will require work up and identification during the remainder of the financial year. It is forecast that the balance sheet and slippage on allocation schemes will allow a one off delivery of the non-recurrent element of the efficiency target

In addition to the above, the key financial risks are:

- Assumptions regarding receipt of anticipated allocations in regards to national Covid, ARRS and Winter Access Fund.
- Assumptions for regional funding to meet costs of the NUH maternity review, estimated at £0.78 million
- These risks are fully mitigated by the use of primary care reserves, balance sheet measures and assumed allocations
- Following a review of commitments, the £3.4m previously unidentified savings have now been identified through slippage on allocations and balance sheet flexibility.

Forecast.

- The overall forecast for the financial year is an income and expenditure break even position in line with the breakeven H2 financial plan together with the H1 reported breakeven position

# Month 9: Cash, BPPC and Debtors

## Cash

- Month 9 cash position is a closing cash balance of £0.205m against a maximum target balance of £1.875m

## BPPC

- Based on the thirty-day compliance, the month 9 BPPC statistics are showing compliance above the 95% for value and volume.

| Volume / Value invoices paid within 30 days | Cumlative Quantity/ Value | DEC-21 | | Non NHS | | NHS | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|
| | | Quantity/ Value | Quantity/ Value Fails | DEC-21 | Cumulative | DEC-21 | Cumulative | DEC-21 | Cumulative |
| Volume | 29,357 | 3,698 | 78 | 97.87% | 96.24% | 98.81% | 98.50% | 97.89% | 96.29% |
| Value | £1,382,730,512 | £143,577,348 | £482,558 | 98.55% | 97.90% | 100.00% | 99.97% | 99.66% | 99.38% |

## 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 | 12 | £98,609 | 9 | £154,477 | 4 | £50,608 | 38 | £382,596 | 63 | £686,290 |
| NHS | 3 | £96,567 | 3 | £326,198 | 1 | £468 | 2 | £24,468 | 9 | £447,702 |

The key debts noted in table are:

- Non NHS – CHC recharges with 14 care homes £108k; Nottinghamshire County Council £200k; Nottingham City Council £101k of which £179k relates to prescribing; Prescribing recharges £261k; £23k other.
- NHS – Recharges with 2 NHS FTs £46k; Recharges with 1 NHS Trust £28k; Recharges with 4 CCGs £49k; Recharges with NHS England & Improvement £325k.
- 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 £0.5 million. We are currently discussing with NHSEI about how this is best managed

- The Mansfield supported living scheme legal agreement has now been signed and NHS EI are expecting the land payment of £0.483 million to go through in January. The contractor has confirmed on site works for have been incurred by the end of March as planned for the remainder

- The GP IT expenditure had been incurred by our IT partner NHIS and we are waiting an invoice

| **Planned spend and profile £000** | | | | | |
|---|---|---|---|---|---|
| Scheme | **Annual Plan** | YTD | Jan | Feb | Mar |
| Mansfield Supported Living (LD Premises Grant) | **1103** | 483.5 | 619.5 | | |
| GP Premises grants | **600** | 125 | 100 | 175 | 200 |
| GPIT | **306** | 306 | | | |
| Grants to support estates rationalisation | **126** | 0 | 50 | 50 | 26 |
| Total | **2135** | **914.5** | **769.5** | **225** | **226** |
| **Actual monthly spend £000** | | | **Forecast** | | |
| Scheme | **Annual Forecast** | YTD | Jan | Feb | Mar |
| Mansfield Supported Living (LD Premises Grant) | **1103** | 0 | 483.5 | 0 | 619.5 |
| GP Premises grants | **219** | 0 | 0 | 0 | 219 |
| GPIT | **306** | 0 | 306 | 0 | 0 |
| Grants to support estates rationalisation | **0** | 0 | 0 | 0 | 0 |
| Total | **1628** | **0** | **789.5** | **0** | **838.5** |
| **Variance £000 Under / (Over) Plan** | | | | | |
| Scheme | **Annual Variance** | YTD | Jan | Feb | Mar |
| Mansfield Supported Living (LD Premises Grant) | **0** | 483.5 | 136 | 0 | -619.5 |
| GP Premises grants | **381** | 125 | 100 | 175 | -19 |
| GPIT | **0** | 306 | -306 | 0 | 0 |
| Grants to support estates rationalisation | **126** | 0 | 50 | 50 | 26 |
| Total | **507** | **914.5** | **-20** | **225** | **-612.5** |

# 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 year to date overspend of £2.750 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 £0.5 million due to Covid pressures and supply chain difficulties

The Governing Body is recommended to:

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

Ian Livsey
Deputy Director of Finance
January 2022

**Appendix 1**

## Operating Cost Statement: M7

| 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 | 478.49 | 478.49 | 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 | 39.84 | 39.84 | (0.00) | 39.84 | 39.84 | (0.00) |
| Sherwood Forest Hospitals | 227.22 | 227.22 | (0.00) | 303.28 | 303.28 | 0.00 |
| Sherwood Forest Hospitals - Non Core | 9.32 | 9.32 | 0.00 | 9.32 | 9.32 | 0.00 |
| East Midlands Ambulance Service | 30.90 | 30.90 | 0.00 | 41.16 | 41.16 | 0.00 |
| University Hospitals Of Derby And Burton | 5.15 | 5.15 | (0.00) | 6.86 | 6.86 | 0.00 |
| United Lincolnshire Hospitals | 4.15 | 4.15 | 0.00 | 5.53 | 5.53 | 0.00 |
| Doncaster & Bassetlaw | 2.72 | 2.72 | 0.00 | 3.62 | 3.62 | 0.00 |
| University Hospitals Leicester | 1.56 | 1.56 | 0.00 | 2.08 | 2.08 | 0.00 |
| Sheffield Teaching | 0.99 | 0.99 | 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 | 1.28 | 1.86 | (0.58) | 1.80 | 2.68 | (0.88) |
| Ramsay Woodthorpe | 10.60 | 8.65 | 1.95 | 13.74 | 11.79 | 1.95 |
| BMI Healthcare | 7.14 | 5.41 | 1.73 | 8.98 | 7.25 | 1.73 |
| Barlborough | 0.66 | 0.39 | 0.27 | 0.83 | 0.55 | 0.27 |
| Spire | 2.65 | 1.40 | 1.24 | 3.12 | 1.79 | 1.33 |
| Other Non NHS - Acute | 0.44 | 0.54 | (0.10) | 0.62 | 0.84 | (0.23) |
| Cancer Monies | 5.07 | 5.01 | 0.06 | 5.61 | 5.53 | 0.09 |
| Diabetes Projects | 0.53 | 0.53 | 0.00 | 0.53 | 0.53 | (0.00) |
| Resilience | 0.00 | 0.00 | (0.00) | 0.00 | 0.00 | (0.00) |
| Urgent Care Centres | 2.20 | 2.24 | (0.04) | 2.95 | 2.99 | (0.04) |
| Acute Investment QIPP | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Activity - Other | 0.01 | (0.00) | 0.01 | 0.01 | (0.00) | 0.01 |
| Acute - COVID | 0.05 | 0.05 | 0.00 | 0.10 | 0.10 | 0.00 |
| ERF ICS system adjustment budget | (11.45) | 0.00 | (11.45) | (12.00) | 0.00 | (12.00) |
| ERF ICS system income requirement | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total Acute Services** | **819.50** | **826.42** | **(6.92)** | **1,076.93** | **1,084.71** | **(7.77)** |
| **Community Services** | | | | | | |
| Nottinghamshire Healthcare - General Health | 74.32 | 74.32 | 0.00 | 98.23 | 98.23 | 0.00 |
| Sherwood Forest Hospitals | 7.98 | 7.98 | 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 | 2.53 | 2.50 | 0.03 | 3.37 | 3.32 | 0.05 |
| Other Non NHS - Community | 46.47 | 45.09 | 1.38 | 61.86 | 60.21 | 1.65 |
| End of Life | 1.33 | 1.31 | 0.02 | 1.76 | 1.74 | 0.02 |
| 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 | 1.00 | 1.25 | (0.25) | 1.45 | 1.74 | (0.29) |
| Community - QIPP | (0.87) | 0.00 | (0.87) | (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** | **132.76** | **132.45** | **0.31** | **176.25** | **175.85** | **0.40** |
| **Mental Health Services** | | | | | | |
| Nottinghamshire Healthcare - Mental Health | 106.54 | 106.54 | (0.00) | 142.86 | 142.86 | 0.00 |
| Other NHS - Mental Health | 0.64 | 0.64 | (0.00) | 0.85 | 0.85 | 0.00 |
| Other Non NHS - Mental Health | 14.83 | 15.12 | (0.29) | 19.78 | 20.01 | (0.23) |
| S117 Placements | 22.78 | 23.37 | (0.59) | 30.38 | 31.36 | (0.98) |
| 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 | 6.84 | 6.84 | 0.00 | 9.76 | 9.76 | (0.00) |
| Mental Health - CCG Coding Change Adjustments | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total Mental Health Services** | **151.66** | **152.49** | **(0.83)** | **203.66** | **204.82** | **(1.16)** |
| **Primary Care Services** | | | | | | |
| Primary Care Contracting | 125.42 | 122.86 | 2.57 | 167.00 | 169.66 | (2.65) |
| Primary Care Contracting - Balancing Adjustments to NHSE/I Model | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Prescribing | 120.39 | 119.59 | 0.80 | 160.64 | 159.48 | 1.15 |
| Prescribing - QIPP | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Medicine Management - Clinical | 2.51 | 2.13 | 0.37 | 3.34 | 2.85 | 0.49 |
| CCG Pathways | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| EH - Primary Care | 0.74 | (0.19) | 0.93 | 1.20 | 0.27 | 0.93 |
| PCTransformation | 7.03 | 6.76 | 0.27 | 9.23 | 8.96 | 0.28 |
| Enhanced Services | 7.78 | 7.48 | 0.31 | 10.38 | 10.07 | 0.31 |
| Practice Transformation fund | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| GPIT | 0.77 | 0.47 | 0.29 | 1.00 | 0.52 | 0.48 |
| Out of Hours | 8.94 | 8.81 | 0.13 | 12.27 | 12.01 | 0.26 |
| Primary Care - Other | 0.39 | 0.33 | 0.06 | 0.52 | 0.44 | 0.08 |
| Primary Care - COVID | 2.27 | 2.22 | 0.04 | 2.31 | 2.25 | 0.06 |
| Primary Care - Balancing Adjustments to NHSE/I 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** | **276.24** | **270.45** | **5.78** | **367.89** | **366.50** | **1.39** |
| **Other Healthcare** | | | | | | |
| Continuing Care & Free Nursing Care | 79.16 | 81.96 | (2.80) | 105.84 | 109.32 | (3.48) |
| City Care CHC Assessment | 2.06 | 2.02 | 0.05 | 2.74 | 2.71 | 0.03 |
| Continuing Care - COVID | 9.85 | 9.85 | 0.00 | 13.19 | 13.19 | (0.00) |
| Continuing Care - Balancing Adjustments to NHSE/I 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** | **91.07** | **93.82** | **(2.75)** | **121.78** | **125.22** | **(3.44)** |
| | | | | | | |
| **TOTAL PROGRAMME HEALTHCARE COSTS** | **1,471.23** | **1,475.64** | **(4.41)** | **1,946.51** | **1,957.10** | **(10.59)** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Other Contracts** | | | | | | | |
| | Other Non-NHS Services | 0.53 | 0.47 | 0.06 | 0.67 | 0.61 | 0.06 |
| | Patient Transport | 5.56 | 5.43 | 0.13 | 7.38 | 7.25 | 0.13 |
| | Other Non-NHS Services - 111 | 4.25 | 4.04 | 0.21 | 5.72 | 5.30 | 0.42 |
| | HDP - COVID | 6.92 | 11.70 | (4.79) | 6.92 | 18.85 | (11.94) |
| | Social Care | 27.09 | 27.09 | 0.00 | 36.12 | 36.12 | 0.00 |
| | Other - COVID | 0.84 | 0.67 | 0.16 | 1.12 | 0.94 | 0.18 |
| | HDP - Local | 0.00 | 0.00 | 0.00 | 2.41 | 2.41 | 0.00 |
| | Other - CCG Coding Change Adjustments | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total Other Contracts** | | **45.19** | **49.42** | **(4.23)** | **60.34** | **71.48** | **(11.15)** |
| **Corporate Non-Running Costs** | | | | | | | |
| | Corporate - Estates | 11.16 | 10.91 | 0.24 | 14.37 | 14.13 | 0.24 |
| | Corporate Costs - Chief Officer | 0.96 | 0.77 | 0.19 | 1.29 | 1.03 | 0.25 |
| | Corporate Costs - Chief Commissioning Officer | 1.66 | 1.71 | (0.05) | 2.19 | 2.30 | (0.10) |
| | Corporate Costs - Chief Finance Officer | 0.00 | 0.00 | 0.00 | 0.01 | 0.00 | 0.01 |
| | Corporate Costs - ICS | 3.77 | 1.94 | 1.82 | 4.98 | 4.98 | 0.00 |
| | Corporate Costs - ICS - Income | (2.59) | (0.77) | (1.82) | (3.59) | (3.59) | 0.00 |
| | Corporate Costs - Chief Nurse | 3.10 | 3.26 | (0.16) | 4.15 | 4.43 | (0.28) |
| | 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 | 0.09 | 0.10 | (0.01) | 0.09 | 0.10 | (0.01) |
| | Depreciation, provisions & technical adjustments | 0.00 | (0.51) | 0.51 | 0.00 | (0.51) | 0.51 |
| **Total Corporate Non-Running Costs** | | **18.15** | **17.41** | **0.74** | **23.50** | **22.87** | **0.62** |
| **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 |
| | QIPP | 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 | (1.12) | 0.00 | (1.12) | 0.19 | 3.43 | (3.24) |
| | Other Reserves - CCG Coding Change Adjustments | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total Programme Reserves** | | **(1.12)** | **0.00** | **(1.12)** | **0.19** | **3.43** | **(3.24)** |
| **TOTAL PROGRAMME NON-HEALTHCARE COSTS** | | **62.21** | **66.83** | **(4.61)** | **84.02** | **97.79** | **(13.77)** |
| | | | | | | | |
| **TOTAL NET OPERATING EXPENDITURE - PROGRAMME** | | **1,533.44** | **1,542.46** | **(9.02)** | **2,030.53** | **2,054.89** | **(24.36)** |
| **Planned Surplus** | | 12.95 | 0.00 | 12.95 | 15.93 | 0.00 | 15.93 |
| **TOTAL AVAILABLE RESOURCE - PROGRAMME** | | **1,546.39** | **1,542.46** | **3.93** | **2,046.46** | **2,054.89** | **(8.42)** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Running Costs** | | | | | | | |
| | Running Costs | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Running Costs - Chief Officer | 1.18 | 1.04 | 0.14 | 1.57 | 1.37 | 0.21 |
| | Running Costs - Chief Finance Officer | 4.11 | 4.12 | (0.01) | 5.47 | 5.40 | 0.07 |
| | Running Costs - Chief Commissioning Officer | 4.45 | 4.51 | (0.06) | 5.91 | 5.98 | (0.07) |
| | Running Costs - Chief Nurse | 1.00 | 1.05 | (0.05) | 1.33 | 1.39 | (0.06) |
| | Running Costs - Special Projects | 0.90 | 0.88 | 0.02 | 1.18 | 1.17 | 0.01 |
| | Running Costs - Communications | 0.43 | 0.45 | (0.02) | 0.57 | 0.61 | (0.04) |
| | Running Costs - Estates | 1.82 | 1.79 | 0.03 | 2.28 | 2.27 | 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 RESOURCE - ADMIN** | | **13.89** | **13.85** | **0.04** | **18.32** | **18.19** | **0.13** |
| | | | | | | | |
| **TOTAL** | | **1,560.28** | **1,556.31** | **3.97** | **2,064.78** | **2,073.08** | **(8.30)** |

# Appendix 2 – Vacancy Factor achievement at month 9

21/22 Pay Budgets with Vacancy Factor Analysis

Variance +ve favourable / -ve adverse

| Corporate Area | YTD Pay Budget £'000 | YTD Pay Actual £'000 | YTD Pay Variance £'000 | YTD Vacancy factor applied £'000 | Post Vacancy Factor Variance £'000 | 21-22 Pay Budget £'000 | 21-22 Pay Forecast £'000 | 21-22 Pay Forecast Variance £'000 | 21-22 Vacancy factor applied £'000 | Post Vacancy Factor Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Programme | | | | | | | | | | |
| Acute - Cancer | 11 | 51 | (40) | 0 | (40) | 15 | 15 | 0 | 0 | 0 |
| Community - Non NHS | 46 | 73 | (27) | 0 | (27) | 61 | 36 | 25 | 0 | 25 |
| CHC Assessment Team | 808 | 816 | (8) | (78) | (87) | 1,077 | 1,109 | (32) | (105) | (136) |
| ICS Staff | 284 | 223 | 61 | 0 | 61 | 378 | 299 | 79 | 0 | 79 |
| Meds Management Team | 2,829 | 2,237 | 592 | (274) | 318 | 3,773 | 2,972 | 801 | (366) | 435 |
| GP IT Team | 164 | 160 | 3 | 0 | 3 | 218 | 125 | 93 | 0 | 93 |
| Chief Commissioning Officer | 1,768 | 1,624 | 144 | (167) | (23) | 2,341 | 2,187 | 154 | (223) | (69) |
| Chief Nurse | 3,099 | 2,923 | 175 | (295) | (119) | 4,139 | 4,015 | 123 | (393) | (269) |
| Chief Officer | 1,068 | 771 | 296 | (107) | 190 | 1,424 | 1,036 | 388 | (142) | 246 |
| Running Costs | | | | | | | | | | |
| Estates | 226 | 216 | 10 | (22) | (12) | 302 | 288 | 14 | (29) | (15) |
| Chief Finance Officer | 3,608 | 3,291 | 317 | (355) | (38) | 4,806 | 4,269 | 537 | (474) | 63 |
| Chief Commissioning Officer | 4,554 | 4,185 | 369 | (431) | (62) | 6,062 | 5,569 | 493 | (575) | (82) |
| Chief Nurse | 1,006 | 904 | 102 | (98) | 4 | 1,341 | 1,214 | 127 | (130) | (3) |
| Chief Officer | 750 | 600 | 150 | (75) | 75 | 1,000 | 773 | 227 | (100) | 127 |
| Comms Team | 463 | 426 | 37 | (45) | (8) | 618 | 576 | 41 | (60) | (19) |
| Special Projects Team | 596 | 547 | 49 | (52) | (4) | 776 | 724 | 52 | (70) | (18) |
| Grand Total | 21,280 | 19,050 | 2,230 | (1,999) | 230 | 28,330 | 25,208 | 3,122 | (2,666) | 457 |

The table shows that at the end of M9 the CCG is meeting the vacancy factor in full.

# Appendix 3 – CCG efficiency

| | H2 Plan | Delivery Risk Rating | M8 Ytd | M8 H2 Forecast | M9 Ytd | M9 H2 Forecast |
|---|---|---|---|---|---|---|
| | £'m | | £'m | £'m | £'m | £'m |
| 21/22 Target | 10.45 | | | | | |
| | | | | | | |
| Transacted: | | | | | | |
| CHC | 1.39 | G | 0.45 | 1.39 | 0.68 | 1.39 |
| Corporate VF | 1.33 | G | 0.14 | 1.33 | 0.21 | 1.79 |
| Prescribing | 0.50 | G | 0.50 | 0.50 | 0.50 | 0.50 |
| Community | 0.65 | G | 0.20 | 0.65 | 0.30 | 0.65 |
| Primary Care | | | | | | |
| Identified Non-recurrent Opportunities | 3.20 | G | | 3.20 | | 6.58 |
| Unidentified Non-recurrent Opportunities* | 3.38 | G | | 3.38 | | - |
| | | | | | | |
| | 10.45 | | 1.29 | 10.45 | 1.69 | 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.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Highlight Report from the meeting of the CCG's Quality and Performance Committee | **Paper Reference:** | **GB 21 128** |
| **Chair of the meeting:** | Eleri de Gilbert, Non-Executive Director | **Attachments/ Appendices:** | None |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Summary of the Meetings**

The Quality and Performance Committee did not meet in December 2021 but did meet on 27 January 2022. Due to the current Coronavirus (Covid-19) situation, the meeting was held virtually.

At its January meeting the Committee:

- **CONSIDERED** essential business only due to the implementation of emergency governance arrangements.
- **RECEIVED** the annual statutory CCG Safeguarding report for the period April 2020 to March 2021. The report provided assurance that the CCG has discharged its statutory responsibility to safeguard the welfare of children and adults. The report also included planned areas for development for 2021/22. The report will be shared with both the Nottingham City and Nottinghamshire Local Safeguarding Children's Partnership (LSCP) and Nottingham City and Nottinghamshire Safeguarding Adults Board (SAB). An update was given to the committee on progress during 2021/22 given that we are now in Quarter 4.
- **RECEIVED** the updated risk register for January 2022.The risk register includes ten risks, five of which are rated red. Risk 174 (*emergency response to a mass casualty event*) will be archived following a major incident planning event undertaken in December 2021. The exercise demonstrated that local providers have appropriate plans in place to be able to respond to a mass casualty event.

**Key messages for 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. The Committee received information about the current market position, quality assurance and safeguarding and the work of the care home and home care quality assurance team. A detailed description of system working across the care sector was provided along with detail of quality initiatives under the Enhanced Health in Care Homes framework. The Committee noted the

strengthening of governance arrangements that had occurred as a result of the Covid-19 pandemic and also noted the challenges faced by the sector; four Nursing Homes are currently under enhanced surveillance. Key areas of focus during quarter four relate to workforce pressures, particularly in respect of nursing recruitment and retention and understanding the impact of mandatory Covid-19 vaccination requirement. There will continue to be a focus on strengthening relationships between providers and the wider system, together with a focus on market management. The team were thanked for their efforts in often challenging circumstances during these unprecedented times.

- **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. The CCG continues to work with the Trust and regulators to ensure that there is alignment of all improvement actions plans and support offers. 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. Based on recent regulatory findings in relation to provider organisations, plus the recent publication of the Integrating Care document, the CCG deemed it timely to review its internal and partnership effectiveness in order to create a set of principles to ensure it has a proactive and systemic approach to managing and improving quality across pathways and services. The report commends the CCG and its committees in terms of its proactive approach to governance both now and moving towards governance in the system space. The report conclusions were really positive but include twelve recommendations for improvement each with a risk rating of high, medium, or low. Two recommendations are rated green and ten are amber. The recommendations on the whole relate to working practices within the CCG/system as opposed to governance systems. All recommendations have been accepted and an action plan is being produced for sign off via the CCG quality assurance process. Updates will be provided to the Committee via scheduled reports and the report will be circulated to Governing Body members.

**The ratified minutes of the January 2022 meeting will be received by the Governing Body in April 2022.**

Nottingham and Nottinghamshire Clinical Commissioning Group

| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Integrated Performance Report | **Paper Reference:** | **GB 21 129** |
| **Sponsor:** | Stuart Poynor, Chief Finance Officer | **Attachments/ Appendices:** | - |
| **Presenter:** | Stuart Poynor, Chief Finance Officer | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• 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?

The 2022/23 Priorities and planning guidance was published on the 24th December 2021, which sets out the objectives required by the NHS over the next financial year. The document highlights a series of key priorities which are summarised below:

A. Invest in the workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
C. C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
D. D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting.
E. E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
F. F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
G. G. Continue to develop the approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure

outcomes with a focus on improving access and health equity for underserved communities.

H. H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
I. I. Make the most effective use of resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
J. J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their Integrated Care System (ICS) to develop a five-year strategic plan for their system and places.

The system has begun to coordinate the development of plans via the existing governance structures, which includes the strategic and technical planning groups. The system is working towards a draft submission of templates on 17th March 2022 with final submission of plans on 28th April 2022.

Weekly monitoring mechanisms are in place to report against the key metrics within the existing H2 21/22 plans which are used to track performance in advance of national data publication. Reporting against the H2 plans using validated data is included on page 44 of this report.

**This month's highlights**

In this month's report, Member's attention is drawn to the following areas:

1. The elective care referral to treatment (RTT) incomplete performance in November deteriorated slightly for the CCG and Nottingham University Hospitals Trust (NUH) from the September position, which was included in the previous performance report. However, a small improvement was seen for Sherwood Forest Hospitals Foundation Trust (SFH).
2. Overall, the number of CCG-registered patients on the waiting list is 91,724, which is an increase of 1,402 patients since the September position was reported. Members are asked to note figure relates 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 patient treatment list.
3. The shape of the waiting list continues to be challenging although page 9 illustrates a reduction (since March 21) in the number of very long-waiting patients, i.e. those over 52-weeks. This is true for the CCG population as well as those patients waiting for treatment at our local acute trusts. Members are reminded that the CCG continues to monitor this and produces a suite of reports weekly so this can be managed across providers, with discussions taking place across the system on flexibilities which might exist in common specialties and within the independent sector.
4. A focus on patients waiting 104 weeks or more can be seen on page 12, alongside the H2 trajectory, which was submitted to NHS England/Improvement (NHSE/I).
5. Diagnostic services show a small improvement in performance against the September position with respect to the number of patients waiting against the 6-week national standard.
6. Cancer services overall continue to show relatively good levels of performance compared to similar populations across the country. The continued high volume of 2 week wait 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 2 week wait services reported is significantly below the national standard (79.84% against the 93% standard). However, treatment volumes remain high.
7. Performance around the 31-day standard remains stable. The 62-day performance remained stable from September to October but reduced in November. The CCG's reported performance standing at 63.7% against the 85% national standard. As a result, the number of patients waiting more than 62-days has increased compared to the previously reported position and the backlog position remains challenging, which is illustrated on page 19.
8. Attendance volumes to A&E departments reduced between September and November by 3.9% or

1,254 attendances. Trusts continue to collaborate in terms of the availability of clinical staffing as this continues to be a challenge. A total of 468 12-hour breaches have been reported in November, of which 445 were at NUH.

9. Conveyance rates via East Midlands Ambulance Service (EMAS) remain low and static.
10. The number of people entering treatment for Improving Access to Psychological Services (IAPT) has increased since the last report and remains lower than the required standard for individual months. Waiting time and recovery performance for the ICS is above the regional and national averages for September 2021.
11. Despite some small improvements in performance, perinatal mental health services continue to be below the standard for 21/22. The September performance is reported at 6.2% compared to the standard of 8.6%. Face-to-face contacts are showing signs of increasing, with telephone contacts reducing. This is expected to support improved performance, though this will not be reflected immediately as the standard is based on a 12-month rolling average.
12. The proportion of patients with severe mental illness who received primary care health check continues to improve although remains below the national standard at 36.1% in December. Some variation is seen between the Integrated Care Partnership-defined areas. The standard for this service increased in April from 60% to 67%.
13. 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 occupied bed days reported in December 2021 has decreased to 0, from 93 in November 2021.
14. Access to eating disorder services for children and younger people deteriorated for urgent and routine patients with 59.09% of patients being seen within 1 week (Q2) and 83.93% within 4-weeks (Q2). Both indicators are performing below the standard. There has been a sustained rise in referrals into the service, which has resulted in the proposal of a revised staffing level by the provider. The model has been reviewed and will inform 2022/23 Mental Health Investment Standard planning.
15. Progress against H1 plans is shown on pages 44 – 53. Activity within secondary care continues to increase, with elective care services, in most cases, above those levels planned for November. Non-elective care remains below the expected levels set out in the H2 plan for November.
16. Cleaning audit scores remain high and above the national standard for all reported sites.
17. Thromboembolism risk assessments for patient admissions were below the 95% national standard at both acute trusts with NUH reporting 94.2% and SFH reporting 93.8% for the year to date.
18. NUH and Nottinghamshire Healthcare NHS Foundation Trust (NHCT) both continue to report challenges in meeting the 80% standard for ward staffing, largely caused by staff sickness, self-isolation and shielding levels.
19. The hospital standardised mortality ratio (HSMR) rate for both acute Trusts is above 100 for the latest 12-month position. The HSMR rates vary in the latest period between 91.2 for NUH and 126.8 for SFH.
20. A single mixed-sex accommodation breach was reported in the latest period, which was caused by a delay in transfer between level 3 care and a ward.
21. The proportion of positive responses to the Friends and Family tests are shown on page 62 of the report. NHCT and A&E and maternity at SFH are below the required standard.
22. The Ambulance Handover standard continues to be unmet at NUH with a reported level of 51% of patients being handed over in 15 minutes, compared to a national standard of 100%. SFH remain above the standard.

Mitigating actions and assurances are provided in the relevant sections of the Integrated Performance Report.

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

**Conflicts of Interest:**

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

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

**Risk(s):**

N/A

**Confidentiality:**

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

**Recommendation(s):**

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

# NHS Nottingham & Nottinghamshire CCG Performance Report February 2022

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

| Table of Contents | |
|---|---|
| **Page 1** | Introduction |
| **Page 2-3** | Indicator Summary |
| **Page 4-21** | Planned Care |
| **Page 22-27** | Urgent Care |
| **Page 28-43** | Mental Health |
| **Page 43-53** | H2 Activity Plan Monitoring |
| **Page 54-72** | Quality |
| **Page 73** | 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?

The 2022/23 Priorities and planning guidance was published on the 24th December 2021, which sets out the objectives required by the NHS over the next financial year. The document highlights a series of key priorities which are bulleted below:
A. Invest in the workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

G. Continue to develop the approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

I. Make the most effective use of resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across the ICS to develop a five-year strategic plan for their system and places.

The system has begun to coordinate the development of plans via the existing governance structures, which includes the strategic and technical planning groups. The system is working towards a draft submission of templates on 17th March 2022 with final submission of plans on 28th April 2022.

Weekly monitoring mechanisms are in place to report against the key metrics within the existing H2 21/22 plans which are used to track performance in advance of national data publication. Reporting against the H2 plans using validated monthly data is included on page 44 of this report.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

## 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 | Nov-21 | => 92% | 70.59% | 4-5 |
| | | Incomplete Waiting List Size | | N/A | 91,724 | 6-8 |
| | | Incomplete number of 52 week waiters | | = 0 | 3,823 | 9-13 |
| | Diagnostics | Percentage of Patients Waiting Longer Than 6 Weeks | Nov-21 | <= 1% | 33.84% | 14-15 |
| | Cancer | 2 Week Wait | Nov-21 | => 93% | 79.84% | 16 |
| | | 2 Week Wait - Breast Symptoms | | => 93% | 69.23% | 16 |
| | | 28 Day Faster Diagnosis Standard | | => 70% | 77.93% | 17 |
| | | 31 Day Decision to Treat to First Treatment | | => 96% | 89.32% | 18 |
| | | 62 Day GP Urgent Referral to Treatment | | => 85% | 63.73% | 19-21 |
| Urgent Care | A&E | 4 Hour Standard | Nov-21 | => 95% | 66.19% | 22-27 |
| | Ambulance - Nottinghamshire Division (including Bassetlaw) | Category 1 – Life-threatening illnesses or injuries - Average | Nov-21 | <= 00:07:00 | 00:08:24 | |
| | | Category 2 – Emergency calls - Average | | <= 00:18:00 | 00:40:54 | |
| | | Category 1 – Life-threatening illnesses or injuries - 90th centile | | <= 00:15:00 | 00:14:16 | |
| | | Category 2 – Emergency calls - 90th centile | | <= 00:40:00 | 01:25:41 | |
| | | Category 3 – Urgent calls - 90th centile | | <= 02:00:00 | 08:14:02 | |
| | | Category 4 – Less urgent calls - 90th centile | | <= 03:00:00 | 06:07:06 | |
| Mental Health | Improving Access to Psychological Therapies | Entering Treatment - Rolling Three Months | Oct-21 | => 6525 | 6525 | 28-29 |
| | | Recovery Rate - Rolling Three Months | | => 50% | 50.05% | 28-29 |
| | | Waiting Times - First Treatment within 6 Weeks | | => 75% | 93.97% | 28-29 |
| | | Waiting Times - First Treatment within 18 Weeks | | => 95% | 100.00% | 28-29 |
| | Dementia | Diagnosis Rate | Nov-21 | => 66.7% | 69.14% | 30-31 |
| | Perinatal MH | % of Population Birthrate | Sep-21 | => 8.6% | 6.2% | 32 |
| | SMI | Physical Health Checks for People With an SMI | Dec-21 | => 67% | 36.1% | 33-34 |
| | OAP | Inappropriate Out of Area Bed Days | Q3 2021-22 | < 364 | 218 | 35-36 |
| | EIP | Started Treatment in Two Weeks - Rolling Three Months | Sep-21 | => 60% | 80.0% | 37-38 |
| | CYP Eating Disorders | Routine Cases <4 Weeks - Rolling Twelve Months | Q2 2021-22 | => 95% | 83.93% | 41 |
| | | Urgent Case <1 Week - Rolling Twelve Months | | => 95% | 59.09% | 41 |

## Provider Indicator Summary

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

| Theme | Indicator 1 | Indicator 2 | Period | Standard | Performance | | Page Number |
|---|---|---|---|---|---|---|---|
| | | | | | NUH | SFH | |
| Planned Care | RTT | Percentage of Incomplete Patients Waiting Less Than 18 Weeks | Nov-21 | => 92% | 70.83% | 69.78% | 4-5 |
| | | Incomplete Waiting List Size | | N/A | 60,906 | 38,140 | 6-8 |
| | | Incomplete number of 52 week waiters | | = 0 | 3,555 | 745 | 9-13 |
| | Diagnostics | Percentage of Patients Waiting Longer Than 6 Weeks | Nov-21 | <= 1% | 48.89% | 31.91% | 14-15 |
| | Cancer | 2 Week Wait | Nov-21 | => 93% | 73.62% | 90.43% | 16 |
| | | 2 Week Wait - Breast Symptoms | | => 93% | 10.53% | 94.44% | 16 |
| | | 28 Day FD | | => 70% | 80.42% | 75.51% | 17 |
| | | 31 Day Decision to Treat to First Treatment | | => 96% | 88.39% | 91.49% | 18 |
| | | 62 Day GP Urgent Referral to Treatment | | => 85% | 63.09% | 62.56% | 19-21 |
| Urgent Care | A&E | 4 Hour Standard | Nov-21 | => 95% | | 79.05% | 22-27 |
| | | 12hr trolley waits | | = 0 | 445 | 23 | |

## H2 Plans Monitoring

The following charts show the progress against the H2 activity plans submitted in October 2021

Nottingham and Nottinghamshire Clinical Commissioning Group

| NHS Nottingham & Nottinghamshire CCG H2 Plan Summary | Nov-21 Actual | *Nov-21 Plan* | % Difference to Plan | Comparison against 2019/20 | Direction of Travel |
|---|---|---|---|---|---|
| Total outpatient attendances - Face to face (All TFC) | 86,004 | *77,364* | 11.2% | -20.1% | |
| Total outpatient attendances - Telephone/virtual (All TFC) | 24,320 | *26,970* | -9.8% | 475.9% | |
| **Total outpatient attendances (All TFC)** | **110,324** | ***104,334*** | **5.7%** | **-1.4%** | |
| Consultant-led first outpatient attendances (Spec acute) | 20,190 | *23,030* | -12.3% | -8.4% | |
| Consultant-led follow-up outpatient attendances (Spec acute) | **48,964** | ***46,364*** | **5.6%** | **5.7%** | |
| Specific Acute elective day case spells in the period | 10,388 | *10,022* | 3.7% | 0.9% | |
| Specific Acute elective ordinary spells in the period | 1,308 | *1,424* | -8.1% | -12.0% | |
| **Specific Acute elective spells in the period** | **11,696** | ***11,446*** | **2.1%** | **-0.8%** | |
| Specific Acute elective day case spells in the period under 18 years of age | 263 | *268* | -1.9% | -14.1% | |
| Specific Acute elective ordinary spells in the period under 18 years of age | **81** | ***54*** | **50.0%** | **37.3%** | |
| Specific Acute non-elective spells in the period with a LOS of zero days | 3,466 | *4,083* | -15.1% | 5.6% | |
| Specific Acute non-elective spells in the period with a LOS of 1 or more days (COVID) | 284 | *266* | 6.8% | | |
| Specific Acute non-elective spells in the period with a LOS of 1 or more days (Non-COVID) | 5,956 | *6,332* | -5.9% | -9.8% | |
| Specific Acute non-elective spells in the period with a LOS of 1 or more days | 6,240 | *6,598* | -5.4% | -5.5% | |
| **Specific Acute non-elective spells in the period** | **9,706** | ***10,681*** | **-9.1%** | **-1.8%** | |
| Attendances at Type 1 and Type 2 A&E departments, exc planned follow-up attendances | 23,333 | *23,864* | -2.2% | -4.9% | |
| Attendances at Type 3 and Type 4 A&E departments, exc planned follow-up attendances | 7,626 | *7,397* | 3.1% | 1.3% | |
| **Attendances at all A&E departments, excluding planned follow-up attendances** | **30,959** | ***31,261*** | **-1.0%** | **-3.4%** | |
| Diagnostic Tests - Magnetic Resonance Imaging | 5,387 | *5,361* | 0.5% | -9.4% | |
| Diagnostic Tests - Computed Tomography | 10,204 | *9,897* | 3.1% | 17.4% | |
| Diagnostic Tests - Non-Obstetric Ultrasound | 9,772 | *10,061* | -2.9% | -7.5% | |
| Diagnostic Tests - Colonoscopy | 1,134 | *1,112* | 2.0% | 14.3% | |
| Diagnostic Tests - Flexi Sigmoidoscopy | 425 | *374* | 13.6% | 21.8% | |
| Diagnostic Tests - Gastroscopy | 1,259 | *2,990* | -57.9% | -1.7% | |
| Diagnostic Tests - Cardiology - Echocardiography | 2,266 | *2,990* | -24.2% | -26.6% | |

## Mental Health Indicator Summary - January 2022 Update

**NHS Nottingham & Nottinghamshire CCG**

| | Target | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IAPT Access (Rolling 3 Month) | 7675 Q3 | 5.45% | 5.15% | 5.48% | 6405 | 7070 | 7225 | 6990 | 6550 | 6470 | 6525 | | |
| IAPT Recovery Rate | 50.0% | 54.7% | 54.3% | 53.3% | 53.4% | 52.9% | 52.8% | 52.4% | 51.6% | 51.1% | 50.1% | | |
| IAPT Waiting times 6 weeks | 75.0% | 98.2% | 97.1% | 96.7% | 96.8% | 96.9% | 95.1% | 95.1% | 94.1% | 93.1% | 94.0% | | |
| IAPT waiting times 18 weeks | 95.0% | 99.6% | 99.6% | 100.0% | 99.3% | 100.0% | 100.0% | 100.0% | 100.0% | 99.7% | 100.0% | | |
| IAPT waits >90 days between 1st & 2nd Treatment | <10% | 4.1% | 7.4% | 9.9% | 8.8% | 7.7% | 13.1% | 9.6% | 9.1% | 7.9% | 7.4% | | |
| Dementia diagnosis rate - 12mth Rolling | 66.7% | 69.1% | 68.5% | 68.7% | 68.5% | 68.4% | 68.7% | 69.1% | 69.1% | 69.1% | 69.0% | 69.1% | |
| Perinatal Access (Local data) - 12mth Rolling | 1008 | 730 | 690 | 680 | 700 | 725 | 720 | 725 | 730 | 725 | | | |
| Perinatal Access Rate - 12mth Rolling | 8.60% | 6.23% | 5.89% | 5.81% | 5.98% | 6.19% | 6.15% | 6.19% | 6.23% | 6.19% | | | |
| SMI % achievement - 12mth Rolling | 67.0% | 20.6% | 19.7% | 20.5% | 22.5% | 24.4% | 25.7% | 26.1% | 28.3% | 28.7% | 31.0% | 35.2% | 36.1% |
| SMI achievement - 12mth Rolling | 4881 | 1485 | 1417 | 1479 | 1624 | 1766 | 1868 | 1903 | 2054 | 2091 | 2280 | 2605 | 2666 |
| Out of Area Placement bed days (Local) - 3mth | 0 | 592 | 469 | 505 | 516 | 554 | 466 | 399 | 389 | 441 | 453 | 403 | 218 |
| Out of Area Placement bed days (MHSDS) - 3mth | 0 | 590 | 500 | 510 | 535 | 545 | 455 | 440 | 430 | 475 | 450 | | |
| EIP Waiting times - MHSDS - 3mth Rolling | 60.0% | 86.0% | 84.0% | 85.0% | 84.0% | 83.0% | 84.0% | 83.0% | 82.0% | 80.0% | | | |
| CYP Access Rate - 12mth Rolling (2 Contacts) 20/21 | 35.0% | 36.4% | 38.3% | 40.9% | 44.3% | 48.7% | 52.3% | 54.9% | 56.4% | 57.8% | | | |
| CYP Access Rate - 12mth Rolling (1+ Contact) 21/22 | 11709 | 12460 | 12745 | 12955 | 13010 | 13470 | 13690 | 13890 | 13925 | 13985 | | | |
| CYP Eating Disorder WT - Urgent (4 QTR) | 95.0% | | | 72.2% | | | 62.5% | | | 59.1% | | | |
| CYP Eating Disorder WR - Routine (4 QTR) | 95.0% | | | 86.6% | | | 85.4% | | | 83.9% | | | |
| Individual Placement Support (IPS) | 608 | | | | 159 | 191 | 222 | 264 | 287 | 336 | 394 | 437 | |

| 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<br>Acute Providers |

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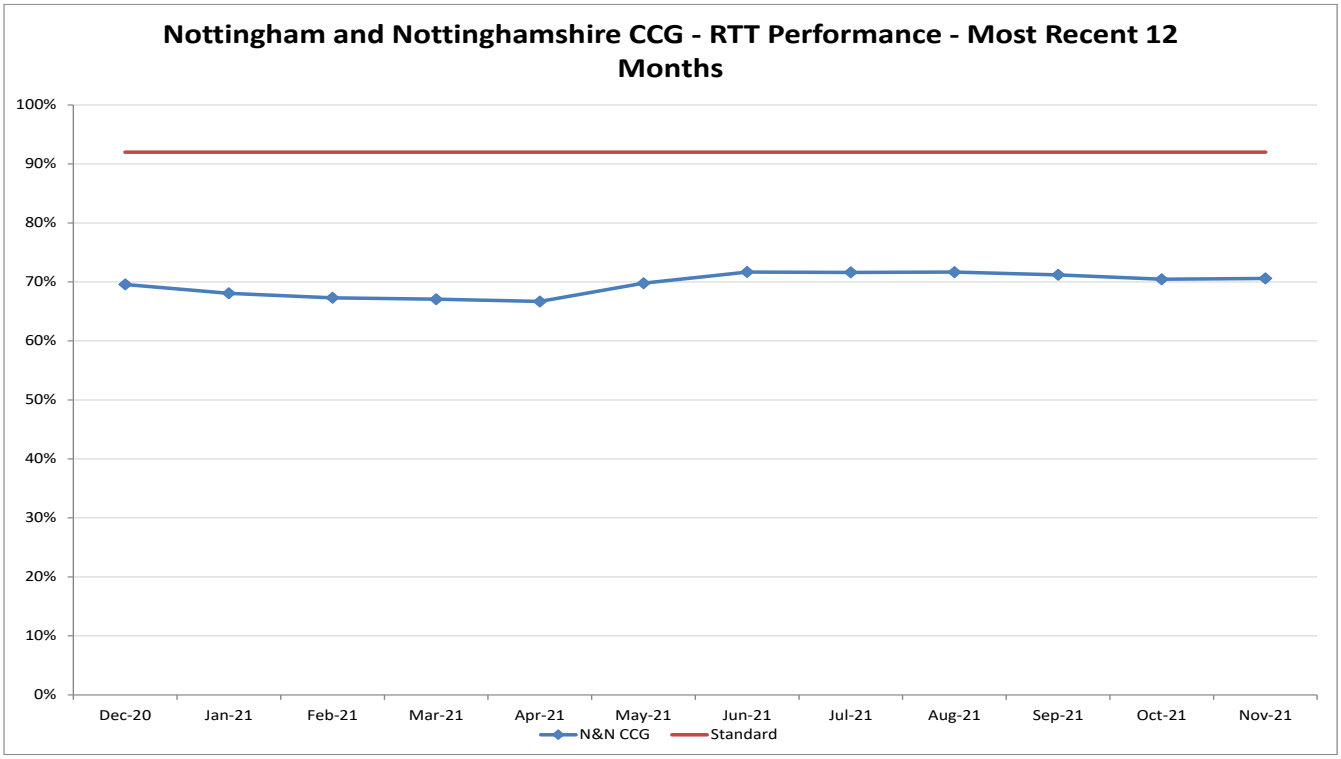
| Organsation | Standard | Most Recent 12 Months Performance | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
| N&N CCG | Greater than or equal to 92% | 89.07% | 89.23% | 88.80% | 86.97% | 80.76% | 73.66% | 64.35% | 57.75% | 62.44% | 68.04% | 70.42% | 71.49% |
| NUH | | 90.00% | 89.73% | 89.56% | 86.52% | 78.85% | 69.85% | 58.64% | 50.61% | 56.75% | 64.26% | 67.92% | 70.83% |
| SFH | | 86.04% | 86.33% | 86.18% | 85.39% | 82.15% | 77.35% | 70.83% | 66.03% | 67.74% | 70.56% | 71.01% | 69.78% |

| Organsation | Standard | Most Recent 12 Months Performance | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 92% | 69.58% | 68.08% | 67.31% | 67.07% | 66.68% | 69.78% | 71.68% | 71.63% | 71.66% | 71.20% | 70.46% | 70.59% | ↑ |
| NUH | | 70.21% | 69.47% | 68.19% | 66.75% | 65.39% | 68.47% | 70.31% | 70.03% | 68.51% | 66.60% | 65.57% | 66.29% | ↑ |
| SFH | | 66.17% | 62.96% | 62.12% | 63.58% | 63.92% | 66.20% | 68.91% | 69.63% | 70.34% | 72.06% | 71.55% | 72.65% | ↑ |




| RTT Specialty - November 2021 | N&N CCG | | | NUH | | | SFH | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patients | Breaches | >18Wks | Patients | Breaches | >18Wks | Patients | Breaches | >18Wks |
| General Surgery | 4553 | 1632 | 64.16% | 878 | 440 | 49.89% | 3873 | 1277 | 67.03% |
| Trauma & Orthopaedics | 9618 | 3725 | 61.27% | 6483 | 3205 | 50.56% | 3406 | 983 | 71.14% |
| Ear, Nose & Throat (ENT) | 7460 | 2600 | 65.15% | 4920 | 1914 | 61.10% | 3807 | 1089 | 71.39% |
| Ophthalmology | 11836 | 3887 | 67.16% | 7423 | 3057 | 58.82% | 4104 | 945 | 76.97% |
| Oral Surgery | 3 | 2 | 33.33% | 2956 | 1678 | 43.23% | 813 | 355 | 56.33% |
| Neurosurgery | 257 | 83 | 67.70% | 570 | 171 | 70.00% | 0 | 0 | |
| Plastic Surgery | 769 | 276 | 64.11% | 977 | 360 | 63.15% | 159 | 46 | 71.07% |
| General Medicine | 34 | 12 | 64.71% | 14 | 10 | 28.57% | 0 | 0 | |
| Gastroenterology | 7551 | 2669 | 64.65% | 4331 | 1922 | 55.62% | 3903 | 1098 | 71.87% |
| Cardiology | 3395 | 1046 | 69.19% | 1684 | 235 | 86.05% | 2152 | 943 | 56.18% |
| Dermatology | 5007 | 694 | 86.14% | 3848 | 384 | 90.02% | 2047 | 411 | 79.92% |
| Thoracic Medicine | 2549 | 881 | 65.44% | 1295 | 456 | 64.79% | 1751 | 573 | 67.28% |
| Neurology | 969 | 84 | 91.33% | 1018 | 67 | 93.42% | 0 | 0 | |
| Geriatric Medicine | 442 | 74 | 83.26% | 118 | 0 | 100.00% | 387 | 86 | 77.78% |
| Gynaecology | 6286 | 2142 | 65.92% | 2667 | 747 | 71.99% | 1704 | 419 | 75.41% |
| Cardiology | 3395 | 1046 | 69.19% | 1684 | 235 | 86.05% | 2152 | 943 | 56.18% |
| Other – Medical Services | 7918 | 1649 | 79.17% | 6407 | 1214 | 81.05% | 2562 | 723 | 71.78% |
| Other – Mental Health Services | 7 | 4 | 42.86% | 0 | 0 | | 0 | 0 | |
| Other - Paediatric Services | 5842 | 924 | 84.18% | 3323 | 553 | 83.36% | 3413 | 554 | 83.77% |
| Other – Other Services | 3870 | 274 | 92.92% | 1196 | 61 | 94.90% | 0 | 0 | |
| **Other (Total)** | **23004** | **4975** | **78.37%** | | | | | | |
| **Total** | **91724** | **26972** | **70.59%** | **60906** | **20531** | **66.29%** | **38140** | **10433** | **72.65%** |

Nottingham and Nottinghamshire Clinical Commissioning Group

**Root Cause**
The position for Nottingham and Nottinghamshire CCG is 70.59% for November 2021 against the national standard of 92%.

This is very similar to the October position of 70.46%. NUH and SFH failed to meet the national standard with performance of 66.29% and 72.65% respectively.

The specialties with the highest proportion of patients waiting beyond 18 weeks for the Nottingham and Nottinghamshire CCG were Ophthalmology, Trauma and Orthopaedics and ENT. Outpatient activity continues to increase but is not yet at pre- Covid levels.

In January 2022, an additional ward (Harvey 2) has been re-purposed to provide essential capacity for emergency patients. In total, there are now four wards that have been re-purposed at NUH, which has materially constrained the volume and type of elective activity that can be undertaken. In particular this has impacted Trauma and Orthopaedics.

Unfortunately, due to very high levels of demand within the system it has been necessary to cancel elective operations. The volume of cancelled operations is monitored on a daily basis and forms part of a daily regulatory submission to NHSE/I, which includes details of the causes, clinical priority level of the patient as well as other information.

**Mitigating Actions**

- Waiting list management is overseen at system level
- The ICS Diagnostic Programme has been successful in receiving national funding to increase diagnostic capacity at both NUH and SFH as a year 1 of system wide plans to implement Community Diagnostic Hubs.
- The Elective and Outpatient Transformation Programme is developing system wide plans across Eye Health and MSK as initial priorities.
- Joint work is being undertaken between SFH and NUH to create and share additional ENT capacity
- 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, including the ICS CCSS.

**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<br>Acute Providers |

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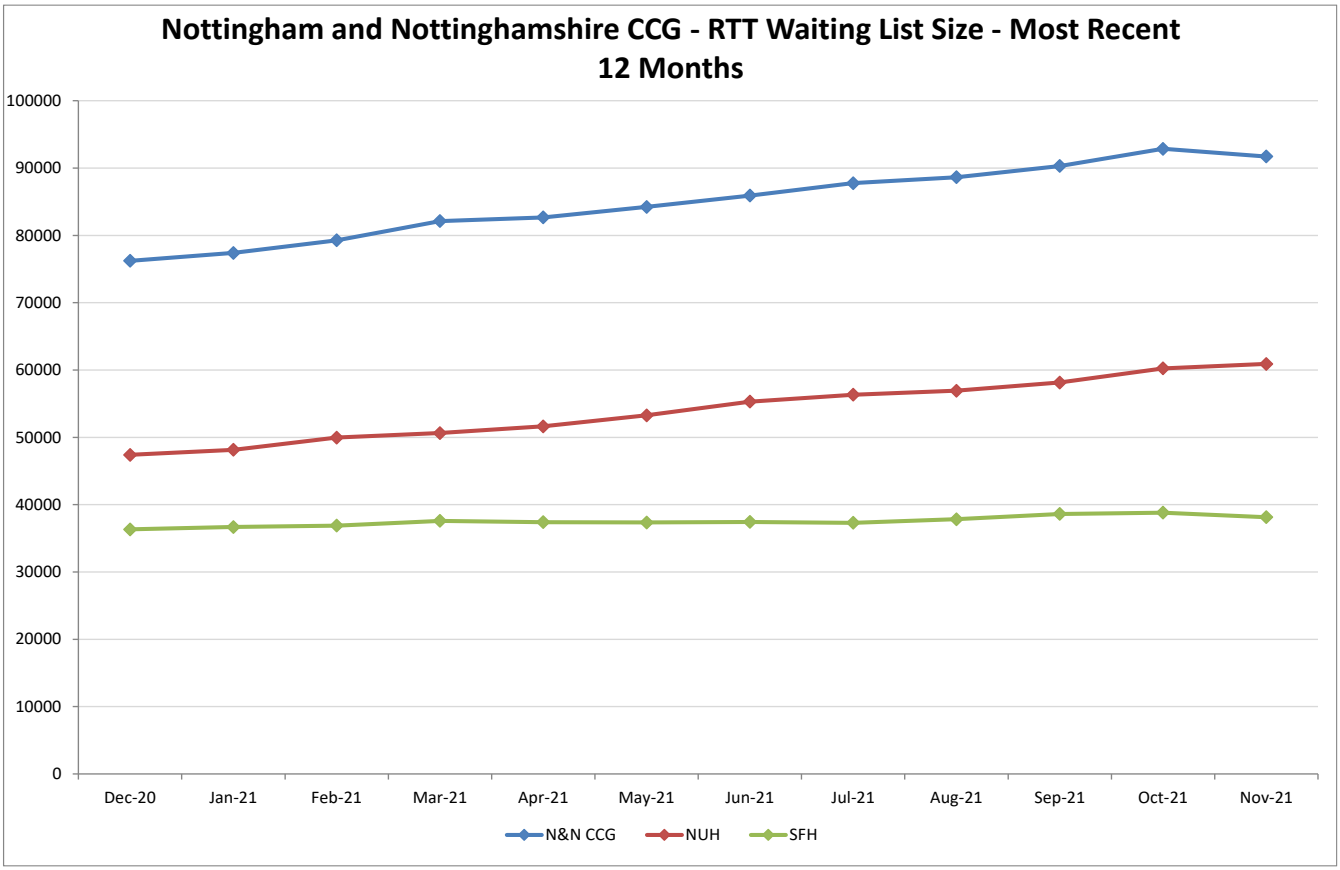
Nottingham and Nottinghamshire
Clinical Commissioning Group

**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 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
| N&N CCG | Reduction in | 67435 | 68412 | 65033 | 62670 | 59969 | 59505 | 60240 | 63228 | 67690 | 70824 | 71656 | 74311 |
| NUH | patients | 45927 | 45515 | 44452 | 42326 | 39684 | 38773 | 39805 | 40491 | 42847 | 43327 | 43101 | 45964 |
| SFH | waiting | 26896 | 26681 | 25812 | 25059 | 26690 | 27763 | 28535 | 30302 | 32612 | 34695 | 35531 | 35379 |

| Organsation | Standard | Most Recent 12 Months Waiting List | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Reduction in | 76232 | 77400 | 79271 | 82141 | 82687 | 84229 | 85921 | 87768 | 88651 | 90322 | 92863 | 91724 | ↑ |
| NUH | patients | 47394 | 48153 | 49964 | 50645 | 51634 | 53279 | 55307 | 56334 | 56933 | 58153 | 60247 | 60906 | ↓ |
| SFH | waiting | 36329 | 36680 | 36895 | 37603 | 37408 | 37358 | 37433 | 37304 | 37834 | 38626 | 38825 | 38140 | ↑ |




| N&N CCG Waiting List Trend | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| General Surgery | 3690 | 3676 | 3850 | 4027 | 4246 | 4370 | 4291 | 4274 | 4326 | 4657 | 4681 | 4553 |
| Trauma & Orthopaedics | 9244 | 9102 | 9032 | 8844 | 8786 | 8908 | 9234 | 9306 | 9033 | 9186 | 9604 | 9618 |
| Ear, Nose & Throat (ENT) | 8294 | 8365 | 8344 | 8241 | 8286 | 8211 | 7818 | 8029 | 7895 | 7486 | 7446 | 7460 |
| Ophthalmology | 14959 | 14884 | 14742 | 14606 | 13673 | 13339 | 13591 | 13367 | 12593 | 12418 | 12288 | 11836 |
| Oral Surgery | 0 | 0 | 0 | 0 | 779 | 13 | 10 | 10 | 13 | 14 | 7 | 3 |
| Neurosurgery | 222 | 238 | 227 | 246 | 226 | 223 | 234 | 257 | 249 | 273 | 290 | 257 |
| Plastic Surgery | 393 | 464 | 555 | 625 | 649 | 642 | 628 | 686 | 680 | 722 | 777 | 769 |
| General Medicine | 15 | 28 | 25 | 17 | 75 | 27 | 27 | 24 | 34 | 37 | 36 | 34 |
| Gastroenterology | 4859 | 5331 | 5458 | 5922 | 6515 | 6320 | 6294 | 6707 | 6824 | 7051 | 7380 | 7551 |
| Cardiology | 2946 | 3138 | 3120 | 2916 | 2915 | 3203 | 3410 | 3503 | 3493 | 3437 | 3451 | 3395 |
| Dermatology | 3067 | 2978 | 3094 | 3077 | 3193 | 3504 | 3953 | 4371 | 4689 | 4806 | 4913 | 5007 |
| Thoracic Medicine | 2098 | 2192 | 2206 | 2237 | 2390 | 2608 | 2714 | 2696 | 2762 | 2716 | 2685 | 2549 |
| Neurology | 558 | 605 | 555 | 420 | 523 | 568 | 759 | 908 | 1017 | 984 | 1065 | 969 |
| Geriatric Medicine | 508 | 518 | 477 | 1804 | 509 | 629 | 712 | 801 | 554 | 359 | 359 | 442 |
| Gynaecology | 5121 | 5156 | 5235 | 5447 | 5658 | 5817 | 6000 | 6042 | 6152 | 6087 | 6237 | 6286 |
| Cardiology | 2946 | 3138 | 3120 | 2916 | 2915 | 3203 | 3410 | 3503 | 3493 | 3437 | 3451 | 3395 |
| Other – Medical Services | 0 | 0 | 0 | 0 | 5674 | 6367 | 6766 | 6718 | 7572 | 8063 | 8662 | 7918 |
| Other – Mental Health Services | 0 | 0 | 0 | 0 | 10 | 12 | 14 | 377 | 21 | 9 | 5 | 7 |
| Other - Paediatric Services | 0 | 0 | 0 | 0 | 3540 | 3856 | 4069 | 4167 | 4444 | 4957 | 5577 | 5842 |
| Other – Other Services | 0 | 0 | 0 | 0 | 3636 | 3864 | 3496 | 3600 | 4060 | 4013 | 3924 | 3870 |
| Other (Total) | 14216 | 14519 | 16002 | 16881 | 17365 | 18748 | 19101 | 19690 | 20775 | 22168 | 23586 | 23004 |
| Total | **76232** | **77400** | **79271** | **82141** | **82687** | **84229** | **85921** | **87768** | **88651** | **90322** | **92863** | **91724** |

Nottingham and Nottinghamshire Clinical Commissioning Group

**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 November 2021 was 91,724, which is a reduction of 1,139 patients from the October position.

'Other' has the largest waiting list at specialty level, although ENT, 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 November both Acute Trusts had a number of long waiting patients:

- Over 52 weeks: NUH had 3,555 and SFH had 745 patients waiting
- Over 78 weeks: NUH had 1,157 and SFH had 83 patients waiting
- Over 104 weeks: NUH had 214 and SFH had 2 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 – 60,906 patients (includes Nottingham Treatment Centre)
- SFH – 38,140 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**

- The system remains committed to eliminating 104 week waits by the end of March, with any remaining patients treated by end of Q1 however a significant level of risk persists across the system most notably in NUH due to system pressures, critical care surge and staffing
- 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, 466 patients have been treated via mutual aid between NUH and SFH this financial year.
- An Insourcing company has been employed at NUH providing weekend 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 is being sought under a national contract agreement as a direct response of the impact of the Omicron variant

Nottingham and Nottinghamshire Clinical Commissioning Group

**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 reduce until current pressures related to COVID non elective admissions subside and Trusts are able to restore elective services and fully utilise 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<br>Acute Providers |

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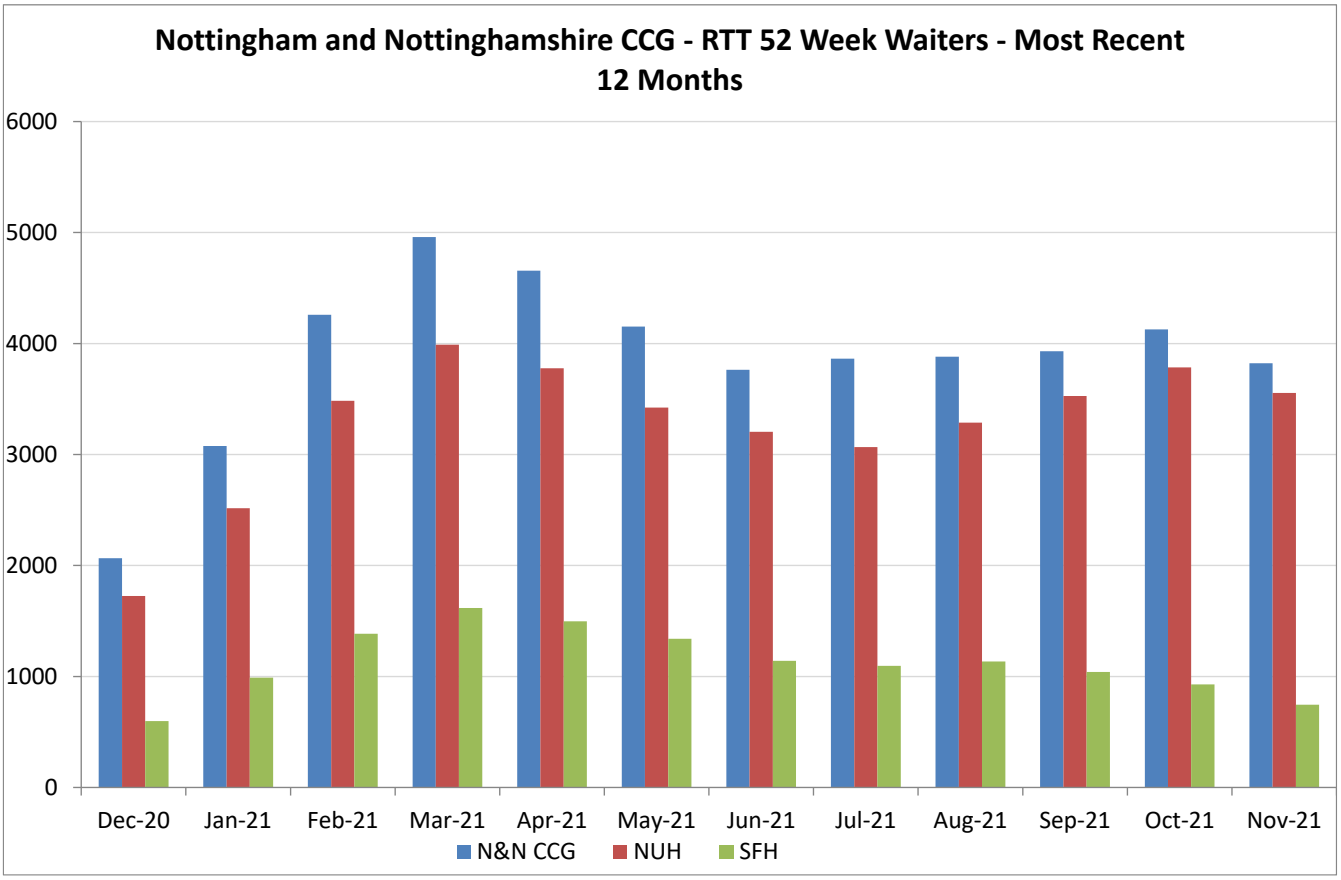
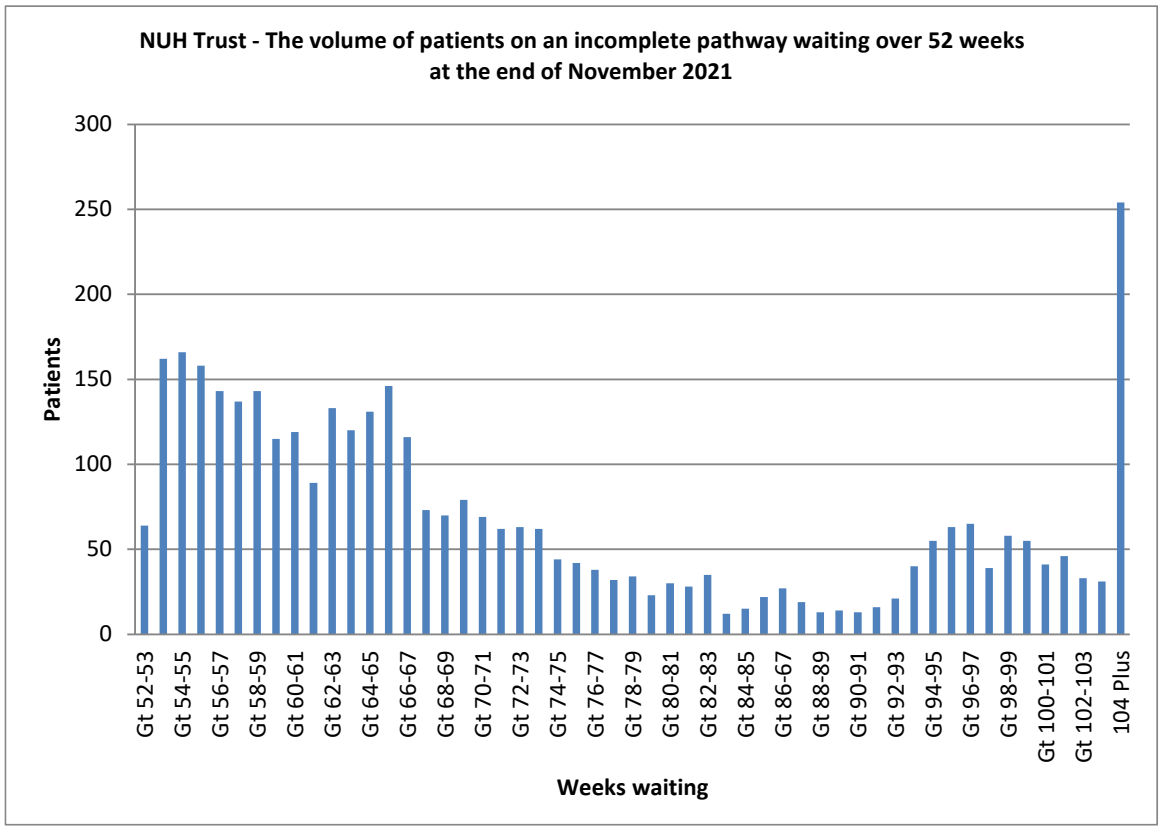
**The number of incomplete pathways exceeding 52 weeks at the end of the month**

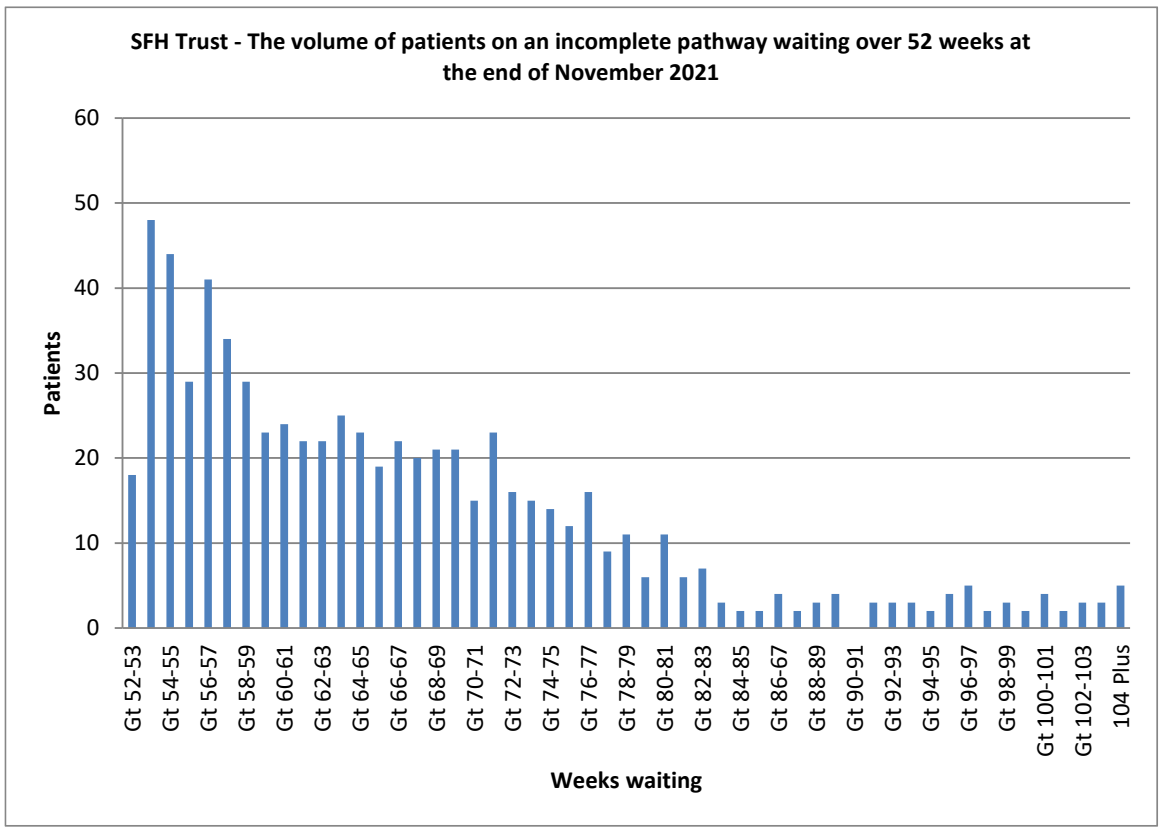
| Organsation | Standard | Most Recent 12 Months 52 Week Waiters | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
| N&N CCG | No patients | 4 | 3 | 2 | 9 | 39 | 117 | 249 | 483 | 716 | 959 | 1175 | 1528 |
| NUH | waiting over | 0 | 0 | 0 | 0 | 15 | 61 | 138 | 272 | 404 | 553 | 806 | 1222 |
| SFH | 52 Weeks | 0 | 0 | 0 | 0 | 15 | 47 | 125 | 217 | 316 | 417 | 418 | 465 |

| Organsation | Standard | Most Recent 12 Months 52 Week Waiters | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | No patients | 2065 | 3076 | 4259 | 4960 | 4656 | 4153 | 3764 | 3864 | 3881 | 3931 | 4128 | 3823 | ↑ |
| NUH | waiting over | 1725 | 2516 | 3484 | 3990 | 3776 | 3422 | 3205 | 3066 | 3287 | 3528 | 3785 | 3555 | ↑ |
| SFH | 52 Weeks | 598 | 990 | 1385 | 1618 | 1498 | 1340 | 1142 | 1096 | 1136 | 1040 | 928 | 745 | ↑ |



Nottingham and Nottinghamshire Clinical Commissioning Group



Nottingham and Nottinghamshire Clinical Commissioning Group

| N&N CCG Patients Waiting Over 52 Wks - Top 10 Providers | Patients |
|---|---|
| NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST | 2595 |
| SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST | 610 |
| UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST | 141 |
| PRIMARY INTEGRATED COMMUNITY SERVICES LTD | 132 |
| UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST | 69 |
| WOODTHORPE HOSPITAL | 69 |
| SPIRE NOTTINGHAM HOSPITAL | 44 |
| BMI - THE PARK HOSPITAL | 32 |
| UNITED LINCOLNSHIRE HOSPITALS NHS TRUST | 19 |
| CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST | 14 |
| OTHER PROVIDERS | 112 |
| **TOTAL** | 3823 |

**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 latest published data illustrates that there were 3823 Nottingham and Nottinghamshire patients waiting 52 weeks or more from referral to treatment at the end of November 2021. This is an improvement from the October 2021 position of 4128 patients waiting.

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 impact 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.

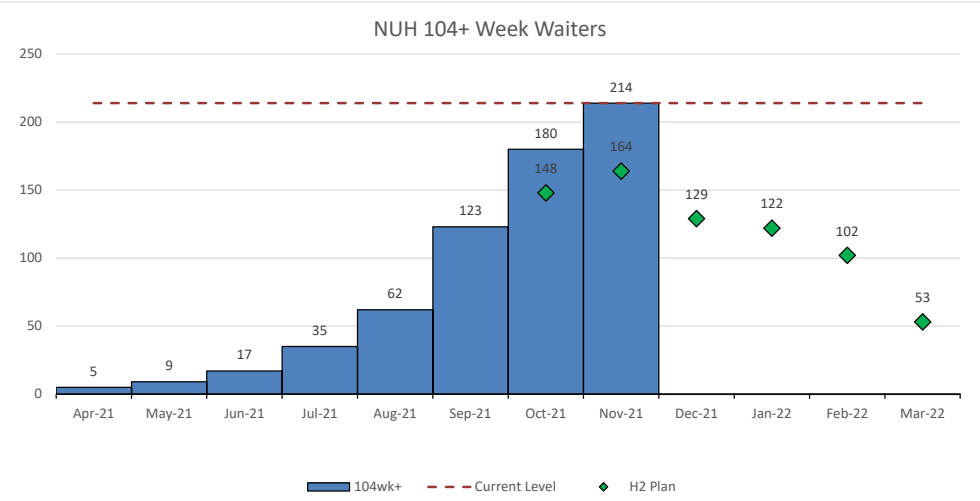
Please note: local Independent Sector (IS) providers also have patients waiting in excess of 52 week waits. This is due to prioritisation of clinically urgent patients from NHS providers and the transfer of long waiting patients to the IS via inter provider transfers.

Nottingham and Nottinghamshire Clinical Commissioning Group

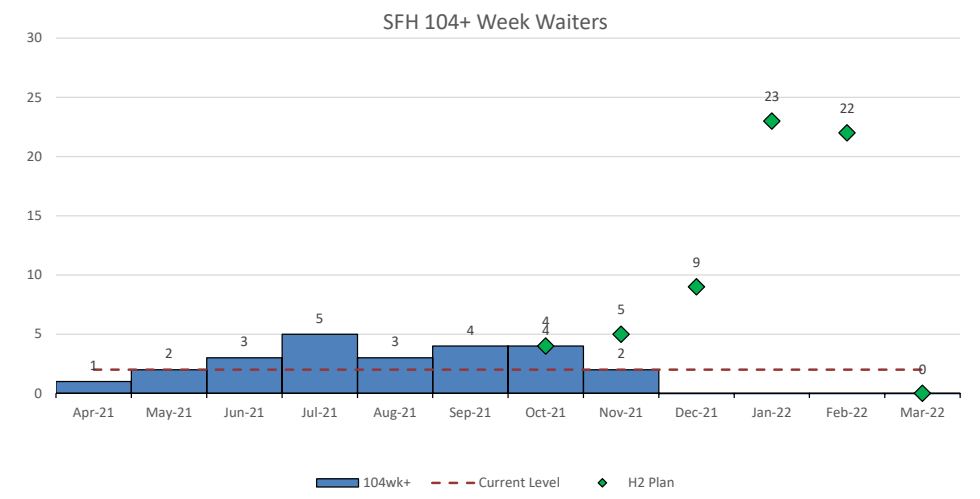
**104 Week Waiters**

The charts below illustrate the volume of patients waiting 104 weeks or more at NUH or SFH at the end of November 2021. Note that this is shown alongside the provider level trajectories that have been submitted as part of the H2 plan.

Key remedial actions are described on page 13 of this report.




| NUH 104+ Week Waiters | |
|---|---|
| Ear, Nose & Throat (ENT) | 113 |
| Trauma & Orthopaedics | 24 |
| Other - Surgical Services | 22 |
| Oral Surgery | 15 |
| Ophthalmology | 12 |
| General Surgery | 9 |
| Other - Paediatric Services | 8 |
| Urology | 5 |
| Cardiothoracic Surgery | 3 |
| Gynaecology | 1 |
| Neurosurgery | 1 |
| Other – Medical Services | 1 |
| **Total** | **214** |




| SFH 104+ Week Waiters | |
|---|---|
| Trauma & Orthopaedics | 2 |
| **Total** | **2** |

Nottingham and Nottinghamshire Clinical Commissioning Group

**Mitigating Actions**
Trajectories to reduce 104 week waits by the end of March 2022 have been submitted to NHSE/I as part of the H2 planning submission and are monitored on a weekly basis. A level of risk persists due to the surge in COVID cases, high level of emergency care demand and workforce shortages.

Specific actions:

- A company providing additional insourced capacity at NUH began operating on weekend lists on 22nd January 2022
- An initial cohort of 21 ENT patients have been transferred to Woodthorpe Hospital for treatment. Further work is taking place to identify a second cohort for transfer
- There are wider risks across specialties at NUH but also most notably in MSK across the system. This is compounded by HDU capacity pressures
- Additional IS capacity is being arranged under new national contract arrangements to support the NHS as a result of the impact of the Omicron variant.

Ongoing actions:

- Decisions to reduce elective capacity for a short period of time are now made as a system via the Health and Social Care Economy Tactical Coordinating Group (HSCETCG) informed by an ICS decision making framework.
- 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 Elective Hub, continues to have oversight of all waiting lists to ensure that capacity is used at a system level, and that all long waiting patients are dated appropriately
- Mutual aid between organisations is in operation between NUH and SFH hospitals for ENT, Urology, Maxillo-Facial Surgery and Cardiac CT Patients.
- All available IS capacity is utilised. IS providers are monitored and managed against the activity plan that forms the basis of the IS contract

**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.
- 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 HSCETCG take material decisions as a system, this is underpinned by an ICS decision making framework which is supported by CEG.

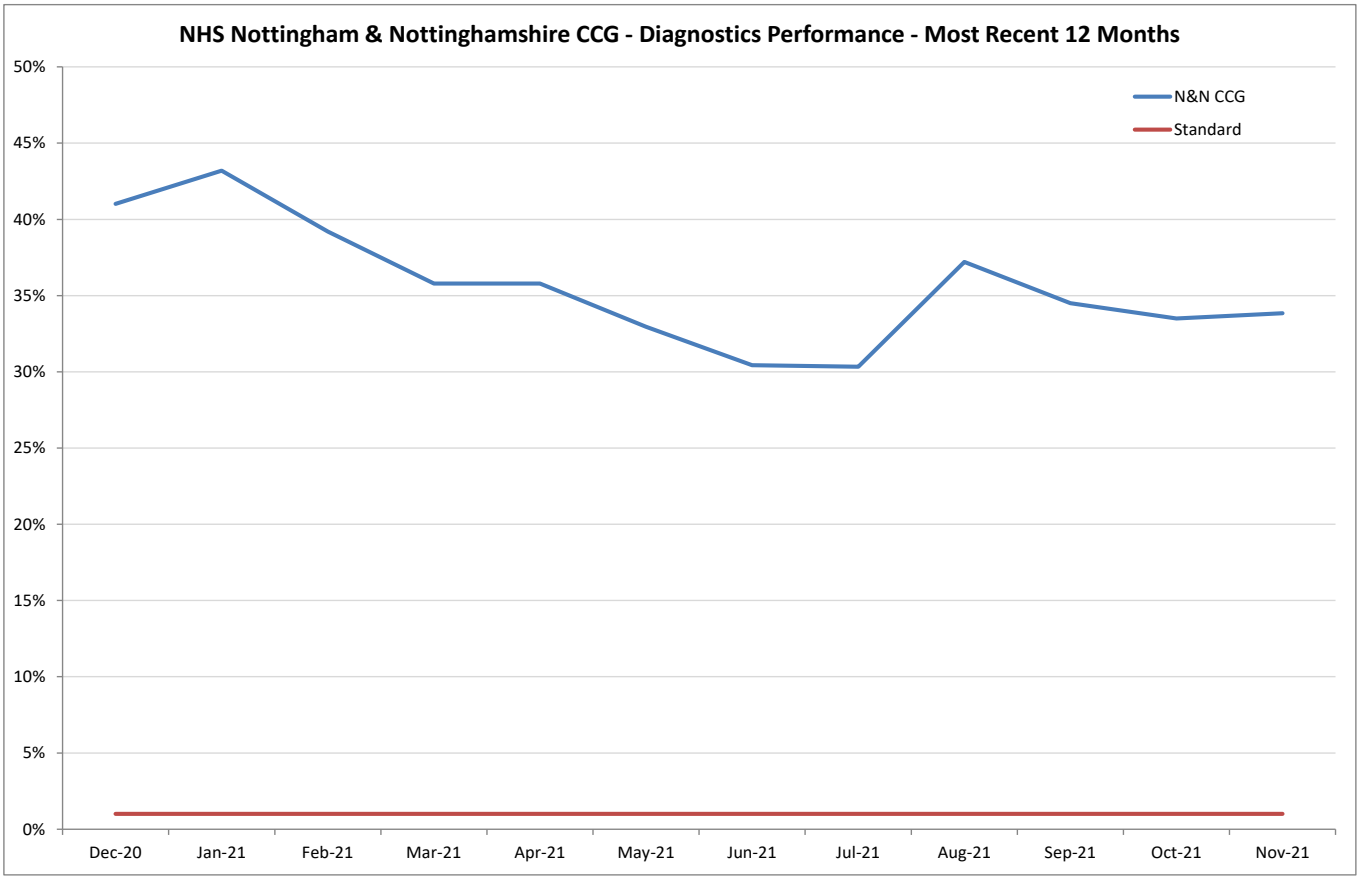
**Gaps in Assurance**
Waiting times will not reduce until current pressures related to COVID non elective admissions subside and Trusts are able to restore elective services

| 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 |

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

| Organsation | Standard | Most Recent 12 Months Performance | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
| N&N CCG | Less than or equal to 1% | 1.08% | 1.87% | 0.99% | 9.97% | 54.73% | 59.68% | 53.26% | 46.80% | 46.06% | 41.60% | 43.36% | 42.22% |
| NUH | | 0.99% | 2.32% | 1.01% | 12.42% | 57.23% | 61.63% | 57.74% | 52.00% | 49.95% | 47.28% | 48.91% | 48.89% |
| SFH | | 0.96% | 1.45% | 1.43% | 6.19% | 53.00% | 57.58% | 50.01% | 40.39% | 38.63% | 32.61% | 35.05% | 31.91% |

| Organsation | Standard | Most Recent 12 Months Performance | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Less than or equal to 1% | 41.01% | 43.19% | 39.20% | 35.79% | 35.79% | 32.95% | 30.43% | 30.33% | 37.20% | 34.50% | 33.50% | 33.84% | ↓ |
| NUH | | 48.00% | 50.57% | 47.60% | 43.46% | 44.23% | 40.63% | 39.17% | 38.54% | 44.38% | 44.65% | 43.81% | 43.75% | ↑ |
| SFH | | 31.24% | 34.00% | 29.75% | 27.35% | 25.36% | 23.05% | 20.08% | 21.75% | 25.13% | 20.02% | 19.71% | 20.02% | ↓ |




| Tests Below Standard - November 2021 | N&N CCG | | | NUH | | | SFH | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patients | Breaches | <6Wks | Patients | Breaches | <6Wks | Patients | Breaches | <6Wks |
| MRI | 7524 | 4341 | 57.70% | 7068 | 4946 | 69.98% | 1507 | 55 | 3.65% |
| Computed Tomography | 2749 | 460 | 16.73% | 2043 | 154 | 7.54% | 1085 | 345 | 31.80% |
| Non-obstetric ultrasound | 7076 | 1042 | 14.73% | 2400 | 288 | 12.00% | 3817 | 780 | 20.43% |
| Barium Enema | 0 | 0 | | 0 | 0 | | 0 | 0 | |
| DEXA Scan | 1405 | 664 | 47.26% | 1191 | 663 | 55.67% | 710 | 56 | 7.89% |
| Audiology | 1139 | 173 | 15.19% | 870 | 191 | 21.95% | 0 | 0 | |
| Echocardiography | 3507 | 1239 | 35.33% | 2382 | 893 | 37.49% | 1413 | 438 | 31.00% |
| Cardiology - Electrophysiology | 1 | 0 | 0.00% | 0 | 0 | | 0 | 0 | |
| Neurophysiology | 212 | 1 | 0.47% | 249 | 0 | 0.00% | 0 | 0 | |
| Sleep studies | 636 | 196 | 30.82% | 579 | 146 | 25.22% | 258 | 92 | 35.66% |
| Urodynamics | 105 | 21 | 20.00% | 41 | 14 | 34.15% | 72 | 9 | 12.50% |
| Colonoscopy | 805 | 284 | 35.28% | 594 | 290 | 48.82% | 266 | 37 | 13.91% |
| Flexi sigmoidoscopy | 308 | 132 | 42.86% | 244 | 132 | 54.10% | 87 | 11 | 12.64% |
| Cystoscopy | 387 | 84 | 21.71% | 184 | 16 | 8.70% | 245 | 83 | 33.88% |
| Gastroscopy | 1233 | 529 | 42.90% | 1087 | 549 | 50.51% | 238 | 36 | 15.13% |
| **Total** | 27087 | 9166 | 33.84% | 18932 | 8282 | 43.75% | 9698 | 1942 | 20.02% |

Nottingham and Nottinghamshire Clinical Commissioning Group

**Root Cause**

- Backlogs and long waits due to reduction in capacity during Covid, particularly Endoscopy where procedures were classified as Aerosol Generating Procedures (AGPs). A significant increase in urgent cancer referrals has been seen during the year to date, which is between 20 and 30% higher than volumes seen in 2019/20.
- The position across the key 15 modalities for the CCG population is 33.8% for November, which a small deterioration from 33.3% reported for October. However, the total waiting list volume has reduced marginally from 27,322 in October to 27,087 in November.
- Analysis by modality highlights that MRI at NUH is challenged with performance at 70.0% against the 1.0% standard. The latest data for November illustrates that there were 7067 patients waiting for an MRI at NUH, however 4946 of these patients are waiting more than 6 weeks. The backlog volume for MRI has reduced over recent months from a high of 5317 in August 2021. Additional investments have been made to secure additional mobile capacity via Community Diagnostic Centre (CDC) funding.

**Mitigating Actions**

- Extensive use of the IS provider hospitals for endoscopy (Ramsay Woodthorpe, BMI Park, The Spire), and mobile IS Diagnostic mobile capacity located at both Trusts for CT, MRI and Endoscopy.
- Extensive use of Day Surgery facilities to increase internal Endoscopy capacity. SFH increased use of Newark Hospital.
- Major estates work completed at City Campus Endoscopy unit to ensure compliance with latest ventilation standards. Will allow for greater productivity.
- Evening and weekend capacity expanded at both trusts to increase capacity.
- NUH utilising portable ventilation system to allow for increased productivity per session.
- Mutual aid has been delivered via agreement at the Elective Hub, with choice offered to patients that live within Newark and the surrounding vicinity to attend Newark Hospital.

**Assurances**

- Activity currently at 98.1% of pre-covid levels across the main diagnostic modalities which benchmarks well against national average and peers.
- DNA rates reducing as vaccination programme continues.
- ICS an Accelerator system for Elective Recovery. Allowed for extension of IS Mobile diagnostic capacity.
- ICS secured significant year 1 Community Diagnostic Centre (CDC) funding to expand IS mobile diagnostic capacity in 21/22 – CT, MRI and Endoscopy. £5.6m revenue. Now received confirmation of £762k further capital funding (endoscopy equipment and pad for 3rd MRI at NUH).
- Bid for year 2-5 funding for CDCs submitted to Regional Team. Indicative figures suggest the ICS will receive £24m capital over 3 years to develop CDC capacity.

**Gaps in Assurance**

- Seeking assurance from National Diagnostics Team on Year 2-5 funding (both capital and revenue) for CDCs.

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

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organsation | Standard | Most Recent 12 Months Performance - Two Week Wait | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 93% | 95.32% | 88.77% | 95.84% | 96.44% | 86.25% | 89.67% | 88.45% | 91.59% | 90.55% | 89.74% | 89.22% | 79.84% | ↓ |
| NUH | | 95.30% | 87.40% | 95.38% | 96.65% | 82.56% | 87.31% | 87.70% | 92.30% | 90.64% | 89.66% | 88.58% | 73.62% | ↓ |
| SFH | | 95.62% | 91.43% | 96.76% | 96.44% | 95.17% | 95.20% | 89.92% | 90.69% | 90.43% | 90.31% | 91.19% | 90.43% | ↓ |

| Organsation | Standard | Most Recent 12 Months Performance - Two Week Wait - Breast Symptoms | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 93% | 93.69% | 97.59% | 96.94% | 96.15% | 63.11% | 74.42% | 75.00% | 89.43% | 95.31% | 92.31% | 95.51% | 69.23% | ↓ |
| NUH | | 91.11% | 97.01% | 98.63% | 96.81% | 45.71% | 68.49% | 71.95% | 90.63% | 96.67% | 94.81% | 93.59% | 10.53% | ↓ |
| SFH | | 100% | 100% | 97.50% | 100% | 100% | 100% | 77.27% | 92.86% | 100% | 92.59% | 94.12% | 94.44% | ↑ |

## Root Cause

**NUH**

- November performance falls to 73.6%.
- Referral rates continue to be 20% higher than pre covid levels and capacity and staffing issues continue to be the biggest concern.
- Breast demand has increased following high profile /celebrity breast cancer diagnosis (Sarah Harding and Julia Bradbury)
- Breast is having the greatest impact on performance and is currently at 13% due to their surge in demand and capacity limitations. Breast report a Surge /dip referral pattern, but are unable to recover performance from the surge.
- Gynae, LGI and Urology also struggling with performance levels

**SFH**

- Number of referrals in November 21 were 26% higher than in the same month in 2020.
- The increase in referrals is not spread equally across specialties. Head & Neck have seen a 55% increase, gynaecology 36%, lower gastrointestinal 31%, urology 28%.

## Mitigating Actions

**NUH**

- Discussions continue with Primary Care regarding the importance of 2WW referrals following face to face consultation wherever possible. Some specific tumour site 'education sessions' for referrals have been delivered - e.g. Lung and Head and Neck.

- Breast – 2ww performance is poor, but the service continue to achieve the Faster Diagnosis Standard and are currently performing at 97% against the 75% national standard.

**SFH**

- Work underway with the CCG and primary care to improve the appropriateness and completeness of LGI referrals.

## 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.

## Gaps in Assurance

**NUH**

- Increase in referrals has impacted 2ww performance. Referral numbers have remained significantly over 19/20 levels since March 21
- Outpatient capacity is becoming increasingly impacted by 2ww referral increases, as follow-up slots have been utilised in some areas to increase 2ww capacity.
- Increasing levels of Covid infection has increased the number of staff being off sick and /or self-isolating.

**SFH**

- Level and duration of increased referral demand is unknown. Referral numbers have remained significantly over 19/20 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 |

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

| Organsation | Standard | Most Recent 12 Months Performance - Twenty Eight Day FDS | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 70% | 79.87% | 74.68% | 83.44% | 83.83% | 79.25% | 79.11% | 81.00% | 76.79% | 78.46% | 76.89% | 80.12% | 77.93% | ↓ |
| NUH | | | | | | 79.67% | 79.03% | 81.36% | 78.72% | 81.80% | 80.81% | 82.29% | 80.42% | ↓ |
| SFH | | | | | | 78.25% | 80.26% | 80.16% | 75.89% | 74.58% | 73.69% | 78.24% | 75.51% | ↓ |

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

This standard is designed to:

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

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

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

The performance level for the Nottingham and Nottinghamshire CCG was 77.93% in November 2021, which is above the national standard of 75%. Performance within the twelve months prior was above the national standard in all months. In four of those months, performance was above 80%.

**Mitigating Actions**
The COVID 19 Pandemic has impacted capacity for diagnostic procedures, largely due to the increase in infection control requirements.

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

SFH are reviewing the 2WW capacity as part of the work taking place around service restoration and recovery. All tumour sites are operating with a mix of face to face, non face to face appointments and triage straight to test where appropriate.

**Assurances**
Beginning to collect the data prior to the establishment of the standard has enabled a more granular understanding to be reached around the key areas for improvement at local providers which include the level of Outpatient and Diagnostic capacity as well as timely methods of communication.

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

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

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

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

| Organsation | Standard | Most Recent 12 Months Performance - 31 Day | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 96% | 91.39% | 87.96% | 93.01% | 92.66% | 91.72% | 92.23% | 87.19% | 90.25% | 91.63% | 90.34% | 89.94% | 89.32% | ↓ |
| NUH | | 90.69% | 86.58% | 91.40% | 91.13% | 90.09% | 90.34% | 86.31% | 89.90% | 89.69% | 89.46% | 90.27% | 88.39% | ↓ |
| SFH | | 95.79% | 89.74% | 99.00% | 96.97% | 95.88% | 97.73% | 91.91% | 92.70% | 95.76% | 91.94% | 91.89% | 91.49% | ↓ |

**Root Cause**

**NUH**

- Day 31 performance has fallen slightly to 88.4%.
- The key reasons for breaches are surgical and HDU capacity and clinical priority - particularly impacting Urology, Gynae, and LGI.
- Increases in referral rates continue to impact on 31-day performance

**SFH**

- There were 12 breaches for 141 treatments in November.
- Breaches were across skin (7), lower gastrointestinal (2), Breast (1) gynaecology (1) and head & neck(1).
- High referral levels, 20% above pre-Covid 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.
- Scale of further winter pressures unknown
- 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.

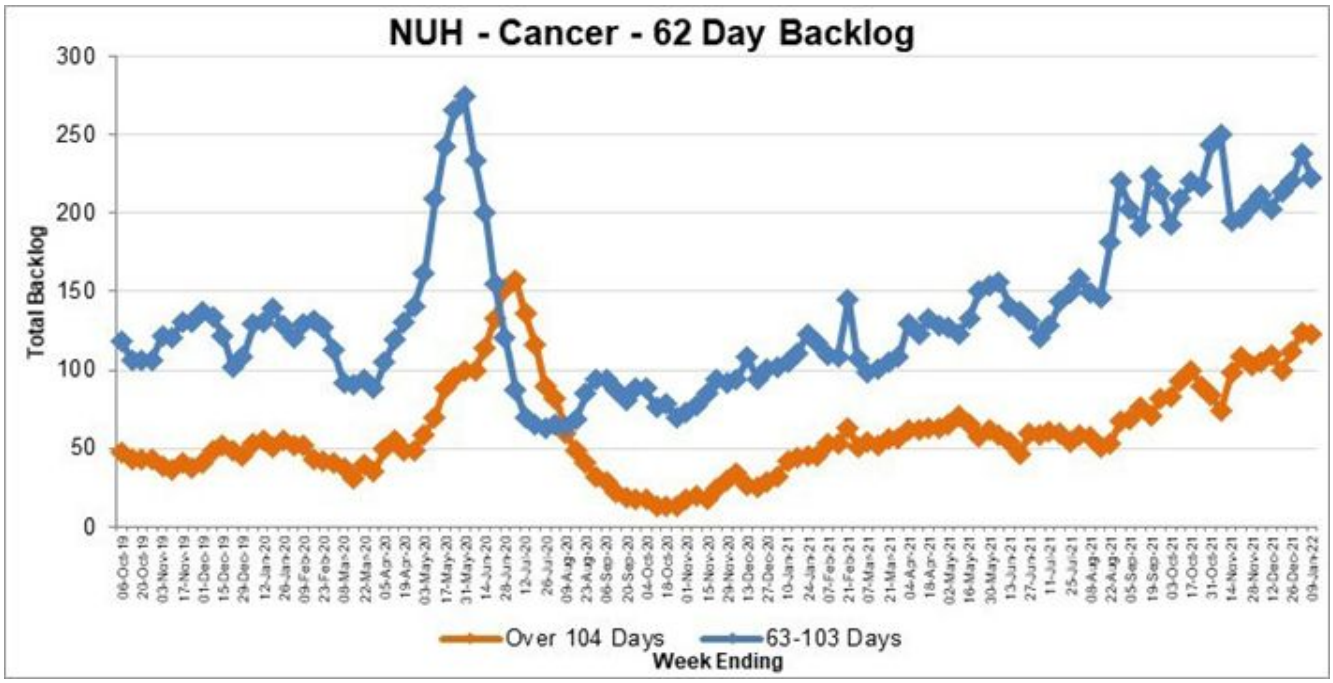
**SFH**

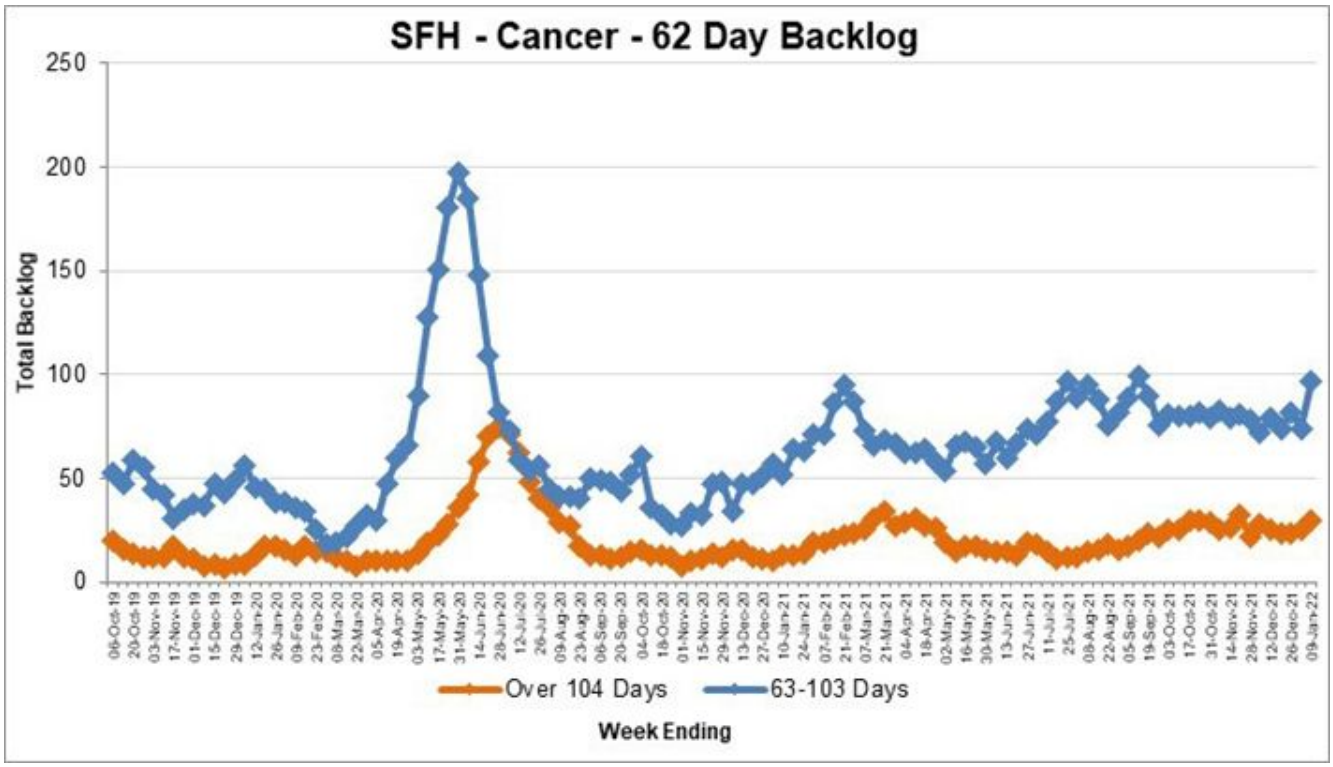
- Future referral levels, magnitude of winter pressures and staff absences are unknown.

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

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organsation | Standard | Most Recent 12 Months Performance - 62 Day | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 85% | 75.73% | 68.15% | 71.50% | 73.26% | 79.10% | 74.66% | 70.90% | 65.85% | 67.32% | 67.10% | 67.73% | 63.73% | ↓ |
| NUH | | 76.22% | 71.43% | 67.51% | 73.83% | 75.12% | 71.18% | 70.16% | 68.09% | 65.56% | 69.31% | 65.97% | 63.09% | ↓ |
| SFH | | 69.57% | 63.16% | 72.79% | 68.75% | 73.61% | 71.13% | 72.73% | 68.95% | 69.27% | 62.29% | 62.83% | 62.56% | ↓ |



## Nottingham University Hospitals Performance Focus

Nottingham and Nottinghamshire Clinical Commissioning Group

**Root Cause**
**September Performance**

- Nov 62 day performance has reduced to 63%
- Almost all specialties are struggling to achieve the 85% target with Gynae, LGI and UGI having the lowest performance.
- Treatment numbers remain high at 206
- Total breaches have increased to 84, with the highest numbers continuing to be in:- Urology 21.5, Gynae 13, LGI 11.5 and Lung 11.5.
- Access to HDU beds, theatre capacity and staffing continue to be major issues. At the begin of November, there were 60 cancer or suspected cancer patients waiting for an HDU bed.
- Staff isolation numbers or off sick due to COVID are high
- Staffing challenges have also created significant delays in chemotherapy, histology, oncology, radiology reporting and provision of specialty outpatient capacity.
- Day 104 patients - Numbers again have also increased to 106.
- 62-day backlog is currently 331 with 119 confirmed cancers (14.12.21) This has remained relatively stable for the past 2 wks.

**Mitigating Actions**

- 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.
- 62-day backlog - All specialties have produced an action plan and trajectory for improvement.
- RDC funding to improve diagnostic capacity has been agreed for 21/22 and business case being developed for 22/23.
- Gynae performance should improve significantly with the development of their RDC pathway which should be implemented in Q4.
- IS - HDU beds are being utilised at The Park and Spire Hospital – only approx. 25% of the capacity previously had at height of covid.

**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.
- Scale of winter pressures unknown.
- 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.

## Sherwood Forest Hospitals Performance Focus

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

**Root Cause**

- Year to date referrals are 20% above the 19/20 average (average is currently 1490 per month compared to 1270)
- Referral increase impact on diagnostic capacity such as CT colon; compounded by a high volume of DNA/patient cancellations.
- Other diagnostic and treatment delays provided by the tertiary centre including EFGR in Lung, PET scans, surgical dates and oncology.

**Mitigating Actions**

- New LGI cancer support worker (CSW) triage role in place allowing nurses to focus on assessing patients and arranging appropriate onward diagnostic tests.
- Increasing CTC list capacity by 1 patient per list (14%) by utilising imaging assistants for cannulation and preparation.
- Temporary mutual aid CTC capacity underway with NUH creating appointments for up to 30 SFH patients (7 days of capacity at SFH).
- Radiology trialling reduced prep to support better backfill for short notice cancellations.
- Increase outpatient/triage capacity in Head and Neck, gynae and urology to help manage demand, aiding one stop testing where possible.

**Assurances**

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

**Gaps in Assurances**

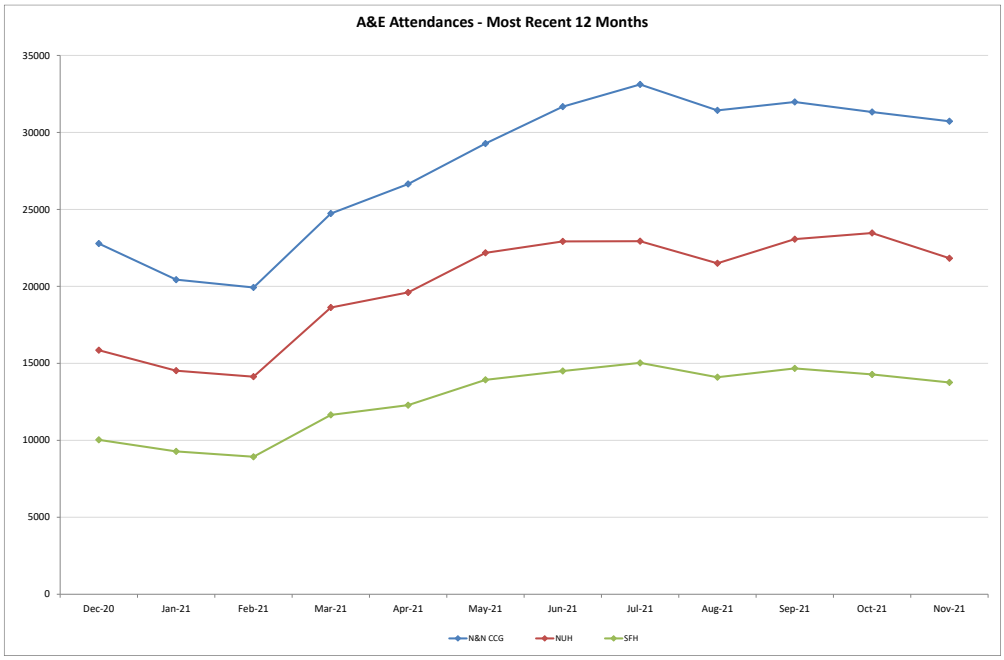
- Number of 2ww referrals are consistently above pre-pandemic levels.
- Impact of winter pressures and staff absence unknown.
- Number of patients waiting over 62 days for treatment continues to grow

| 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 |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

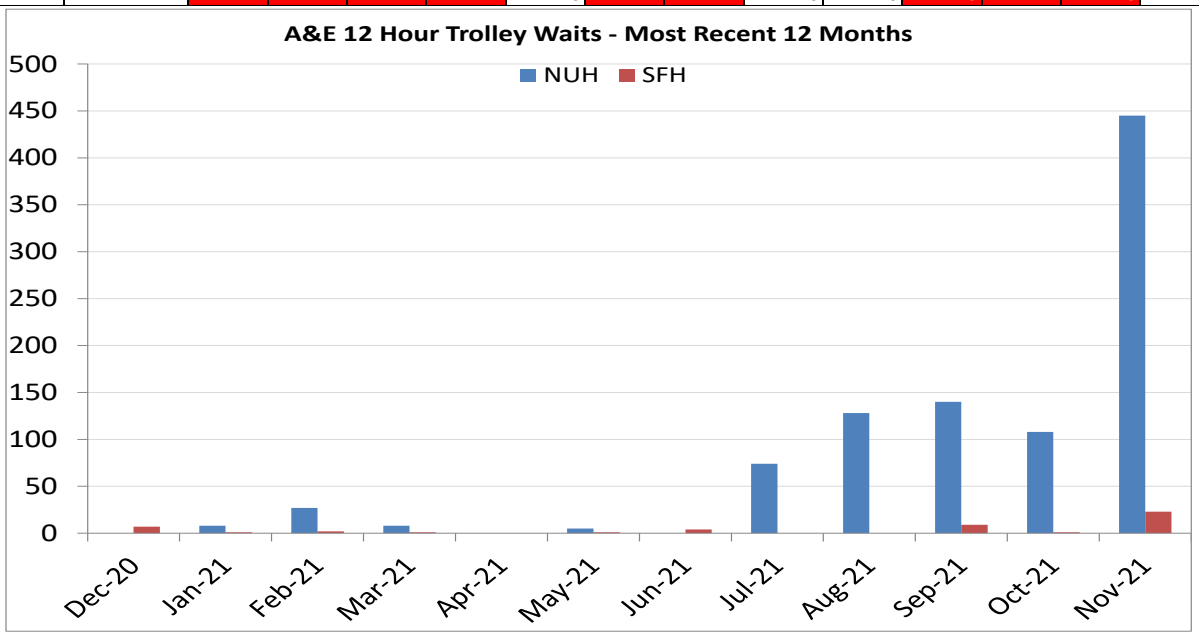
| Organsation | Standard | Most Recent 12 Months Performance | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 95% | 75.71% | 73.01% | 76.64% | 76.04% | 76.30% | 73.27% | 72.23% | 70.14% | 68.70% | 65.41% | 63.75% | 66.19% | ↑ |
| NUH | | Reporting suspended due to trial of new indicators | | | | | | | | | | | | ⇔ |
| SFH | | 89.88% | 85.41% | 92.26% | 94.11% | 93.77% | 91.75% | 88.84% | 86.34% | 86.61% | 82.42% | 82.74% | 84.01% | ↑ |

| Organsation | Standard | Most Recent 12 Months - Attendances | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | N/A | 22781 | 20438 | 19930 | 24735 | 26651 | 29282 | 31676 | 33120 | 31436 | 31980 | 31328 | 30726 | N/A |
| NUH | | 15855 | 14526 | 14134 | 18627 | 19607 | 22179 | 22924 | 22938 | 21502 | 23070 | 23469 | 21831 | N/A |
| SFH | | 10031 | 9283 | 8932 | 11654 | 12284 | 13930 | 14505 | 15029 | 14099 | 14673 | 14279 | 13761 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| 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 | | 0 | 8 | 27 | 8 | 0 | 5 | 0 | 74 | 128 | 140 | 108 | 445 | ↓ |
| SFH | | 7 | 1 | 2 | 1 | 0 | 1 | 4 | 0 | 0 | 9 | 1 | 23 | ↓ |



**Root Cause**

Key Bullet Points:

1. Additional interim beds have been commissioned by health and both Local Authorities to increase the capacity to discharge from the Acute Trusts and D2A beds. Yet the challenge to ensure these patients are discharged home at the earliest opportunity is significant. A bed tracker is in place and is reliant on organisations completing this to ensure system oversight.
2. Significant pressures sourcing homecare packages and challenges around pathway 1 and pathway 0.
3. Additional support for ward staff to utilise volunteer and community support, as well as family and friends support to promote pathway 0 where safe and appropriate to do so.
4. Significant social worker pressures, with increasing number of people waiting allocation across the system
5. which further impacts on the ability to move patients to onward placements, balanced with supporting hospital avoidance and safeguarding requirements.
6. MADE events to be organised to identify greater system oversight of issues and identify key areas of challenge and opportunity. This will identify pathways and service gaps to improve the patient journey, in particular those more complex with a higher acuity.

Headline Data:

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| Performance Indicator - Nottingham University Hospital | Performance Metric | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|
| ED Attendance NUH (Type 1 only) | Daily Average | 537 | 525 | 494 | 542 | 534 | |
| London Road UTC Attendances | Daily Average | 165 | 157 | 149 | 175 | 162 | |
| Referrals from NUH to UTC | Month Total | 253 | 333 | 276 | 137 | 149 | 79 |
| Streaming to NEMS Primary Care | Month Total | 1209 | 1423 | 1538 | 1365 | 1910 | 1930 |

| Performance Indicator - Kings Mill Hospital | Performance Metric | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|
| ED Attendance KMH (Type 1 only) | Daily Average | 323 | 325 | 304 | 318 | 295 | |
| Newark UCC Attendances | Daily Average | 69 | 75 | 68 | 77 | 71 | |
| PC24 AE Attendances | Daily Average | 81 | 91 | 85 | 86 | 95 | 93 |
| PC24 as a % of ED attends | Month Performance | 21.10% | 22.00% | 20.70% | 22% | 23% | 24.10% |

Pre-Hospital & Front Door

Primary Care

General practice continued to deliver services during core hours over the Christmas / New Year period on all days except weekends and bank holidays.

The challenge experienced over this period was similar to all providers, managing staff absence due to COVID sickness and isolation, other sickness and other leave which peaked for general practice between the two bank holiday weekends. Practices continue to deliver COVID Vaccinations, including house bound and care homes with some delivering on the bank holidays too.

Whilst nationally there has been permission to relax some routine and non-essential work, this has not been entirely stood down by practices across Nottingham and Nottinghamshire. Our practices have continued to work through some of the backlogs of long-term condition work and reviews. Practices have flexed routine and urgent appointments to meet patient demand, with extended hours/access being used in a similar manner to respond to patient need. There will be variation in how this has been flexed across practices as the focus has been on meeting the needs of populations. Patient demand has been higher this winter than in previous years.

Many practices have utilised additional locum sessions utilising Winter Access Fund support, but this has been offset by staff absence.

OPEL reporting for general practice suggests staff absence levels experienced over this period and into the first week of Jan has started to plateau. Practices are continuing to manage challenges on the whole, although some individual practices are facing significant issues requiring consideration of business continuity options within their PCN/Locality

Note: Data for primary care remains a month behind

*Table 1 – Primary Care activity for 6 months up to November 2021*

| Performance Indicator | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|
| % of Same Day Appointments | 44% | 44% | 46% | 42% | 39% | 41% |
| Number of Same Day Appointments Booked | 231,702 | 216,590 | 206,755 | 229,897 | 223,063 | 236,250 |
| Total Number of Appointments Booked | 522,336 | 492,711 | 454,315 | 548,322 | 577,747 | 581,070 |

**NHS111**

*Table 2 – Direct bookings into Primary Care over 6 months up to October 2021*

| Performance Indicator | Jun-21 | Jul – 21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|
| Total Direct Bookings into Primary Care from 111 | 2352 | 2358 | 2183 | 2474 | 2509 | 2323 |
| NHS111 dispositions recommended for ED diverted by the Clinical Advisory Service | 68% | 71% | 68% | 71% | 69% | 71 |

**EMAS**

Both the pre and post-handover performance at both trusts remains below the national target.

*Table 3 – EMAS Performance standard monthly comparison*

| Workstream | Performance Indicator | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|
| Urgent Care | Urgent Care - 111 First | | | | | | |
| | Average Pre Handover NUH | 00:17:09 | 00:19:16 | 00:19:53 | 00:19:51 | 00:20:53 | 00:18:39 |
| | Average Post Handover NUH | 00:19:32 | 00:18:37 | 00:19:27 | 00:18:55 | 00:18:51 | 00:19:56 |
| | Average Pre Handover KMH | 00:16:03 | 00:15:54 | 00:16:47 | 00:17:34 | 00:17:06 | 00:20:56 |
| | Average Post Handover KMH | 00:20:37 | 00:20:09 | 00:20:44 | 00:20:07 | 00:20:04 | 00:36:44 |

**Handover Delays > than 30 minutes:**

Overall, Nottingham continues to perform well against Regional colleagues, with lower numbers of handover delays. HALOs have been on site proactively to manage any potential delays.

**Conveyance Performance**

Conveyance rates remain relatively static across both trusts with scope to improve this position.

*Table 4 – EMAS Conveyance Rate to NUH and SFH - 6 monthly comparisons*

| Performance Indicator | Performance Metric | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|
| Conveyance Rate to NUH for GN incidents | Monthly % | 56.70% | 53.20% | 55.90% | 55.20% | 56.60% | 54.40% |
| Conveyance Rate to SFH for MN Incidents | Monthly % | 60.00% | 59.00% | 57.50% | 58.40% | 61.80% | 59.70% |

**ED ACTIVITY**

12 hour breaches remain a challenge. Delays continue to be around medicine, HCOP and mental health.

<u>12 hour breaches</u>

| NUH | SFH |
|---|---|
| November = 445 | November = 23 |
| December = 363 | December = 57 |
| Decrease of 18.4% | Increase of 147% |

Themes have included capacity issues in the main. RCAs have not been received at the time of writing to identify details or themes.

**ACUTE TRUST FLOW**

<u>Same day Emergency Care (SDEC) Performance</u>

SDEC as a percentage of admissions continues to be well over target for both trusts. 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 5 – SDEC performance over 6 months up to October 2021*

| Performance Indicator | Target | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|---|
| % of admissions classed as SDEC - NUH | 30% | 36.00% | 34% | 35% | 37.3 | 34.6 | 34.7 |
| % of admissions classed as SDEC – SFH | 30% | 39.00% | 39% | 39% | 41.5 | 41.1 | 39.8 |

Admissions

Overall attendances and admissions have remained static over the last 4 months.

**NUH**

*Table 6 – NUH ED Attendance to Admissions over 6 months up to October 2021*

| Performance Indicator | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|
| ED Attendance to Admission | 29.90% | 30.00% | 29.70% | 27.40% | 27.50% | 27% |
| Admissions from ED | 168 | 162 | 153 | 153 | 153 | 143 |
| Total Admissions | 329 | 318 | 228 | 309 | 292 | 301 |
| Care Homes Admissions | 237 | 217 | 183 | 171 | 213 | 132 |

**SFH**

*Table 7 – SFHFT ED Attendance to Admissions over 6 months up to October 2021*

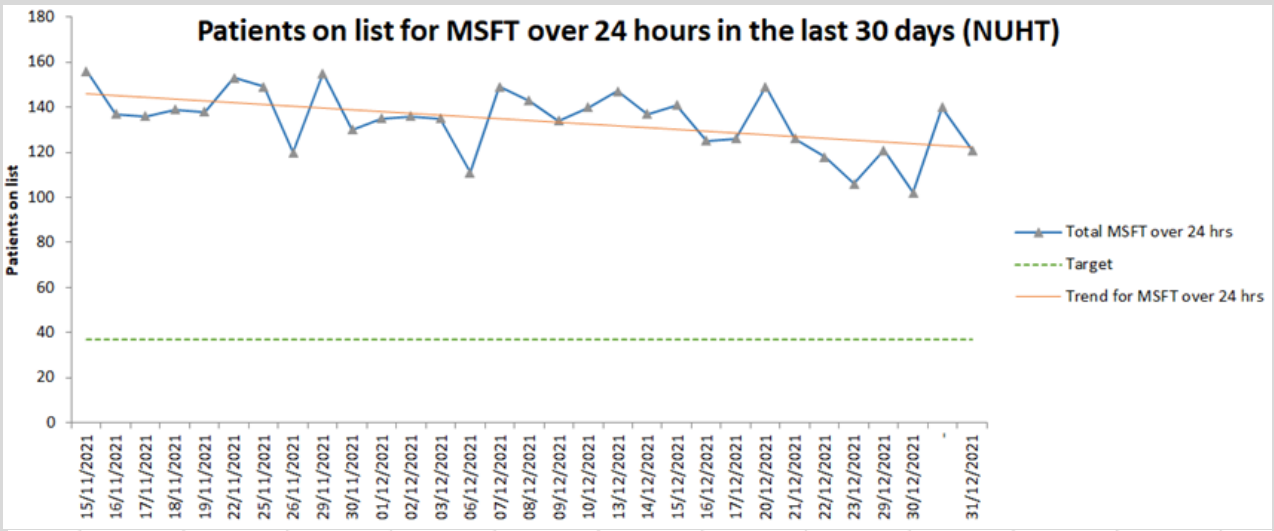
| Performance Indicator | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
|---|---|---|---|---|---|---|
| ED Attendance to Admission | 32.10% | 31.60% | 33.90% | 33.40% | 34.40% | 34.40% |
| Admissions from ED | 80 | 78 | 77 | 80 | 77 | 76 |
| Total Admissions | 94 | 94 | 86 | 88 | 84 | 85 |
| Care Homes Admissions | 159 | 192 | 182 | 174 | 166 | 162 |

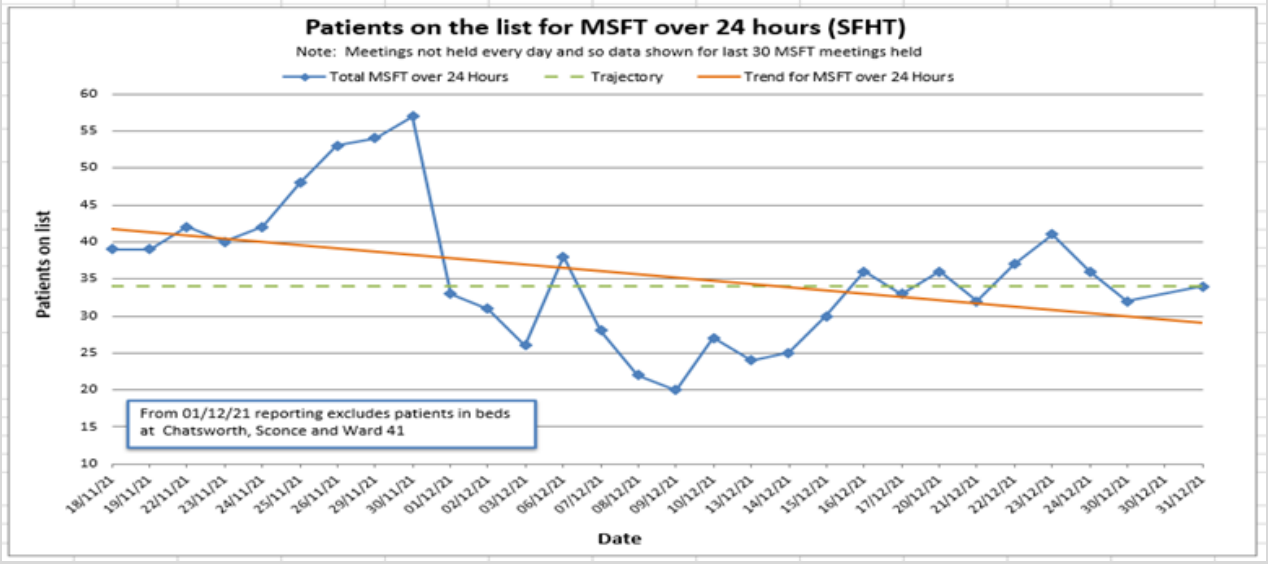
**Discharges and System Flow**

**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. This challenge is further impacted by the collapse of the homecare market and the increasing dependency and acuity of patients requiring supported care.

Graphs dated 31.12.2021



**Interim Care Home & Home Care Capacity**

Interim Care Home Placements:
A huge amount of work has been ongoing to identify interim care home placements across the system for patients who are waiting for a package of care and are delayed in any bedded facility.

**SFH:** Have identified an additional 52 beds have been sourced across Ward 41, Chatsworth and Lindhurst.
**County LA:** Commissioned 33 beds across Maun View, Sycamores & Poplars, Lawn Park, Braywood Gardens, Coppice Lodge and Charnward House.
**City LA:** Additional 10 across Winterfell, Connect and Kingfisher Court as well as spot purchasing across all City care homes.
**CityCare:** 20 beds at Wilford View
**System Wide:** Additional 54 beds across The Grand (18), and Rusticus (36) plus COVID positive capacity being sourced at Park House (Garden View) (14 beds)

- Total core and interim bed capacity = 441

Flow into the beds remains challenging due to outbreaks of COVID, the number of patients with COVID and who are COVID contacts making placement difficult. Lings Bar Hospital is configuring the beds to allow for COVID positive placements, along with Clifton View. This will support greater movement of COVID positive pathway 2 and 3 patients from the Acute Trusts.

**Home Care**

Sciensus has increased its daily capacity to 70 hours per week.
British Red Cross and Turvida continue to further support additional hours and packages of care
These additional contracts are expensive as reliant of utilisation of agency staff to provide the capacity.

- **IPC closures**

There are 117 care homes closed to new admissions due to COVID across the ICS footprint.
D2A beds are closed across Clifton View, Wilford View, Connect House, Wollaton View and 1 ward at Lings Bar. This is impacting on flow, but also a recognised national picture. Over the Christmas and New Year 2 weeks, there was a delay with PCR results impacting on staff sickness figures and care home closures. This was escalated and additional resources have been put in place to manage the backlog. For D2A capacity, additional near testing has been implemented if results are not back w/c 10.1.22.
COVID positive isolation remain at 14 days isolation, but it is anticipated there will be an update from SAGE soon to reduce the isolation period recommendations.

- **Transport**

ERS have supported additional transport requests to include the interim placements, as well as juggle the demands for outpatients. There have been issues with transport and transfers for patients where access to property has been a challenge, and the movement of bariatric patients. ERS and the CCG urgent care team are reviewing the concerns as they are raised.

**Gaps in Assurance:**
**MSFT Gaps**
The MSFT lists at NUH are currently considerably above target as a result of poor discharge flow in the wider system, this in turn is increasing the pressure on acute beds with the potential for increased ED delays for patients needing a bed as well as cancelled elective operations. Despite numbers being above target, there continues to be daily progress reducing the MSFT waiting lists.

Whilst plans are in place for mitigations to the projected bed gap more needs to be done, especially in pathway 1 homecare capacity to increase flow and reduce the pressure on the systems acute bedded capacity.

Mitigating actions linked to MSFT winter challenges are needed to develop inclusive comprehensive plans that cater for people with learning disabilities and mental health needs who may face long stays in assessment and treatment units. The transfer of patients with learning disabilities and mental health needs to appropriate placements should be a smooth rapid process.

**System Staffing Capacity**
Staffing challenges across the system are affecting the levels of service delivery. All system providers as well as homecare services are carrying vacancies that impact on capacity to meet demand. Despite efforts to recruit into vacancies, there has been little success to attract suitable candidates and this reflects the national picture.

Challenges resulting from staffing issues include social care unallocated packages of care, healthcare community teams not being able to operate at full capacity and care homes being unable rapidly to absorb patients on pathway 2 or 3. This in turn is impacting on patient flow through the system.

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

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| Organsation | Standard | Most Recent 12 Months Performance - Patients Entering Treatment (Rolling Three Months) | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | |
| N&N CCG | Rolling Three Months Performance | 4.18% | 4.82% | 5.45% | 5.15% | 5.48% | 5.84% | 6.45% | 6.59% | 6.38% | 5.97% | 5.90% | 5.95% | ↑ |
| | Standard | 6.10% | 6.10% | 6.25% | 6.25% | 6.25% | 7306 | 7306 | 7306 | 7490 | 7490 | 7490 | 7675 | N/A |
| | Patients Entering Treatment | 4580 | 5285 | 5970 | 5645 | 6005 | 6405 | 7070 | 7225 | 6990 | 6550 | 6470 | 6525 | ↑ |
| | Additional Patients Required | 2107 | 1402 | 882 | 1207 | 847 | 901 | 236 | 81 | 500 | 940 | 1020 | 1150 | ↓ |

| Organsation | Standard | Most Recent 12 Months Performance - Recovery Rate (Rolling Three Months) | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | |
| N&N CCG | Greater than or equal to 50% | 55.59% | 55.24% | 54.66% | 54.25% | 53.30% | 53.39% | 52.86% | 52.78% | 52.37% | 51.64% | 51.06% | 50.05% | ↓ |

| Organsation | Standard | Most Recent 12 Months Performance - Waiting Times - First Treatment Within 6 Weeks | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | |
| N&N CCG | Greater than or equal to 75% | 97.50% | 97.39% | 98.15% | 97.05% | 96.68% | 96.80% | 96.93% | 95.07% | 95.11% | 94.10% | 93.08% | 93.97% | ↑ |

| Organsation | Standard | Most Recent 12 Months Performance - Waiting Times - First Treatment Within 18 Weeks | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | |
| N&N CCG | Greater than or equal to 95% | 100% | 99.63% | 99.63% | 99.58% | 100% | 99.29% | 100% | 100% | 100% | 100% | 99.71% | 100% | ↑ |

| Organsation | Standard | IAPT waits >90 days between 1st & 2nd treatment | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | |
| N&N CCG | Less than 10% | 2.33% | 2.90% | 4.14% | 7.41% | 9.89% | 8.83% | 7.65% | 13.12% | 9.59% | 9.06% | 7.85% | 7.36% | ↑ |

| | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Referrals | 2785 | 2270 | 2690 | 2785 | 3290 | 2780 | 3120 | 3070 | 2970 | 2925 | 3270 | 3270 |
| Number entering treatment | 2165 | 1860 | 1945 | 1840 | 2220 | 2345 | 2505 | 2375 | 2110 | 2065 | 2295 | 2165 |
| Rolling 3 month treated | 6290 | 6105 | 5970 | 5645 | 6005 | 6405 | 7070 | 7225 | 6990 | 6550 | 6470 | 6525 |

**Root Cause**
ICS 3-month rolling access performance at October 2021 has increased to 6525 patients against the increased target of 7675 patients; this reflects usual increases after seasonal trends during summer months. Benchmarking shows that only one system in the Midlands region is achieving the access target at September 2021.

The service continues to achieve and exceed waiting time and recovery standards. The average wait for an appointment in December 2021 was 19 days. The downward recovery trend reflects trends seen in other areas and relates to a reported increase in complexity of presentations. However, in October 2021 69% of patients showed reliable improvement upon completing treatment. Waiting time and recovery performance for the ICS is above the regional and national averages at September 2021.

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**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 recruitment of community engagement workers (due to commence in post in January 2022), 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 NHSE and HEE.
- The 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, drop- in support sessions and a Delivered Practice Programme for staff with lower recovery rates.

**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 |

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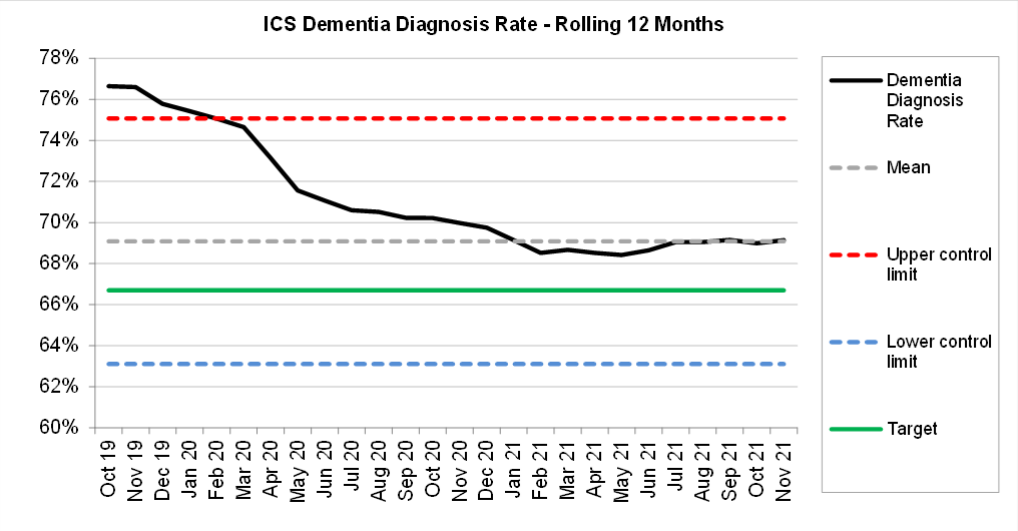
| Organsation | Standard | Most Recent 12 Months Performance - Dementia Diagnosis Rate | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Greater than or equal to 66.7% | 69.75% | 69.14% | 68.52% | 68.67% | 68.52% | 68.42% | 68.65% | 69.05% | 69.05% | 69.15% | 68.99% | 69.14% | ↑ |




| Organsation | Metric | Most Recent 12 Months - Dementia Diagnosis & Prevalence | | | | | | | | | | | | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | |
| N&N CCG | Patients Diagnosed | 8420 | 8316 | 8217 | 8247 | 8245 | 8263 | 8309 | 8367 | 8385 | 8412 | 8400 | 8426 | ↑ |
| | Estimated Prevalence | 12072 | 12028 | 11992 | 12009 | 12033 | 12076 | 12103 | 12117 | 12143 | 12165 | 12176 | 12186 | ↑ |

**Average waiting time from Referral to Assessment**

| | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MHSOP MAS - City | 12.3 | 12.2 | 10.0 | 8.6 | 8.1 | 6.6 | 4.4 | 4.3 | 4.9 | 4.7 | 5.0 | 4.6 |
| MHSOP MAS - Ashfield & Mansfield | 10.8 | 9.5 | 10.4 | 11.3 | 9.6 | 3.4 | 1.5 | 2.0 | 2.4 | 2.6 | 3.1 | 1.8 |
| MHSOP MAS - Broxtowe | 6.2 | 7.8 | 7.4 | 7.8 | 7.4 | 8.5 | 8.4 | 6.8 | 8.1 | 9.0 | 9.4 | 9.2 |
| MHSOP MAS - Gedling & Hucknall | 7.9 | 4.7 | 3.8 | 3.5 | 4.0 | 5.1 | 4.5 | 5.8 | 5.9 | 7.0 | 8.3 | 8.5 |
| MHSOP MAS - Newark & Sherwood | 9.9 | 8.0 | 8.5 | 8.1 | 6.6 | 5.6 | 5.8 | 5.1 | 6.4 | 5.5 | 5.9 | 5.4 |
| MHSOP MAS - Rushcliffe | 6.4 | 5.1 | 3.7 | 2.0 | 3.2 | 4.7 | 3.8 | 3.9 | 3.8 | 5.0 | 5.4 | 4.7 |
| **N&N CCG** | **10.2** | **9.8** | **8.7** | **7.8** | **6.9** | **6.0** | **5.1** | **5.0** | **5.6** | **5.9** | **6.5** | **6.0** |

**Patients Waiting for Assessment**

| | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MHSOP MAS - City | 242 | 242 | 210 | 178 | 150 | 114 | 105 | 87 | 95 | 105 | 111 | 119 |
| MHSOP MAS - Ashfield & Mansfield | 79 | 77 | 74 | 72 | 46 | 25 | 21 | 26 | 38 | 41 | 40 | 35 |
| MHSOP MAS - Broxtowe | 74 | 57 | 54 | 65 | 58 | 51 | 62 | 64 | 73 | 70 | 66 | 57 |
| MHSOP MAS - Gedling & Hucknall | 42 | 33 | 40 | 53 | 54 | 53 | 68 | 83 | 97 | 107 | 119 | 108 |
| MHSOP MAS - Newark & Sherwood | 116 | 94 | 77 | 75 | 70 | 78 | 73 | 72 | 85 | 82 | 82 | 78 |
| MHSOP MAS - Rushcliffe | 36 | 27 | 19 | 29 | 46 | 37 | 42 | 48 | 51 | 60 | 59 | 61 |
| **N&N CCG** | **589** | **530** | **474** | **472** | **424** | **358** | **371** | **380** | **439** | **466** | **481** | **459** |

**Root Cause**
The ICS continues to meet the dementia diagnosis rate standard.

The number of people being diagnosed with dementia has increased since February 2021, though this has only resulted in a slight percentage increase in the diagnosis rate as the estimated prevalence is also increasing.

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 slightly since September 2021. December's data shows a slight improvement in waiting time.

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**Mitigating Actions**
As waiting times have now reduced in the areas with the longest waits historically (Gedling, Newark and Rushcliffe), the focus is to bring other areas in line with the lower waiting times that have been achieved, whilst maintaining the lower waits across the system.

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

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

A waiting time recovery trajectory was agreed to ensure the historical backlog will be cleared and to monitor the 8-week waiting time to diagnosis target; This is now captured 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

**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 this will be reported from next month.

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

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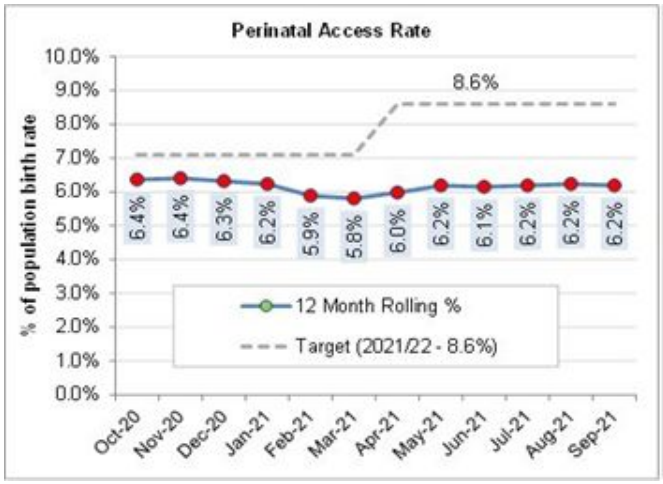
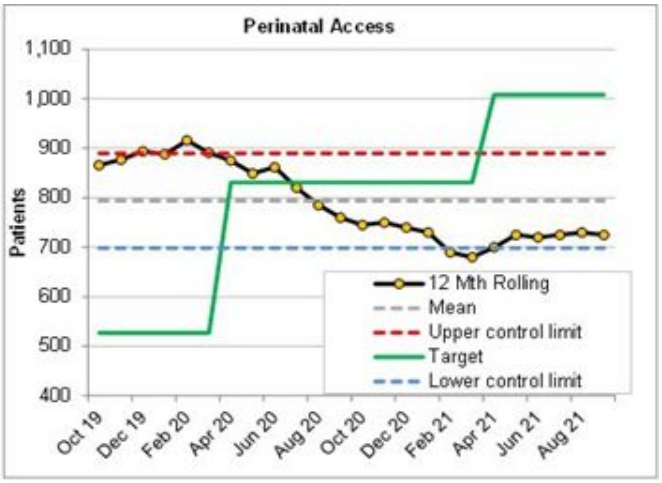
| Organsation | Measure | Most Recent Rolling 12 Months Performance - Perinatal Mental Health | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | |
| N&N CCG | % of Population Birthrate | 6.4% | 6.4% | 6.3% | 6.2% | 5.9% | 5.8% | 6.0% | 6.2% | 6.1% | 6.2% | 6.2% | 6.2% | → |
| | Patients | 745 | 750 | 740 | 730 | 690 | 680 | 700 | 725 | 720 | 725 | 730 | 725 | ↓ |
| | Standard | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 8.6% | 8.6% | 8.6% | 8.6% | 8.6% | 8.6% | N/A |




| Organisation | Most Recent Rolling 12 Months Performance - Perinatal Mental Health | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 |
| Mid Notts ICP | 6.05% | 5.47% | 5.13% | 4.82% | 5.13% | 5.47% | 5.30% | 5.50% | 5.87% | 5.82% | 6.07% | 6.30% |
| Nottingham City ICP | 6.17% | 6.05% | 5.66% | 5.56% | 5.63% | 5.77% | 5.96% | 5.84% | 5.89% | 6.07% | 5.91% | 5.91% |
| South Notts ICP | 6.61% | 6.56% | 6.23% | 6.43% | 6.41% | 6.69% | 6.28% | 6.35% | 6.38% | 6.48% | 6.61% | 7.12% |
| ICS | 6.31% | 6.08% | 5.72% | 5.66% | 5.78% | 6.02% | 5.89% | 5.93% | 6.07% | 6.16% | 6.23% | 6.46% |

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 September 2021 has been maintained at 6.2% and remains below the standard of 8.6%. National October data is delayed until the end of the month. Local data for November demonstrates there has been an improvement in performance with 756 patients seen (6.46%).

National reporting guidance specifies that only face-to-face and video conferencing contacts contribute to access performance. This has resulted in a decline in reportable performance since July 2020, in line with other areas regionally and nationally. 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 7.33% access rate.

**Mitigating Actions**
Face-to-face contacts are showing signs of increasing, with telephone contacts reducing. This is expected to support improved performance, though will not be reflected immediately as the standard is based on a 12-month rolling average.

Investment 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; most of the additional roles are now in place. The service

**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 |

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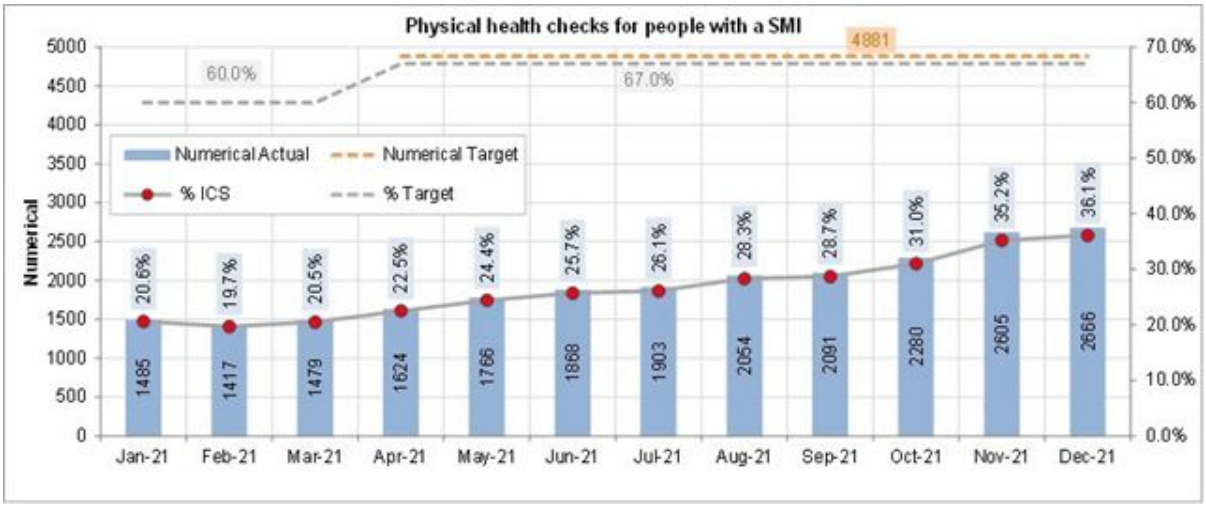
| N&N CCG | Standard | Most Recent 12 Months Performance - Physical Health Check for people with a SMI | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | |
| % Standard | 60% 2020/21<br>67% 2021/22 | 20.6% | 19.7% | 20.5% | 22.5% | 24.4% | 25.7% | 26.1% | 28.3% | 28.7% | 31.0% | 35.2% | 36.1% | ↑ |
| Numerical Standard | 4881 2020/21<br>5592 2021/22 | 1485 | 1417 | 1479 | 1624 | 1766 | 1868 | 1903 | 2054 | 2091 | 2280 | 2605 | 2666 | |




| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mid-Notts ICP | 19.6% | 17.9% | 16.7% | 17.6% | 19.8% | 22.1% | 23.4% | 25.0% | 28.7% | 29.9% | 34.3% | 38.6% | 40.3% |
| Nottm City ICP | 17.8% | 17.0% | 16.4% | 16.9% | 18.9% | 21.1% | 22.8% | 22.4% | 24.6% | 24.8% | 27.2% | 31.6% | 31.9% |
| South Notts ICP | 31.7% | 29.1% | 28.0% | 29.6% | 31.2% | 32.3% | 32.8% | 33.3% | 33.8% | 33.9% | 34.0% | 37.8% | 38.7% |
| ICS | 22.1% | 20.6% | 19.7% | 20.5% | 22.5% | 24.4% | 25.7% | 26.1% | 28.3% | 28.7% | 31.0% | 35.2% | 36.1% |
| Target | 60.0% | 60.0% | 60.0% | 60.0% | 67.0% | 67.0% | 67.0% | 67.0% | 67.0% | 67.0% | 67.0% | 67.0% | 67.0% |

**Root Cause**
The national 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 December 2021 for the tenth consecutive month with ICS performance increasing to 36.1% (2,666 checks), remaining above the regional (28.3%) and national (29.9%) averages.

Performance against the national standard declined from April 2020; this level of reduction locally is in line with the regional trend during this period and is attributable to reduced face-to-face access in primary care throughout Covid-19.

The QOF for PH SMI has been suspended/income protected for the rest of the year due to re-prioritisation of the vaccination programme. This is likely to impact on primary care capacity and prioritisation to undertake health checks in line with the Q3 and 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 a SMI.

The Audit C alcohol assessment tool is not a recognised code for the alcohol assessment QOF this year, which may impact on alcohol performance as this is the tool predominantly used in Nottingham City and South Notts PBPs. Local data which includes Audit C is to be compared against QOF performance data to understand if there is a discrepancy.

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**Mitigating Actions**

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

- Monthly monitoring of practice and PCN level data continues, identifying areas requiring additional focussed support. Performance dashboards are reviewed at GP and 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.
- 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 PH SMI 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.
- HIW posts continue to support the uptake of physical health checks for patients accessing secondary care mental health services.
- 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. Currently 81.5% of people on the SMI register have received their first vaccination dose, 76.9% have received their second vaccination, and 54.8% have received their booster.
- The lead for the vaccination support (health inequalities) and commissioners continue to explore opportunities to provide additional outreach support for the COVID and flu vaccinations, tailored to the needs of the place based SMI population. SMI only vaccination clinics are now being set up, and the roving team are also prioritising those SMI patients who are housebound.

**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 PH SMI LES will continue for the rest of the year to support primary care with the health checks.

**Gaps in Assurance**

The anticipated impact of the QOF and LES is not quantifiable, though 98% of practices have signed up to the LES. Performance against the QOF and LES is monitored on a monthly basis by the PHSMI Steering Group and practice level performance data is shared with PCNs.

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

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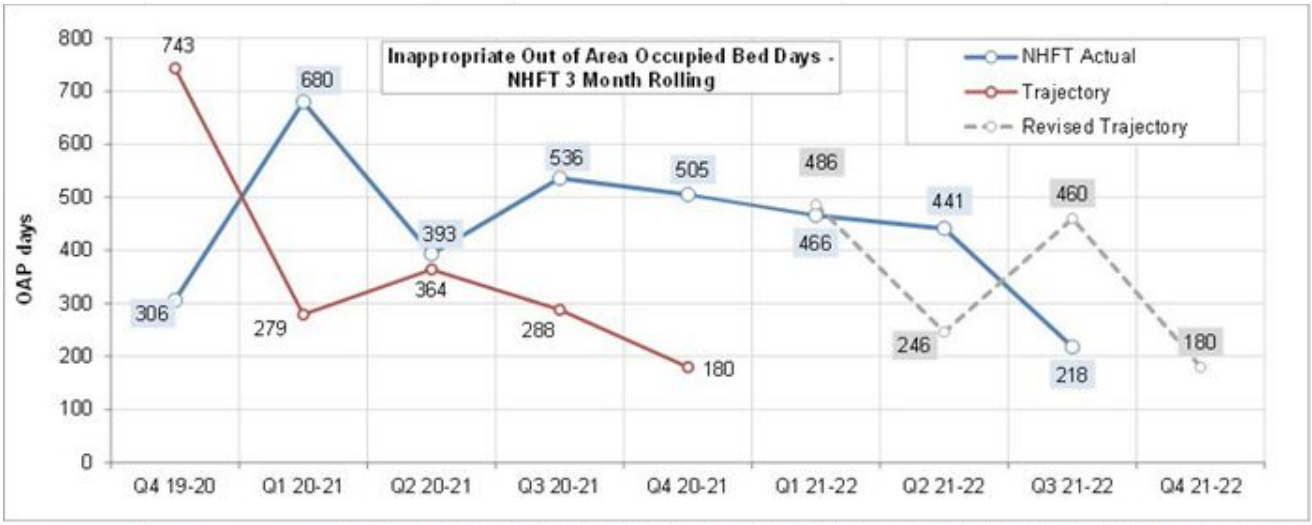
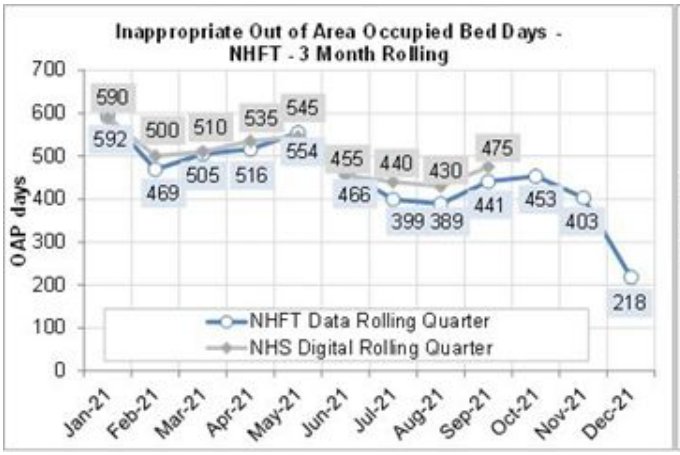
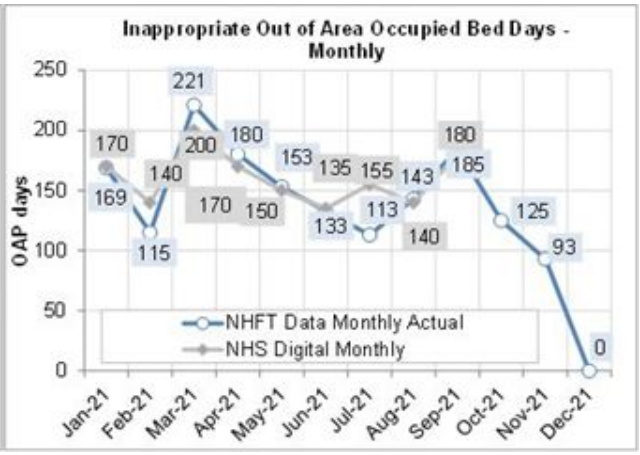
| Organsation | Measure | Monthly Performance - Inappropriate Out of Area Occupied Bed Days | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
| NHS N&N CCG | NHFT Data | 169 | 115 | 221 | 180 | 153 | 133 | 113 | 143 | 185 | 125 | 93 | 0 |
| | NHSD Data | 170 | 140 | 200 | 170 | 150 | 135 | 155 | 140 | 180 | | | |




| Organsation | Measure | Q1 2019-20 | Q2 2019-20 | Q3 2019-20 | Q4 2019-20 | Q1 2020-21 | Q2 2020-21 | Q3 2020-21 | Q4 2020-21 | Q1 2021-22 | Q2 2021-22 | Q3 2021-22 | Q4 2021-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nottinghamshire Healthcare Trust | NHFT Actual (QTR) | 2555 | 2085 | 618 | 306 | 680 | 393 | 536 | 505 | 466 | 441 | 218 | |
| | Revised Trajectory | 3432 | 2024 | 1748 | 743 | 279 | 364 | 288 | 180 | 486 | 246 | 460 | 180 |




| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult acute long length of stay (60+ days) - rolling quarter **(Target 8)** | 8 | 7.7 | 7.2 | 5.5 | 5.5 | 6.5 | 7.1 | 7.1 | 6.3 | 6.1 | 6 | 7 |
| Older adult acute long length of stay (90+ days) - rolling quarter **(Target 10.75)** | 10.6 | 9.1 | 9.1 | 8.5 | 10.6 | 12.8 | 13.8 | 12.2 | 11.7 | 10.2 | 10 | 11 |

**Root Cause**
In quarter 3 2021/22 there were 218 OBDs, against a local trajectory of 460. The number of OBDs reported in December 2021 has decreased to 0, from 93 in November 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.

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**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).
- Crisis sanctuaries commenced in quarter 4 2020/21. Since the start of the pilot (Feb 2021 to end of November 2021) there have been more than 600 attendances. The pilot is being reviewed and will inform the long-term delivery model, which will be implemented from Q2.

**Inpatients and discharge**

- Long stay patients have been reviewed to identify reasons for discharge delays and inform system actions and utilise discharge funding.
- 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 will start in January 2022 and will be completed within 4 months. The review will propose options for inpatient and community services.
- Discharge2Assess beds have been commissioned since November 2021.
- 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 |

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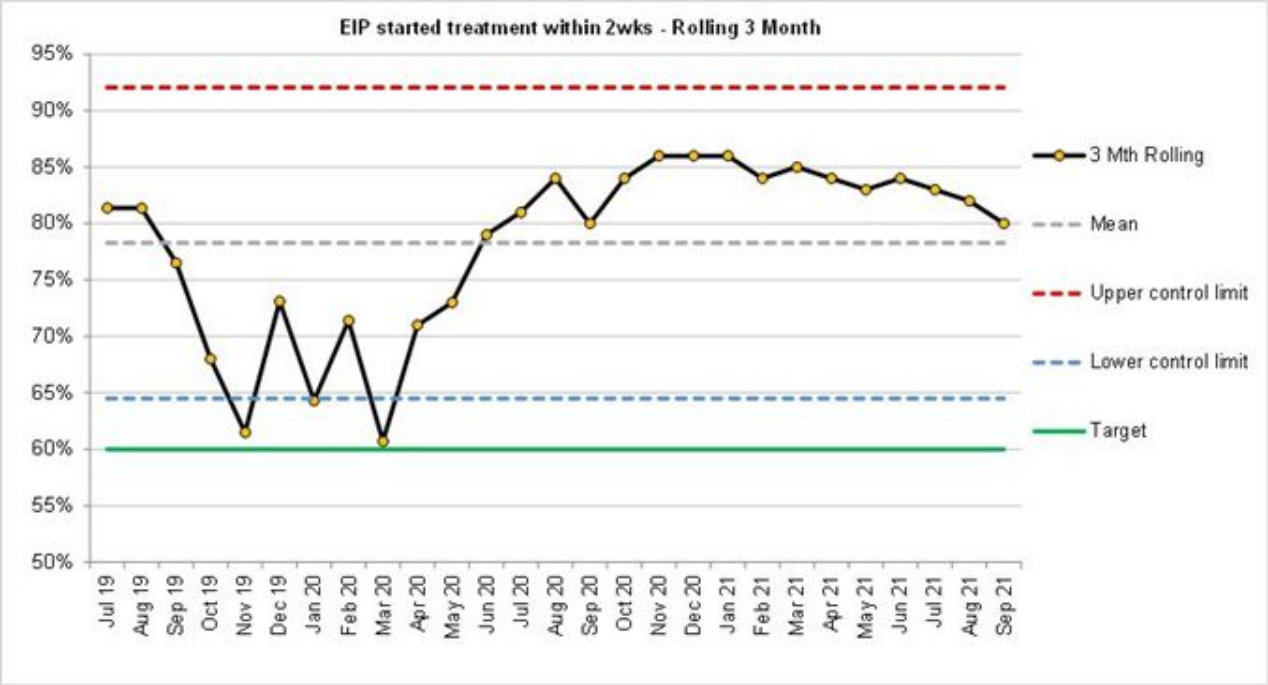
| Organsation | Measure | Most Recent 12 Months Performance - EIP Waiting Times (Rolling Three Months) | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | |
| N&N CCG | Started treatment in 2 weeks | 84.0% | 86.0% | 86.0% | 86.0% | 84.0% | 85.0% | 84.0% | 83.0% | 84.0% | 83.0% | 82.0% | 80.0% | ↓ |
| | 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 |




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals on EIP pathway entering treatment | 125 | 115 | 110 | 120 | 115 | 115 | 130 | 145 | 145 | 140 | 135 | 115 | 100 |
| Referrals on EIP pathway entering treatment within two weeks | 100 | 95 | 95 | 100 | 100 | 100 | 110 | 120 | 120 | 115 | 115 | 95 | 80 |

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 November 2021:

| NICE standard | Current performance | Rating |
|---|---|---|
| Access | **Level 4** | Top Performer |
| CBTp | **Level 3** | Performing Well |
| Family Interventions | **Level 3** | Performing Well |
| 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. NHT are currently reviewing the Family Interventions indicator (currently reported as level 3) to ensure it meets that national requirement, an update will be provided by the end of January and reflected in next months report.

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**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 the February Steering Group.

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

**Gaps in Assurance**
No gaps identified

| ICP | Measure | Most Recent 12 Months Performance - EIP Waiting Times (Rolling Three Months) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 |
| Mid Notts | Started treatment in 2 weeks | 76.0% | 81.5% | 76.5% | 77.1% | 74.2% | 80.0% | 76.0% | 81.5% | 77.3% | 84.6% | 79.3% | N/A |
| City | | 69.2% | 76.5% | 81.9% | 84.8% | 83.6% | 84.7% | 89.5% | 84.7% | 85.5% | 80.7% | 86.7% | N/A |
| South Notts | | 75.0% | 79.5% | 90.0% | 86.8% | 84.8% | 85.2% | 86.7% | 93.5% | 92.1% | 90.9% | 85.0% | N/A |

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

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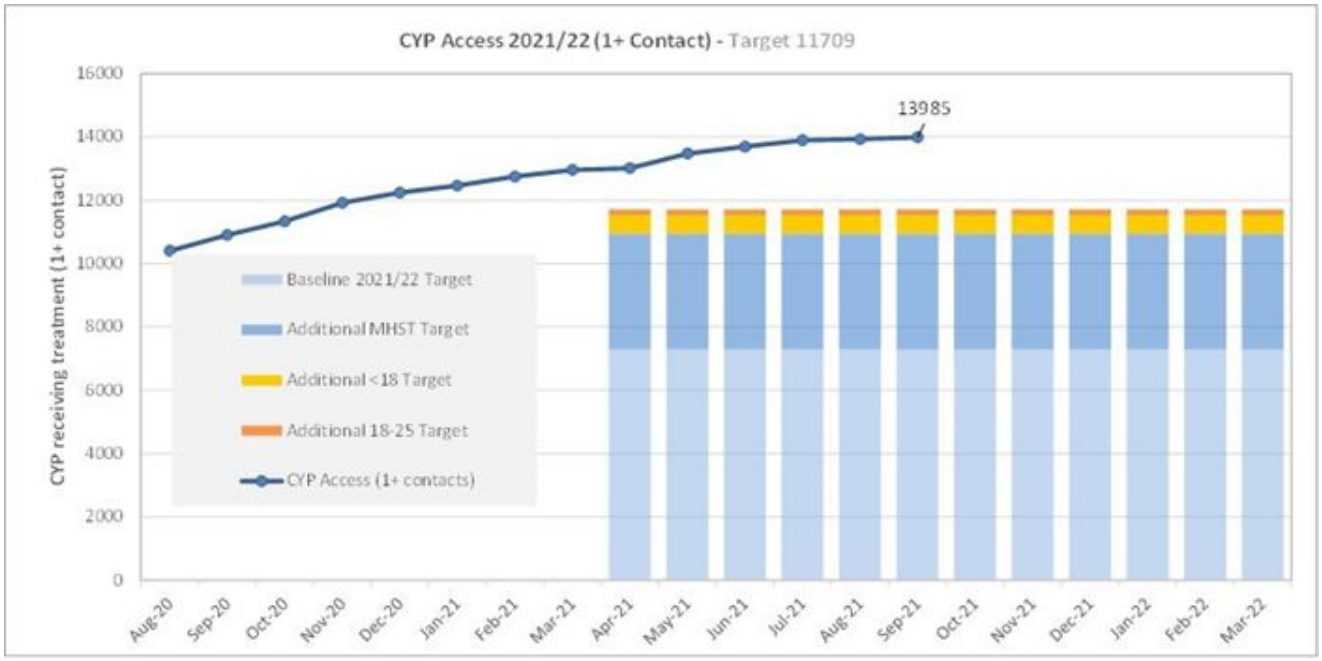
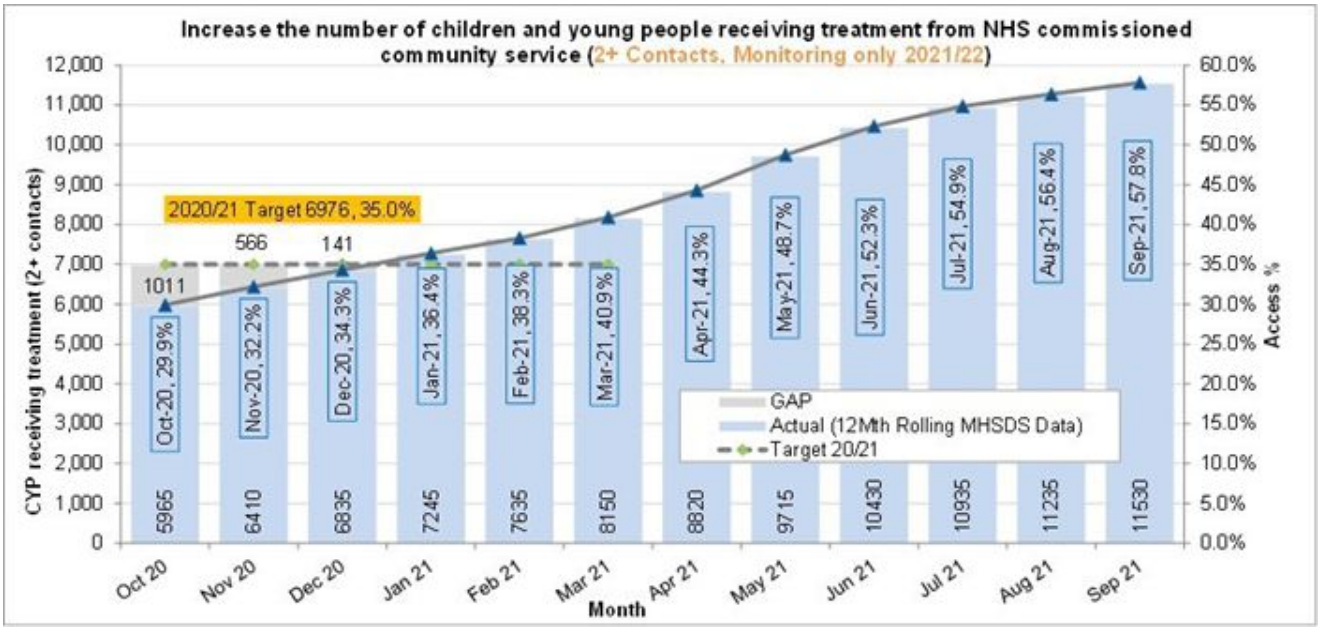
**1+ Contact (Target introduced from April 2021)**

| Organsation | Standard | CYP Access (1+ Contact) | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | |
| N&N CCG | 2021/22 - 11709 | 11330 | 11915 | 12235 | 12460 | 12745 | 12955 | 13010 | 13470 | 13690 | 13890 | 13925 | 13985 | ↑ |




**2+ Contacts (Target removed April 2021)**

| Organsation | Standard | CYP Access (2+ Contacts) | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | |
| N&N CCG | 2020/21 35% | 29.9% | 32.2% | 34.3% | 36.4% | 38.3% | 40.9% | 44.3% | 48.7% | 52.3% | 54.9% | 56.4% | 57.8% | ↑ |



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**Root Cause**
The ICS is achieving the new access target of number receiving support (1-contact). An annual plan of 11,709 this financial year has been set; YTD this has been achieved, 13,985 CYP were recorded as having at least 1 contact in the rolling 12 months ending September 2021. October data is not yet available but it is expected that performance will continue to improve.

The previous target for the number of CYP receiving support (2-contacts) continues to be reported, for the 12 months rolling to September 2021 the rate was 57.8%, exceeding the 2020/21 national standard of 35%.

**Mitigating Actions**
No action required.

**Assurances**
Investment has been agreed to deliver the Long Term Plan objectives in 2021/22 which enables 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.

Nottingham City Council and NHT are working jointly on the national 4-week waiting time pilot, which will fully mobilise in 2022/23.

**Gaps in Assurance**
None

| 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 |

Nottingham and Nottinghamshire Clinical Commissioning Group

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

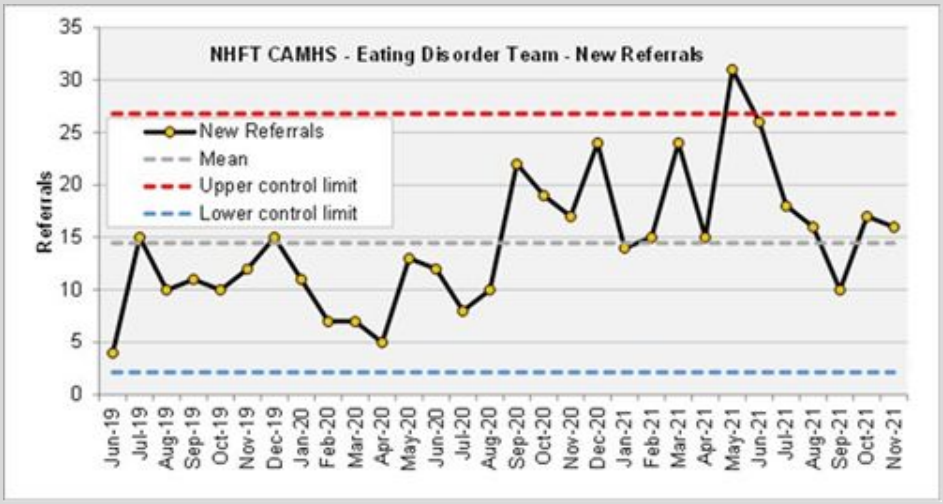
| Organsation | Standard | Most Recent - Routine Complete (Rolling 4 Quarters) | | | | Performance Direction |
|---|---|---|---|---|---|---|
| | | Q3 2020-21 | Q4 2020-21 | Q1 2021-22 | Q2 2021-22 | |
| N&N CCG | 95% Under 4 Weeks | 91.03% | 86.60% | 85.38% | 83.93% | ↓ |
| | | 78 | 97 | 130 | 112 | N/A |

| Organsation | Standard | Most Recent - Urgent Complete (Rolling 4 Quarters) | | | | Performance Direction |
|---|---|---|---|---|---|---|
| | | Q3 2020-21 | Q4 2020-21 | Q1 2021-22 | Q2 2021-22 | |
| N&N CCG | 95% Under 1 Week | 63.64% | 72.22% | 62.50% | 59.09% | ↓ |
| | | 11 | 18 | 24 | 22 | N/A |

**Root Cause**

Q2 data (2021/22) shows performance at 83.93% (routine) and 59.09% (urgent). There were 23 routine breaches and 1 urgent breach. Clinical capacity was the primary reason with some appointments rearranged due to patient choice. Local and national data for Q3 is not yet available.

The system benchmarked the workforce against CYP ED guidance and identified a staffing capacity gap based on number of referrals received by the service historically. Investment plans to address this gap were agreed as part of the Mental Health Transformation Programme in order to achieve waiting standards by Q4 2021/22. However, a recent review of performance evidenced a clear and sustained increase in referrals from September 2020 onwards with 13 of the previous 15 months reporting above the mean (see below graph). This reflects the trends reported by regional peers




This year referral numbers have exceeded those which informed the agreed investment plans. If referral levels reduce in line with pre covid-19 levels (as per September 21), capacity (including planned increases) would have been sufficient to ensure achievement of the waiting time standards. The East Midlands Clinical Network have advised areas plan for increased referral rates. Additional mitigation planning has been undertaken and the provider has proposed a revised staffing model to ensure capacity is sufficient to meet future demand (150 referrals per year).

**Mitigating Actions**

Recruitment in line with agreed investment is progressing; 5.4 WTE posts have been recruited and remaining 1 WTE Psychology post is currently out to advert and the service is shortlisting for the 0.8 Speciality Doctor post. Recruiting to some posts (Doctor time and psychologist) have been challenging.

A proposal has been submitted by the provider to increase the workforce capacity by a further 8.3 WTE, based on 150 referrals (as per Access and Waiting Time Standard workforce benchmarking). This proposal has been reviewed by commissioners and feedback provided to NHT and will inform 22/23 MHIS planning.

Nottingham and Nottinghamshire Clinical Commissioning Group

**Assurances**
Transformation meetings continue, which address any performance issues and agree required remedial action. Support from the NHS England Clinical Network has been requested in response to referral pressures.

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.

**Gaps in Assurance**
It not expected referral levels will plateau. As of November 2021 referrals continued to rise above the mean and the national team at NHS E advise areas 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 |

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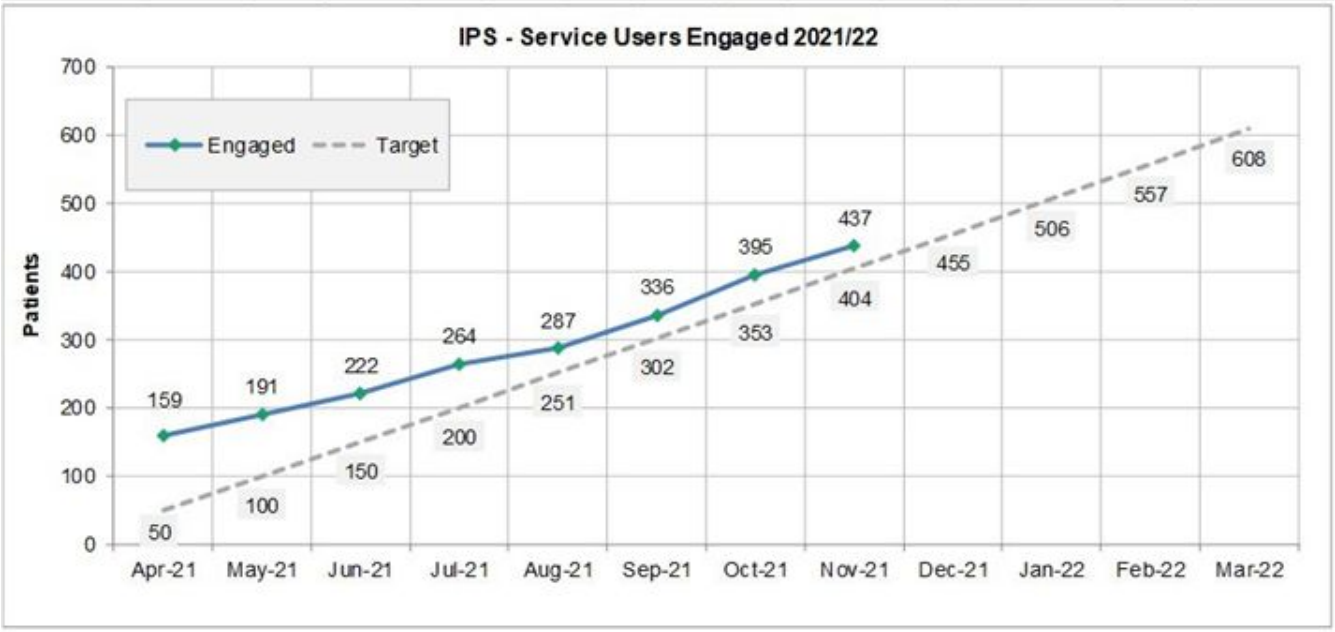
| Organsation | Standard | IPS Service Users Engaged 2021/22 | | | | | | | | | | | | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | |
| N&N CCG | Engaged | 159 | 191 | 222 | 264 | 287 | 336 | 395 | 437 | | | | | ↑ |
| | Target | 50 | 100 | 150 | 200 | 251 | 302 | 353 | 404 | 455 | 506 | 557 | 608 | N/A |




**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 to be reviewed in January 2021.

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 Greater Notts fidelity review will be scheduled for Q4 2021/22.

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

**Gaps in Assurance**
None

## H2 Plans Monitoring

NHS
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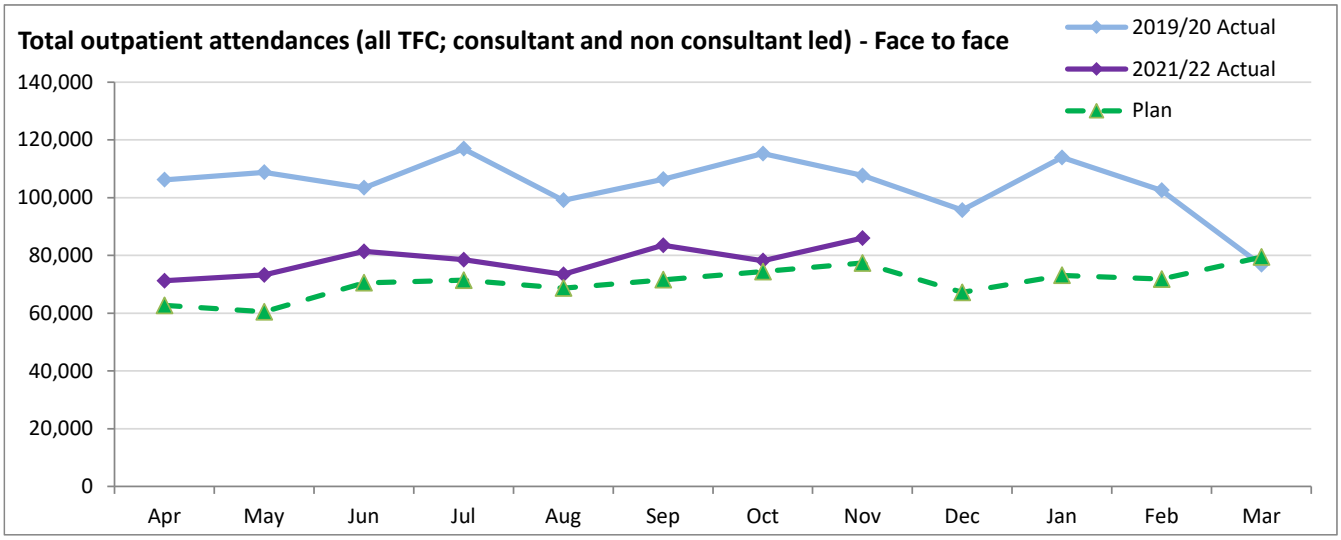
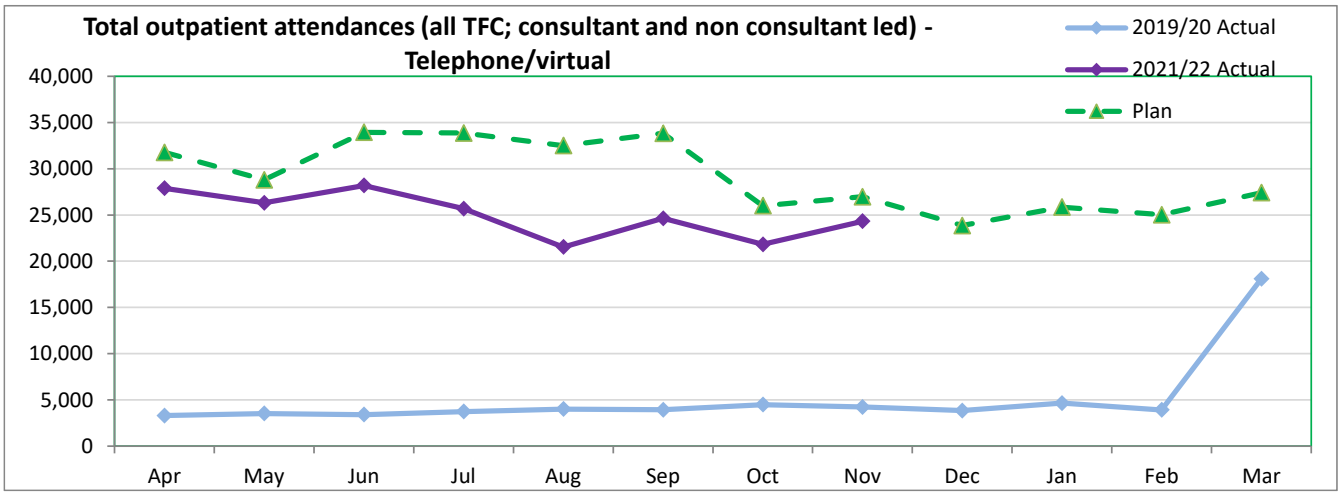
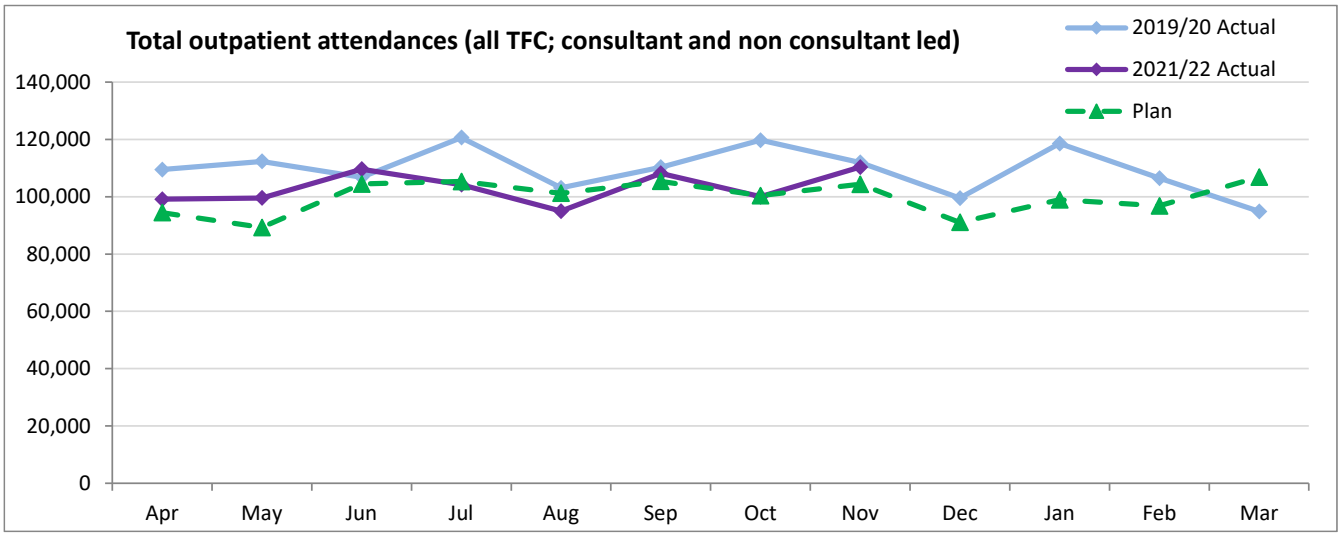
**Outpatients**



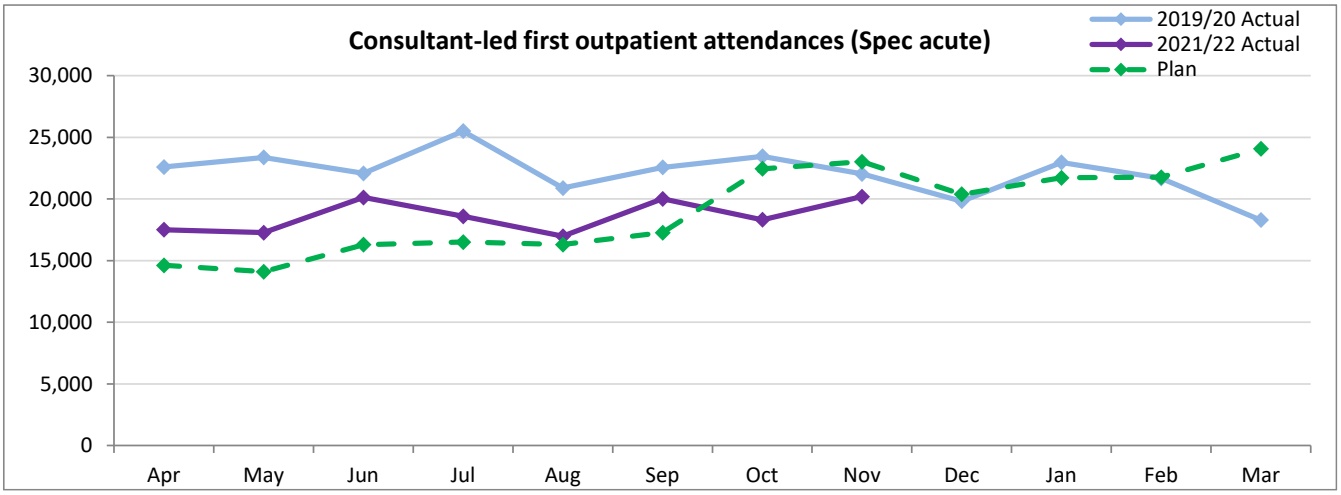



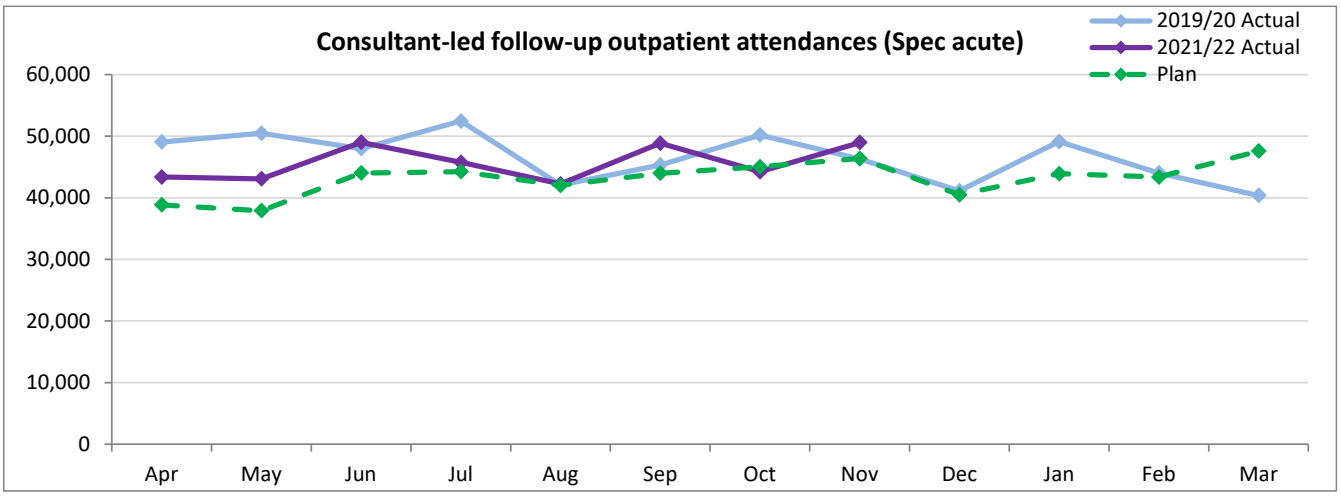



## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Outpatients (continued)**

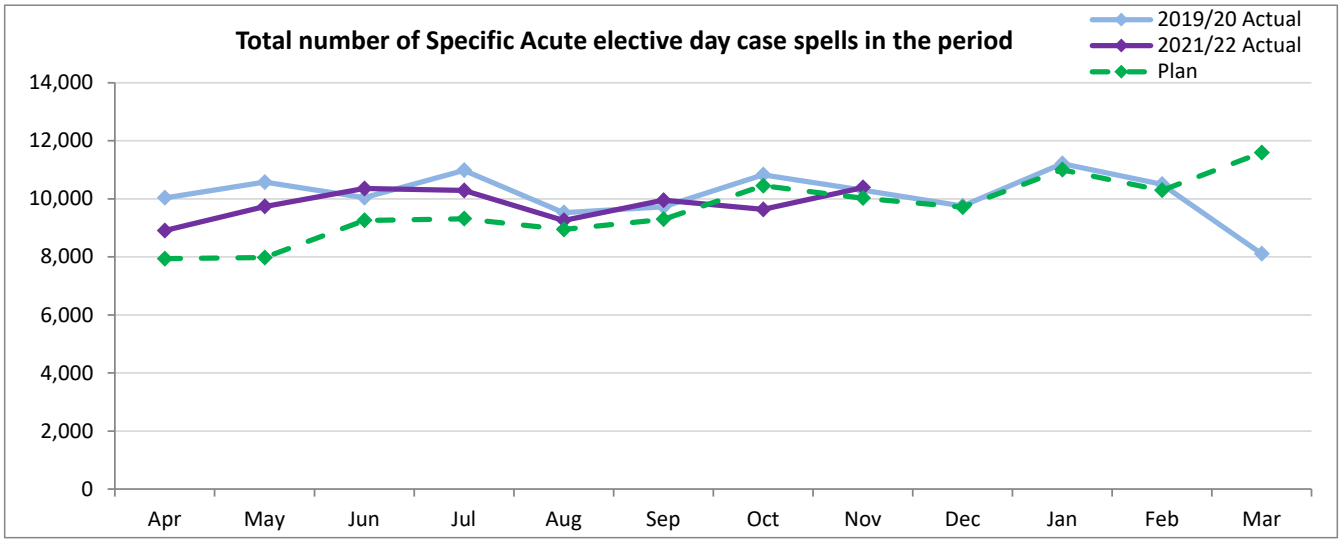


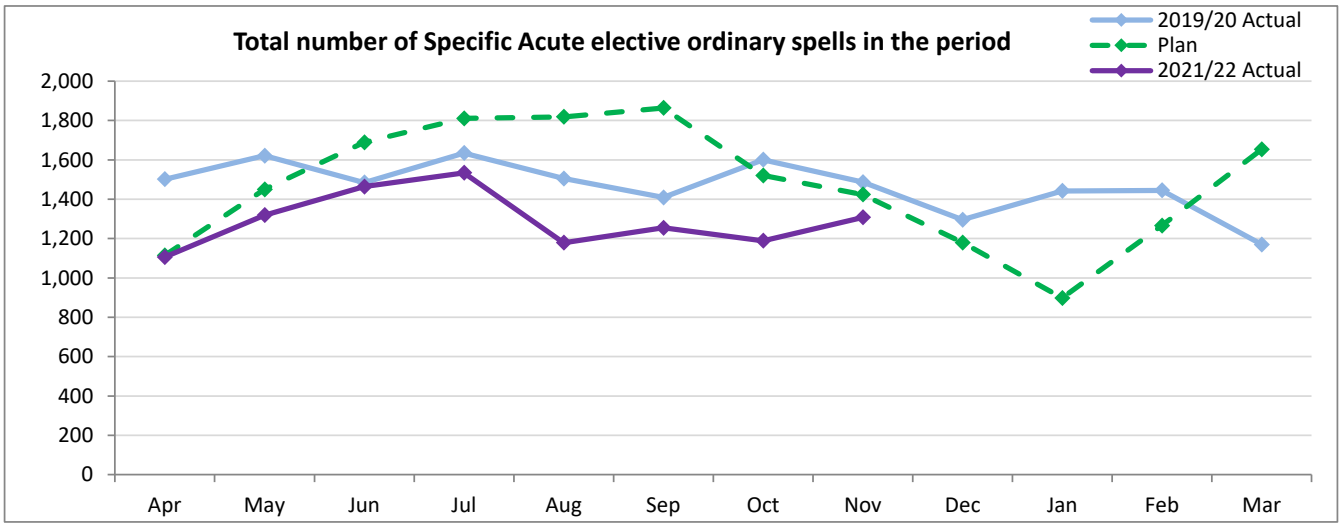



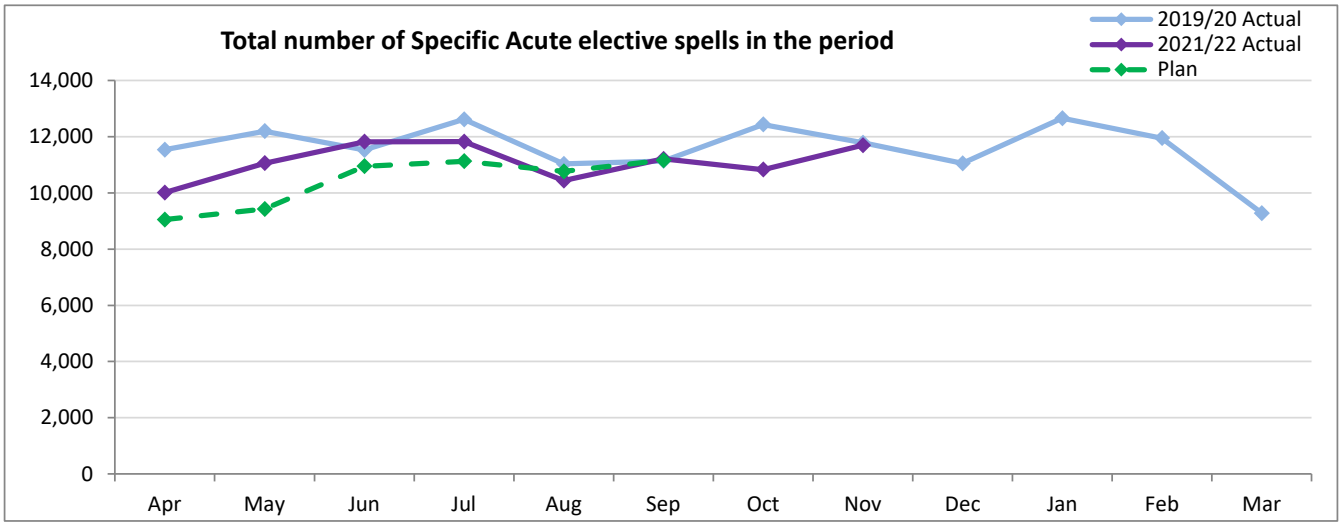
## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Elective**



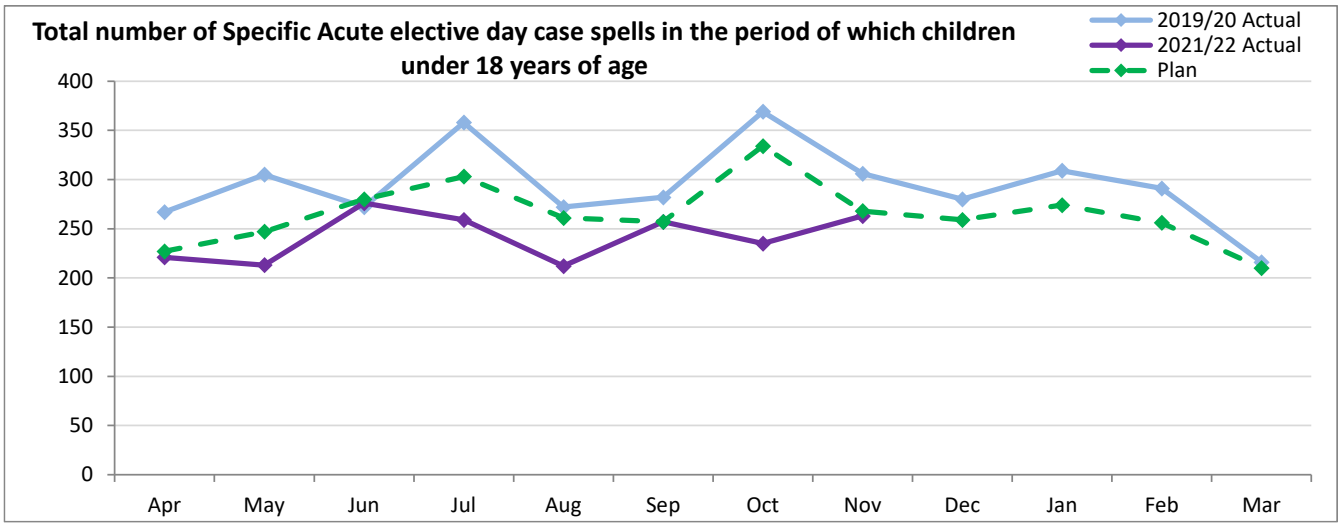



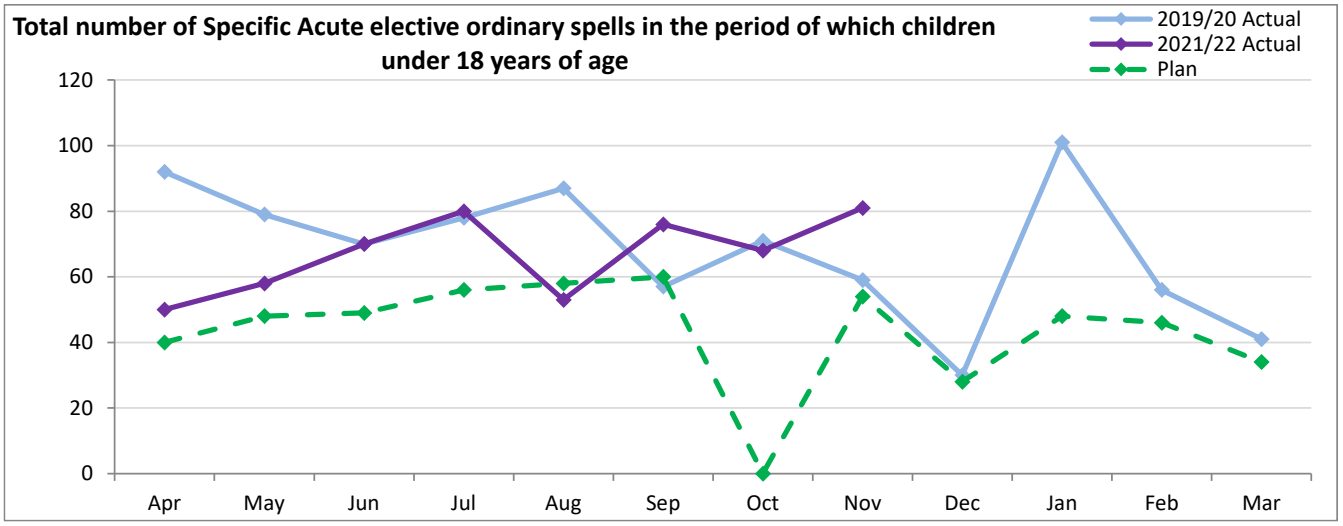



## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Elective (continued)**



## H2 Plans Monitoring (continued)

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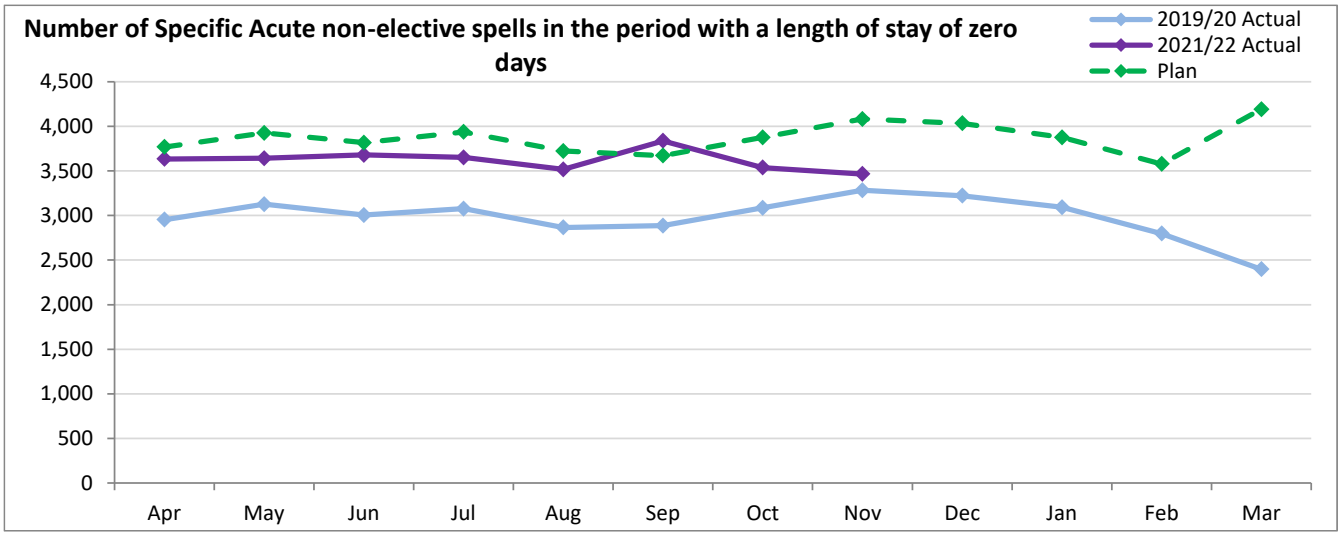
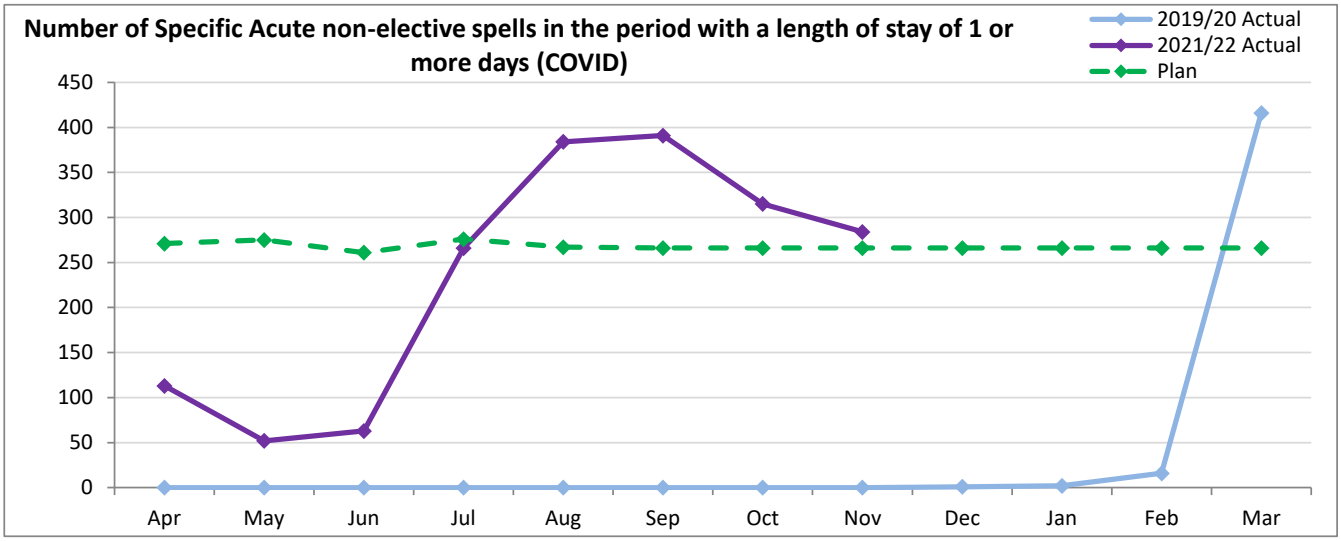
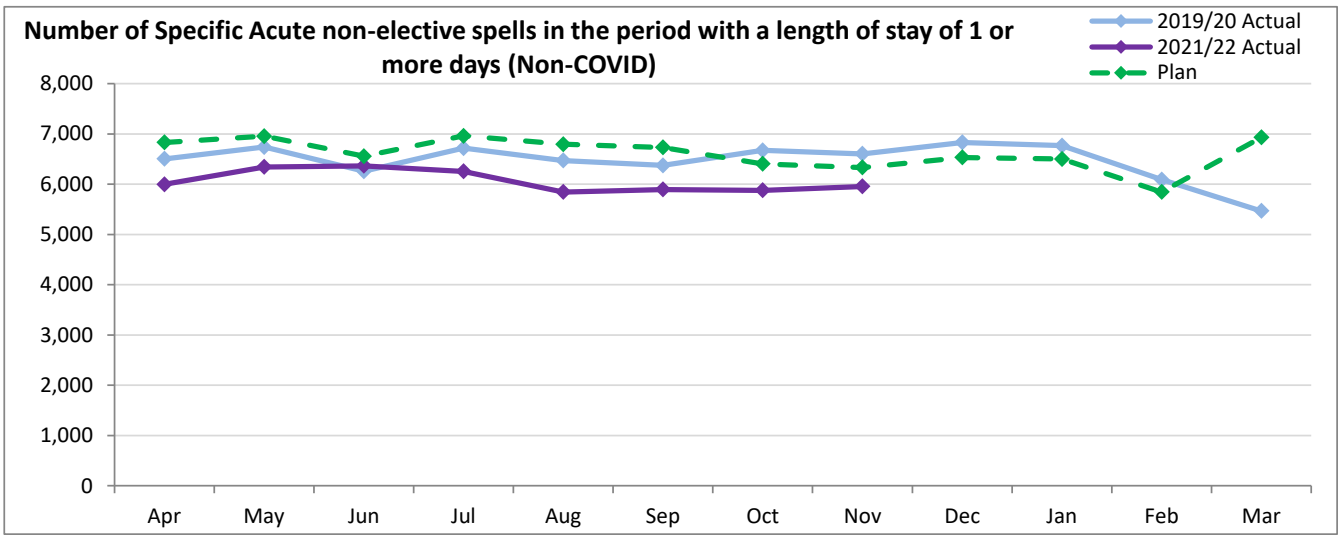
**Non-Elective**



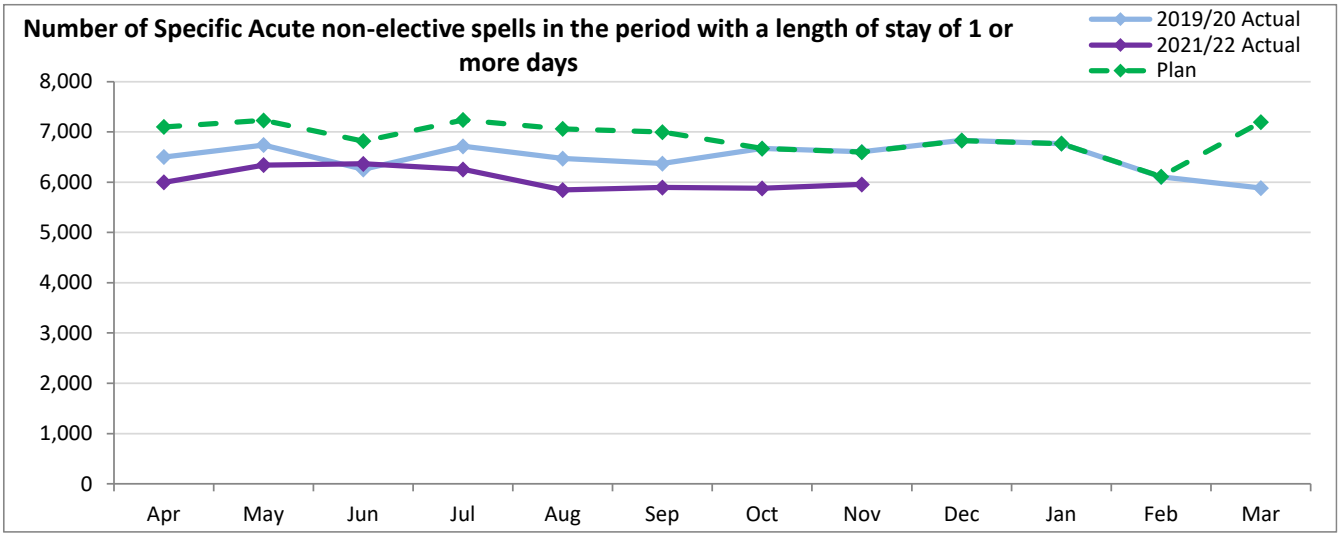



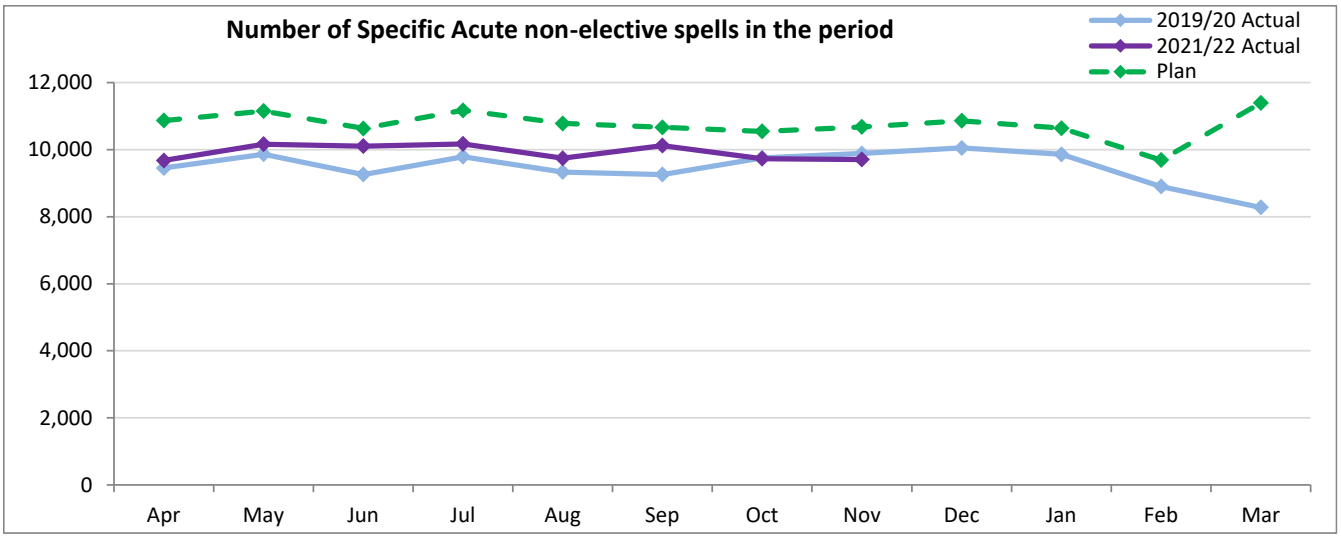



## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Non-Elective (continued)**

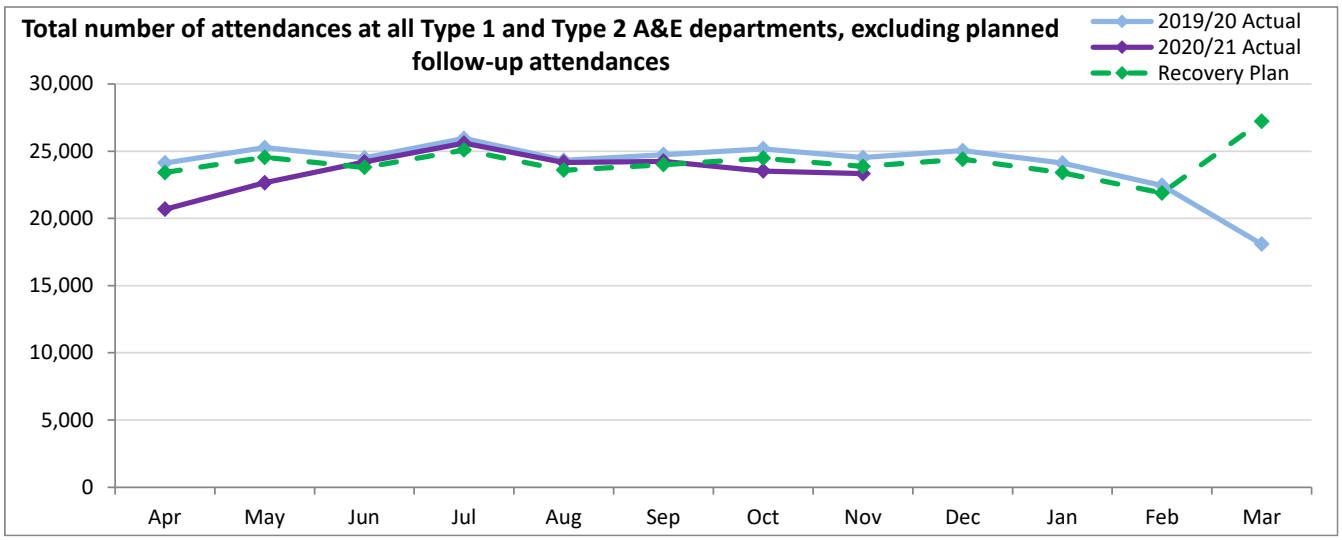


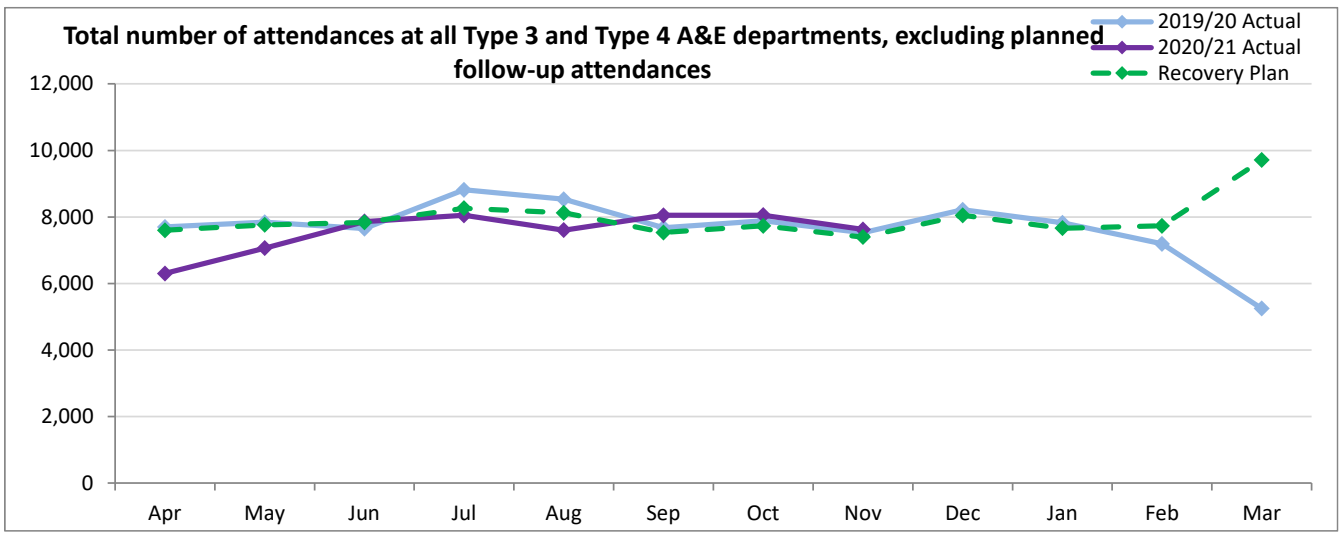



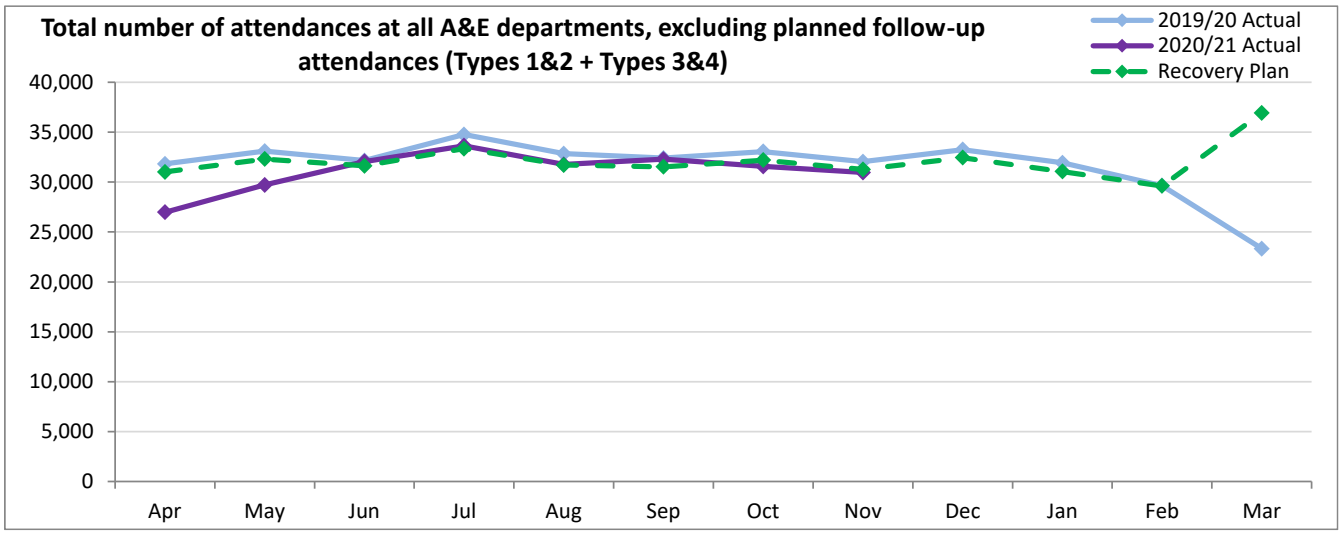
## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**A&E**



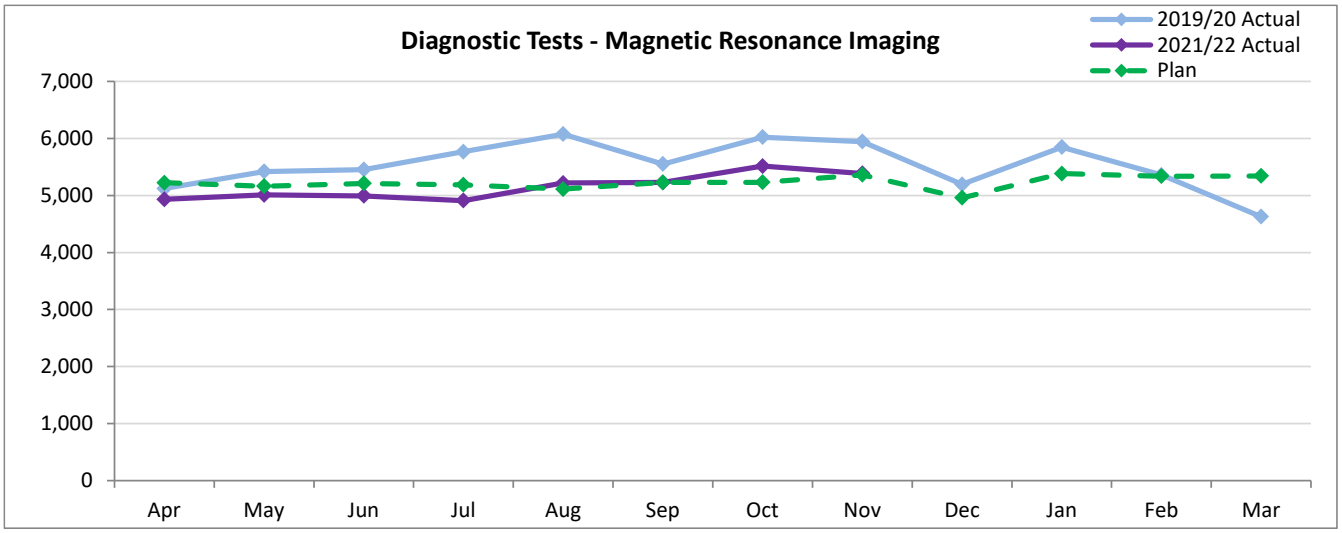



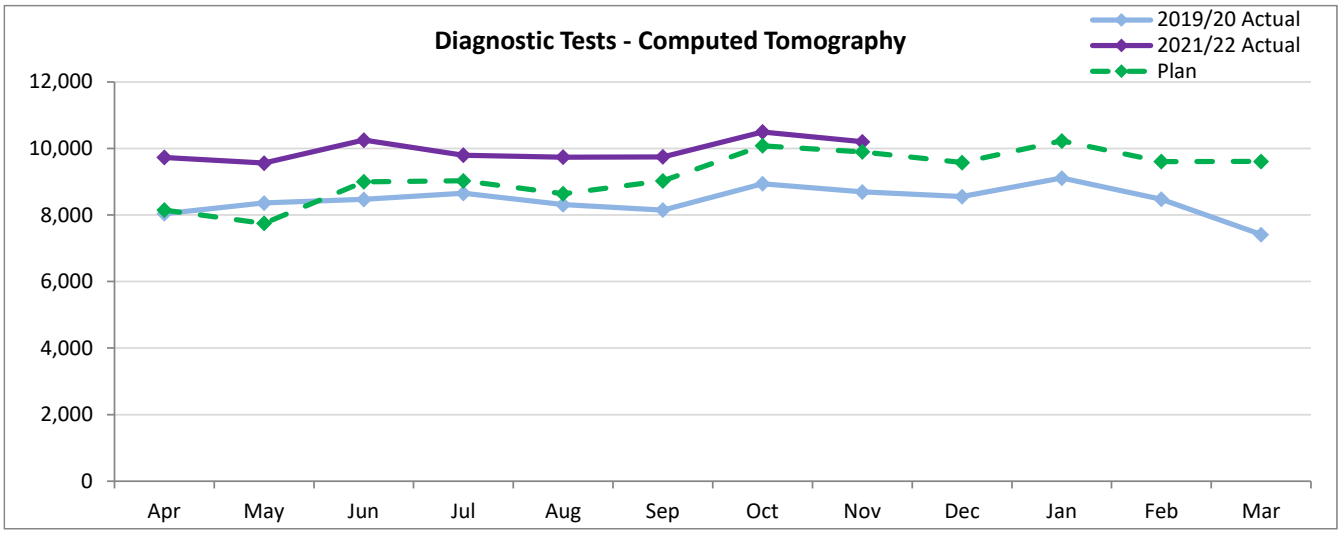



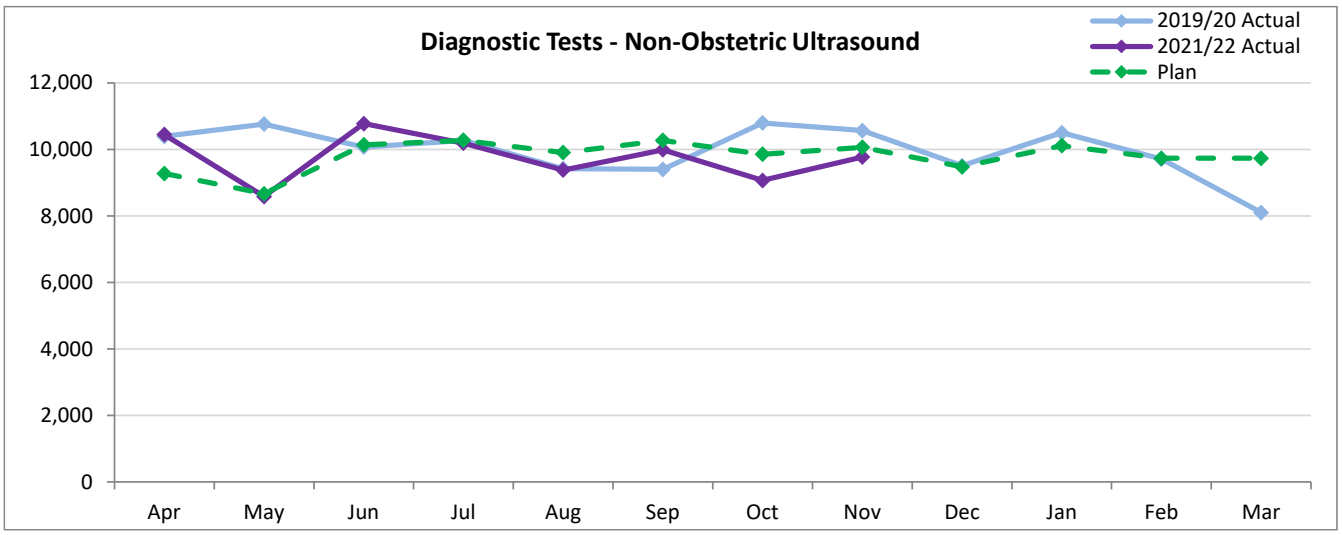
## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Diagnostics**



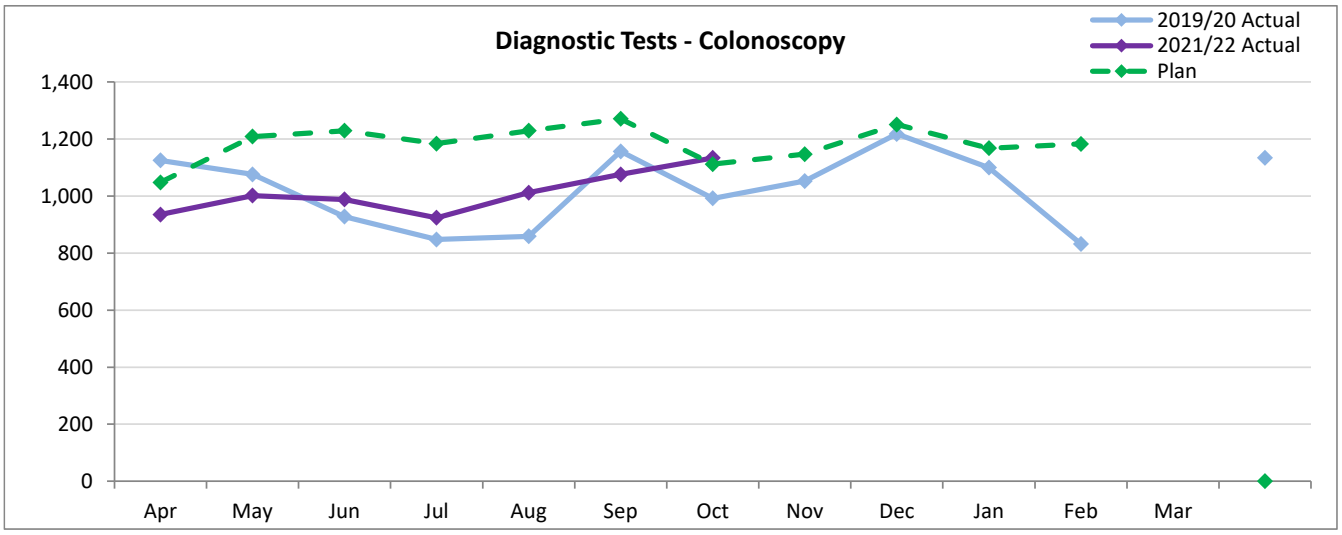



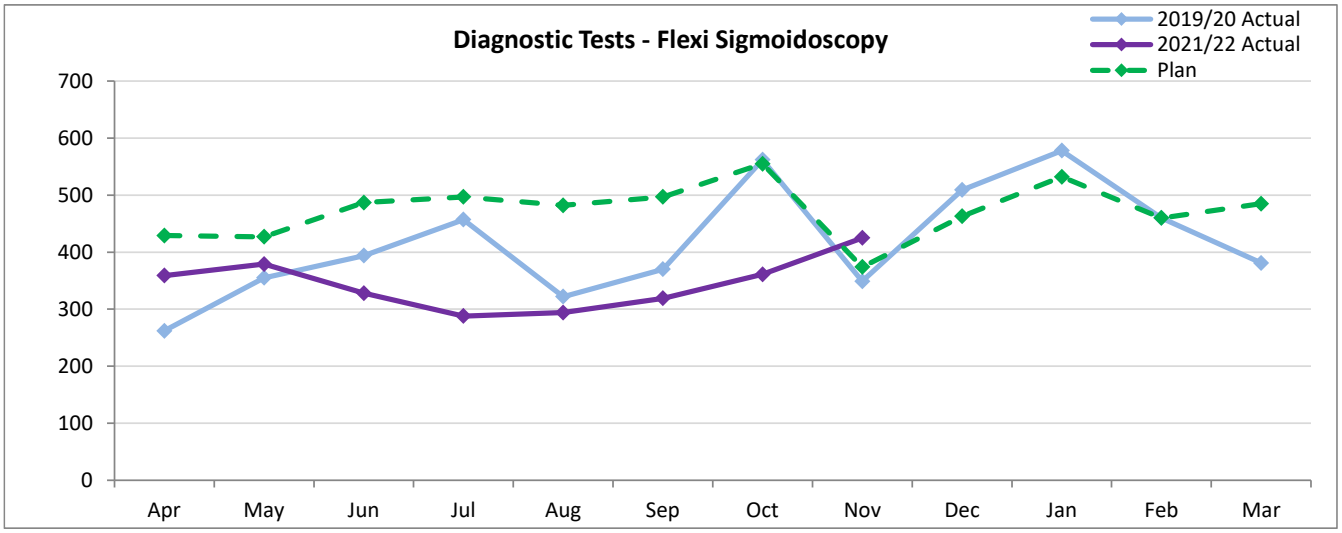



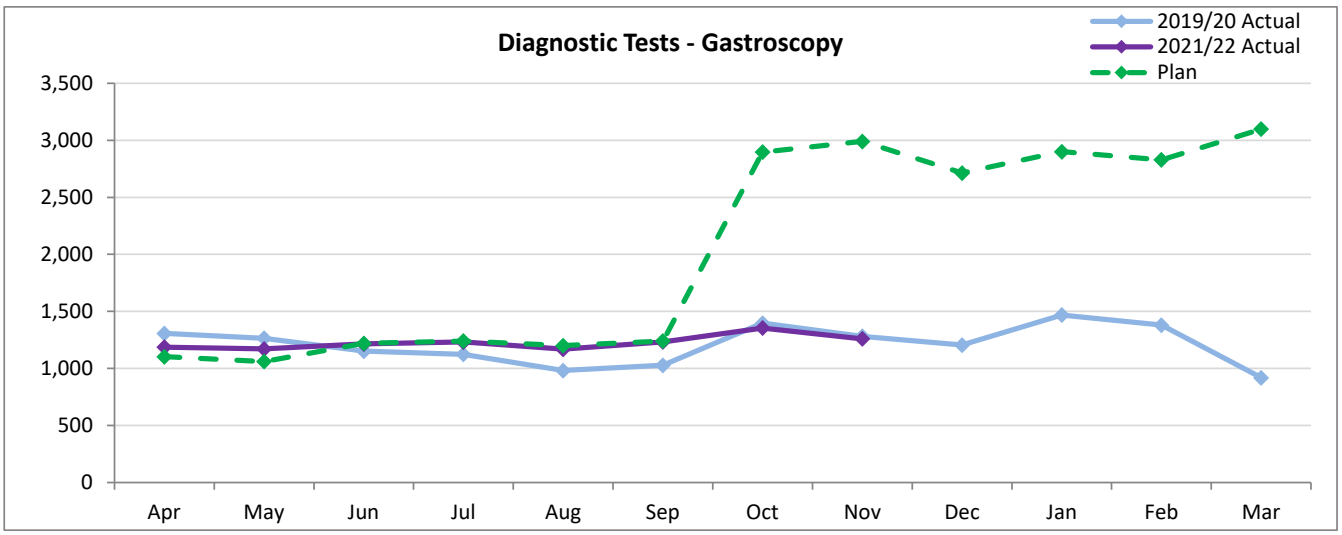
## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Diagnostics (continued)**



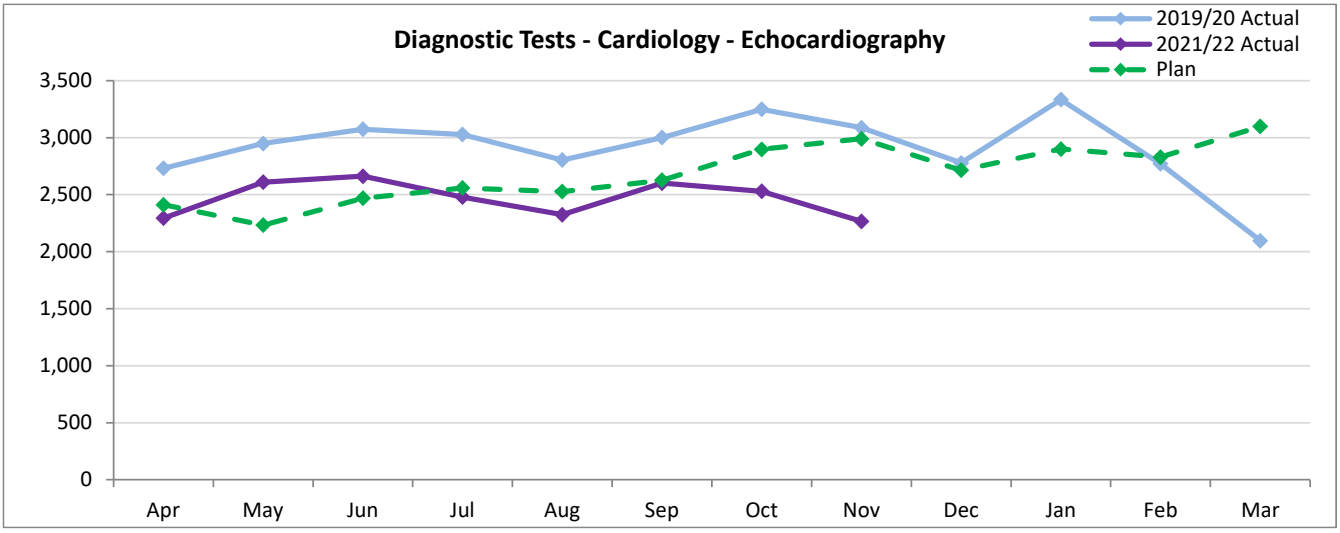



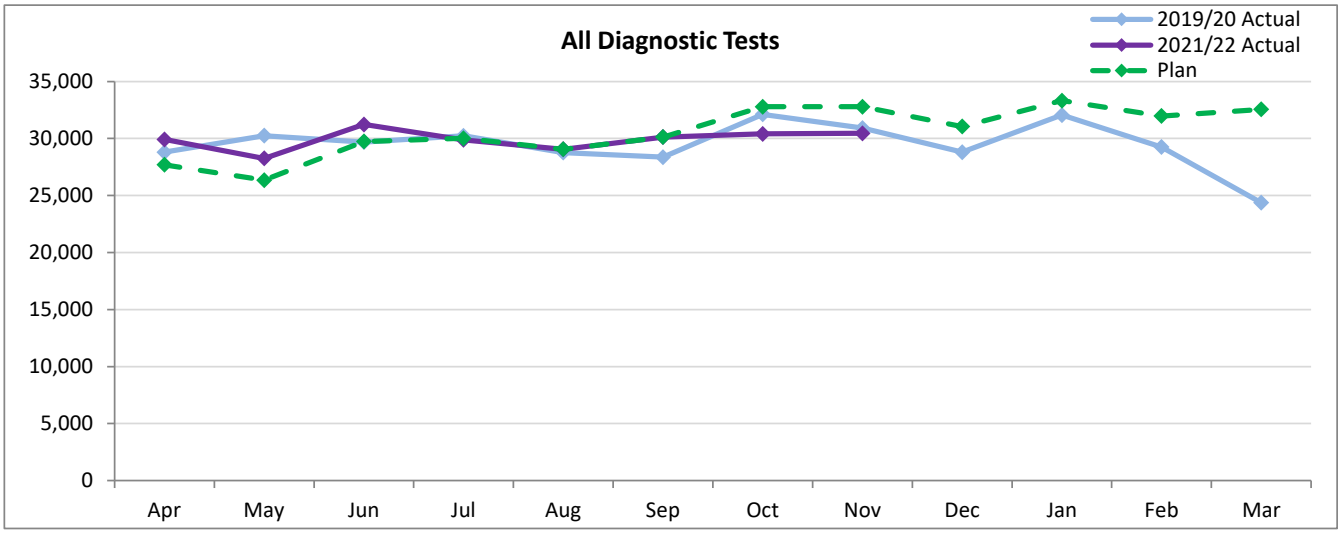



## H2 Plans Monitoring (continued)

Nottingham and Nottinghamshire Clinical Commissioning Group

**Diagnostics (continued)**



| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Cleaning Audit Score | Outcome of audits reviewing the cleanliness of provider environments | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | Greater than or equal to 92.3% | 98.00% | 98.60% | 98.00% | 98.00% | 97.50% | 97.60% | 98.20% | 97.50% | 98.40% | YTD Actual |
| SFH | | - | - | - | - | - | - | - | - | - | - |
| NHT Millbrook | | 94.00% | 93.00% | 95.00% | 95.00% | 93.20% | 93.00% | 93.00% | - | 93.00% | ↑ |
| NHT Lings Bar | | 93.60% | 94.00% | 96.00% | 96.00% | 95.00% | 97.00% | 95.00% | - | COVID | ↑ |
| NHT Highbury | | 96.75% | 99.00% | 96.00% | 96.00% | 98.00% | 97.00% | 97.00% | - | 97.00% | ↑ |
| CityCare | | 93.50% | 94.50% | 94.80% | 93.60% | Not Available | 92.70% | 93.80% | 92.70% | Not Available | ↑ |

**Current Issue/Risk**
**NUH**
NUH's cleaning audit score has been consistently above the national target.

**SFH**
Cleaning/environment audit data has routinely been collected using the Perfect Ward metrics. This data is shared via the Trust's IPC committee, which is attended by a member of the CCG Quality Assurance Team.

**NHT**
The monthly cleanliness audit scores for all wards are above the standard of 92.3%. Unfortunately, due to Covid-19 some of the areas have been inaccessible so this data is unavailable.

**CityCare**
CityCare's cleaning audit score has remained within target and now report this on a quarterly basis

**Mitigating Actions (Provider)**
**NHT**
Cleaning and deep cleaning is in place as part of the management of outbreaks on wards and communal areas. Updates on the correct use of PPE are continually shared with all staff along with regular training sessions. Regular audits are undertaken of all areas. Increased touch point cleaning remains in place. There are multiple locations across all sites where staff/patients can access PPE. Following a recent Covid outbreak, NHCT have sent out reminder communication to all staff, which is reinforced in handovers regarding the importance of maintaining excellent PPE usage and social distancing.

**SFH**
A report provided to the Trusts Infection Prevention Committee provides the overall Trust position relating to audits performed during November 2021. Overall performance has been strong this month across the various audits conducted, with most areas seeing the high 90% - 100% for compliance. Commodes have seen a continued high rate of compliance across the Trust and general cleanliness is excellent. There has been a significant improvement in Hand Hygiene this month also. IV lines Catheters continues to see fluctuating results. Where any non-compliance is identified these are escalated immediately for actions and closely monitored.

**Assurances (CCG)**
**SFH**
The Quality Assurance Team continues to attend the Trusts monthly Infection Prevention and Control Committee meetings where cleanliness data is routinely discussed. The Trust continues to monitor compliance against each monthly and weekly audit cycle.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Venous Thromboembolism (VTE) risk assessment | Assessment of risk of VTE for all patients admitted to hospital | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | Greater than or equal to 95% | 96.20% | 94.50% | 94.20% | 94.30% | 93.30% | 93.80% | 96.00% | 93.40% | 93.80% | YTD 94.2% |
| SFH | | N/A | N/A | N/A | 93.20% | 94.60% | N/A | 94.10% | 92.30% | - | YTD 93.8% |

**Current Issue/Risk**
**NUH**
VTE risk assessment compliance has not met the national target at 93.8% for November. The target has been met twice in 2021/22. Electronic VTE risk assessment compliance has fallen since the introduction of the new VTE RA platform on Nervecentre.

**SFH**
Latest performance relates to October 2021 and is 92.3% (YTD 93.8%) against the 95% standard. National reporting of VTE risk assessment screening was paused in March 2020 in response to the developing Covid crisis.

**Mitigating Actions (Provider)**
**NUH**
- Previous GIRFT thrombosis audit confirmed 100% prescription of enoxaparin in surgery and critical care
- Previous local audit data has shown overall prescription of prophylaxis exceeds 95% in the areas investigated; there is on-going audit in maternity, gynaecology, urology, and orthopaedics
- Educational information has been circulated to all clinical staff in maternity regarding VTE risk assessment
- Correspondence has gone out to medical teams within NUH regarding the current situation and need to ensure VTE RA is completed.
- Divisional teams have been requested to report on plans to improve the overall position via the QSC.
- When ePrescribing (EPMA) is introduced, VTE risk assessment will be linked as a mandatory field
- Extended thromboprophylaxis guideline drafted, awaiting ratification at MSG/HT governance

**SFH**
- The GSU team resumed the pre-COVID method of form collection; this was commenced on the 1st April 2021.
- The data collection process for VTE risk assessment is a manual process requiring a significant number of man hours to achieve and the data is this far behind due to the laborious manual effort required to capture the data.
- EPMA will resolve the data collection issues as the VTE assessment will be included as part of the package and will be mandatory. The EPMA VTE screening tool will be based on the NG89 standards. NerveCentre EPMA will resolve the data collection issues as the VTE assessment will be included as part of the package and will be a mandatory gateway, this is planned for Q4

**Assurances (CCG)**
Exceptional patient safety incidents related to VTE risk assessment are picked up via the SI route.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Falls | Falls (resulting in harm per 1,000 bed days or total number) | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | <= 98 | 107 | 118 | 94 | 94 | 65 | 128 | 107 | - | 114 | ↓ |
| SFH | Total Falls | 105 | 114 | 100 | 114 | 106 | 128 | 125 | 103 | 134 | ↓ |
| NHT | | 156 | 130 | 92 | 114 | 68 | 70 | 78 | 90 | A/W | ↓ |
| CityCare | | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | ↓ |

Providers have set locally defined internal standard set by their respective Boards, which are included in the table above.

Current issue/risk

**NUH**

Falls per 1000 occupied bed days resulting in harm have exceeded the standard. Improvement work continues within the Trust to reduce the number of falls.

**SFH**

The rate of falls per 1000 occupied bed days (OBD) nationally has increased during the pandemic and the position for SFH has mirrored this rise. Falls reduction work remains high on the agenda with a continued focus on reducing deconditioning through mobility awareness to promote patient independence. It is recognised that there is a complex balance between mobility, rapid deconditioning, length of stay and falls.

**NHT**

There is no set target at trust level, but patient falls incidents have seen an increase for October. The Falls strategy has been started to align with the frailty work. Good work has been completed with MHSOP on falls prevention. MHSOP are working with the Trust's Falls Prevention Lead to identify learning and improve compliance with the fall's pathway.

**CityCare**

There was 1 fall recorded for May at CityCare, but no falls have been recorded following that date.

**Mitigating Actions (Provider)**

**NUH**

- The Trust has started reporting all severe harm falls on STEIS from 1st April 2021.
- Continue IRM and QRC processes
- Education around falls is enhanced through a Trust podcast
- Divisional Falls related performance data and themes from investigations are shared at the Falls Learning Group to support trust wide improvements
-

**SFH**

- End PJ paralysis audit live on AMaT, all medical wards participating in month and roll out to other areas planned (data shared at harms free group)
- 'I CAN' posters in use successfully in 3 ward areas to promote safe mobility- plan to roll out
- Falls prevention practitioners continue to visit wards/departments in hours and OOH to provide support
- Live datix review for trends/themes and real time intervention/support
- Multiple service improvement projects in place as part of ward accreditations and pathway to excellent where reduction in falls is central
- Ward maps have been obtained and team will identify area of fall and help to understand pattern/occurrence
- Planning audit for falls documentation as well as review of all documentation
- Themes of month established
- Re-launch and training dates confirmed for falls/dementia/M&H
- Work on going at the Trust to reduce falls includes Nerve Centre adding a question on the falls risk assessment which states "has the patient had or got COVID", and there is a reminder to staff to complete a lying and standing blood pressure. Falls documentation is to be streamlined with a fall's investigation template developed which follows NICE guidelines.

**NHT**

- Mitigations previously detailed remain in place

Nottingham and Nottinghamshire Clinical Commissioning Group

**Assurances (CCG)**
**NUH**
A member of the Quality Assurance team attends the monthly Falls Learning Group and Incident Review meetings set up at NUH to gain assurance around the Trust's actions around falls, processes of reporting falls, etc. The Falls Incident Review meetings have been set up to review retrospective and current falls and ensure appropriate escalation.

**SFH**
A CCG representative attends the Mobility and Falls Steering Group and the Harm Free Care group for further assurance Significant trend in September of highest number of falls occurring when a patient is standing/or mobilising, this is a positive as SFH encourage movement and mobility

**NHT**
The CCG Quality Assurance team meet weekly with the Head of Safety at NHT to discuss any serious incidents or emerging themes from incidents.

**CityCare**
The CCG Quality Assurance team meet fortnightly with the Quality Lead at CityCare to discuss serious incidents, emerging themes and actions being taken.
The Quality Assurance team are working together to promote shared learning and approaches around falls response and prevention.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Number of wards below 80% fill rate / safe staffing | Actual v. planned staffing | Sandy Smith | CCG<br>Acute Providers |

Nottingham and Nottinghamshire Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | 0 | 6 | 2 | 5 | 7 | 6 | 5 | 7 | 8 | 7 | YTD = 47 |
| SFH | Safe staffing care hours per patient day >8 | 9.5 | 9.5 | 9.3 | 9 | 8.9 | 9.1 | 8.7 | 8.7 | 8.9 | YTD = 9.0 |
| NHT | 0 | 9 | 5 | 4 | 6 | 16 | 18 | 20 | 18 | A/W | YTD = 49 |

The current pandemic has impacted on providers' ability to safely staff wards. Increased staff sickness, self-isolation and shielding have all contributed to increase staff absence. There has been some mutual aid at times however each provider is risk assessing each ward when declared unsafe and managing appropriately internally.

**Current issue/risk**

**NUH**

7 wards out of 84 in November 2021 reported fill rates <80%. Trust overall fill rate in November was 96.1%, which increased from 94% in October. The fill rate is shown below for the wards below 80% fill rate:

- PCCU- fill rate 67%
- NNU QMC-fill rate 74%
- Labour suite QMC-fill rate 74.6%
- B26-fill rate 78.5%
- C29-fill rate 76%
- Burns-fill rate 77%
- Winifred 2-fill rate 64%

**NHT**

Overall, the level of wards in the Trust with significantly low staffing has increased since July 21, with the highest number of wards below 85% recorded for 24 months. The trust wide safer staffing Matron continues to monitor and support clinical divisions regarding the impact of patient safety.

**CityCare**

Staff sickness rates have increased from 5.28% in September to 5.63% in November, with the higher increase in November (+0.20%). Stress, anxiety and depression continue to be the main reasons for absence. Staff vacancy rates are particularly high in nursing:

- Nursing: 49.10% (increase of 8.04% since October)
- AHPs: 16.55% (increase of 0.79% since October)
- Support staff: 23.31% (increase of 2.14% since October)

Agency usage has increased by 2.63% to 11.78% in November. However, this figure fluctuates with the second highest figure for the year in June (11.5%).

Nottingham and Nottinghamshire Clinical Commissioning Group

**Mitigating Actions (Provider)**

**NUH**

- Staffing in ED, Neonates, Children's intensive Care remains challenging due to increased sickness and vacancies and unprecedented demand and bed waits in ED, while ward staffing levels have improved slightly
- In November, 38 Critical Care patients nursed on derogated ratio (more than 1:1 care) compared to 4 in October
- Additional beds remain open on Harvey1, Winifred 2, Loxley and C4 for medical patients
- Overall Trust RN sickness has increased to 10.86% from 7.7%. Overall, HCA sickness has increased to 13.49% from 8.8%
- Critical Care sickness increased to 8.6% from 7.8%
- Maternity sickness remains static at 8.5%
- ED sickness increased to 8.8% from 7.7%
- Maternity staff continue to receive enhanced pay rates until January 2022. In November overall maternity fill rate was 82.5% from 87.4%.
- Both Safecare and the staffing app records when wards suboptimal. This is reported per shift through the staffing report and safety wheel. Divisions manage patient safety and staffing daily, through movement of staff and increasing staffing levels with temporary staff.
- An established review carried out annually to review safe staffing requirements is currently in progress.
- Additional mitigating actions to support safe staffing include:
- Enhanced bank pay rates for all staff from 1/11/21, which has increased both RN fill rates
- Increasing RN and ENP supply in ED
- Daily escalation staffing calls
- Continued use of Off Framework agencies
- International RN arrivals continue

**SFH**

Emergency access deteriorated in November. The main driver of this is increased ED demand and admission demand along with the increase in the number of patients who are medically safe waiting for home care. To manage these issues, additional beds have been opened as well as additional staffing for ED, notably in the evenings, although fill rates are variable.

**NHCT**

Within the Community Health Division, a Safer staffing review is underway to confirm safe staffing levels moving forward and this may change the current parameters in which the Division determine the safety of the service. The Community Health Division has commissioned a quality review and improvement process regarding Lings Bar Hospital, and this will have a direct bearing on how NHCT approach safe staffing levels hence the need for the review. The Forensics Division records, as serious incidents, reduced staffing occurrences, and ensure NHSE/I and CQC are aware of staffing difficulties. Shortfalls are monitored, to mitigate possible issues and concerns, through weekly planning and daily demand meetings. Contingency plans continue to be in place within Rampton with Therapies and Education staff redeployed to wards, to support wards and offer on ward activities. Psychology, Social Work and Allied Health Professionals are on a rota, held by the central resource team to be redeployed to wards if necessary.

**CityCare**

Stress Risk Assessments and personalised Wellbeing Plans are being undertaken to address staff sickness. They have also reinstated the Stress and Resilience Group and are trying to develop a coaching culture that encourages ongoing coaching conversations via MS Teams.

**Assurances (CCG)**

The CCG monitors this standard through Trust Board reports and with discussions with the patient safety team of individual cases. Maternity staffing levels are also detailed in the Safe Today submission to the CCG.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | HSMR (basket of 56 diagnosis groups) | Adjust mortality data to take account of some of the factors known to affect the underlying risk of death | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | 12 Month Position |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | Standard ≤ 100 | 120.6 | 112.2 | 105.2 | 96.5 | 110.3 | 106.1 | 134.9 | 91.2 | - | 114.4 |
| SFH | Standard ≤ 100 | 164.2 | 105.3 | 101.1 | 87.4 | 108.6 | 96.6 | 111.0 | 126.8 | - | 104 |

**Current issue/risk**
**NUH**
HSMR for 12-months ending October 2021 (latest data) is outside the expected range at 114.

**SFH**
HSMR; performance 104 against a expected level of 100. The trust consistently has higher than the national average but continues to track the peer groups. There have been delays progressing with several areas of work, reasons which have included changes to Head of Service, the demands of the pandemic and difficulties over the summer period in establishing opportunity for teams / personnel to meet. However, whilst recognising this is part of an improvement journey, the need for timely action is required and these areas remain a Trust priority. The request (through Learning from Deaths) has therefore been consistent to all services in asking for a timely and clear action plan regarding implementing change where improvements are identified.

**Mitigating Actions (Provider)**
**NUH**
The Trusts HSMR and SHMI were reviewed at the Mortality and End of Life Care Group on 08.10.2021. One area NUH are exploring is the rate of secondary malignancies in the SHMI model and whether this has been impacted during Covid-19. Extensive analysis (both via internal and external stakeholders) has been undertaken to understand NUH's elevated HSMR position.
Specific diagnostic groups have been reviewed in detail (such as pneumonia) which alone do not account for the above expected position. Other sources of intelligence such as NUH's national audit outcomes and care quality reviews through the Structured Judgement Case Review process do not suggest systemic issues with outcomes/care quality (SJCR provides significant assurance of care in general being rated as good or excellent).

**SFH**
Taken from the November 2021 Trust board papers is a summary of HSMR / mortality review over the past 12 months, it states it has not revealed a single cause for historical and continued elevated or outlier position but, through more focused analysis, discussion with Dr Foster and interrogation, several areas were felt to be significant contributors and highlighted for potential improvements to pathways, processes and management. Recent changes to data analysis methodology (by Dr Foster) have impacted on their figures with the latest summary reporting the Trust HSMR to be "as expected". It has been suggested by Dr Foster that they await the next round of analysis and report, prior to drawing conclusions as to new and projected Trust position. However, the areas for improvement remain a key area of continued focus.
Palliative Care: · The Trust continues to be one of the lowest for coding, nationally. Analysis and discussion with Dr Foster indicate that, if they were at the national (or regional) average, their overall HSMR would be lower. Work continues documentation and against an action plan with the End-of-Life team.
Alcohol Liver Disease (ALD) · Specialty review and discussion led to a clinical (virtual) walk-through of early of "front-door" management and use of specific management care bundles. This highlighted the need for review of the management "bundle" itself (to make easier to use) but also front-door processes. A change in Head of Service has led to delay in progress with the areas highlighted but some improvements have been made around education. The work around ALD remains on the service risk radar and internal action plan
Fractured Neck of Femur: Although no longer an HSMR outlier, this area was an historical data anomaly. Earlier review had highlighted specific improvements regarding collaborative decision-making and documentation / rationale for management decisions (surgical and non-surgical). · The Head of Service has highlighted performance appears to lie within that expected nationally. The service has been asked to provide an action plan for the next Learning from Deaths meeting as to the recommendations highlighted earlier in the year.
Chronic Obstructive Pulmonary Disease (COPD): This continues to be an alert on Dr Foster reporting. Further discussion between Lead clinician and Dr Foster highlighted several areas to be possible contributory factors, including palliative care and case mix, with influence from coding and co-morbidities. The Trust have seen good engagement from the specialty with a keen interest in understanding the data, alongside instigation of a deeper dive and correlating with "on the ground" intelligence and evidence.

**Assurances (CCG)**
The CCG continues to monitor this standard through attendance at provider Mortality and End of Life and Learning from Deaths groups. SFH meet monthly and NUH meet bi-monthly. Any issues are raised with appropriate teams across the CCG. Mortality outlier alert notifications from the Dr Foster Unit are shared with the CCG by the providers as received with responses shared to the Chief Nurse at the CCG.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Caring | Same Sex accommodation breaches (National target is 0) | Breach of same sex accommodation national guidance | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | ↓ |
| SFH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | → |
| NHT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | → |

**Current issue/risk**
**NUH**
There was 1 same sex accommodation breach during November affecting 1 patient.
It related to a patient (male) who was suitable to step down from Level 3 care and move to a ward, but there was a delay in transfer. The breach was a total of 9 hrs and 5 mins. There were 16 (14 male/2 female) patients who were in Level 3 beds and therefore within mixed sex accommodation.

**SFH**
Nil reported

**NHT**
Nil reported for this period

**Mitigating Actions (Provider)**
Nil required

**Assurances (CCG)**
**NUH & SFH**
The Chief Nurse/Deputy Chief Nurse from the Trusts contacts the Head of Quality Assurance when a breach is unavoidable at the Trust. Discussions take place, including review of IPC and Single Sex guidelines to mitigate the impact of the breach.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Caring | Friends and Family Test | Understanding whether patients are happy with the service | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | F&F Inpatients & Day cases ≥90% | 96.0% | 97.0% | 100.0% | 96.0% | 97.0% | 97.0% | 96.0% | 98.0% | 97.0% | YTD Actual 97.0% |
| SFH | A and E ≥ 94% | 93.1% | 91.9% | 91.5% | 91.9% | 88.7% | 91.2% | 92.2% | 87.9% | 89.6% | YTD Actual 90.9% |
| | Inpatients ≥93% | 98.6% | 98.4% | 97.5% | 97.2% | 98.1% | 97.9% | 97.5% | 97.8% | 97.7% | YTD Actual 97.8% |
| | Maternity ≥ 93% | 89.9% | - | - | - | - | Not provided | Not provided | Not provided | Not provided | YTD Actuals 89% |
| NHT | ≥95% | 99.0% | 81.0% | 89.0% | 86.0% | 88.0% | 86.0% | 74.0% | 90.0% | A/W | ↑ |
| CityCare | | 96.0% | 93.0% | 93.0% | 93.0% | - | 89.0% | - | 91.0% | 93.0% | ↑ |

**Current issue/risk**

**NUH**

Friends and Family Test Inpatient and Day cases is above standard for November 2021 at 97%. During this month NUH collected 4139 comments and individual insights in to experiences of care through the feedback collection methods. It shows that many people continue to have a positive experience of services. However, communication remains a significant area of concern with many families and carers seeking explanation and reassurance about patient care during the covid-19 pandemic.

**SFH**

Report by exception: ED Performance 89.6% (YTD 90.9%) against a target of 90%. This compares favourably with national performance at 72.3%. Work with IQVIA and PET is on-going to address key themes and improve the overall response rate Response rate remains low which affects the recommended rate score (5658 eligible patients and 382 responses). Positive themes identified around staff being caring and professional. Communication and waiting times were identified as areas requiring improvement.

**NHT**

The percentage of FFT has increased to 90% during October 2021 (benchmark is 97.4%). The low rates of the FFT could suggest that the Trust may not be receiving the feedback it requires to identify areas for improvement in its care and treatment and/or areas of good practice for Organisational learning.

**CityCare**

Performance figures consistently above target. 151 people surveyed in November said that their overall satisfaction with the care they received was good or very good. City Care's Adult out of Hospital Services received 0 complaints in November.

Nottingham and Nottinghamshire Clinical Commissioning Group

**Mitigating Actions (Provider)**

**NUH**

- In November 30/65 adult IP wards achieved the minimum response rate (10%) for the local IP survey which is a requirement of Magnet. A total of 8 Paediatric IP surveys were completed and 32 carers surveys (of which 17 related to dementia care). The IP survey and carers survey remain available on the NUH applications for use and will only transition when the build work on the online system has been completed. All services encourage feedback through the Friends and Family Test survey, available to everyone who wishes to give feedback. It is also important that services publicly promote that they are learning from the feedback. The complaints and patient experience team have established a patient's surveys working group to develop systems, processes, resources, and guidance for staff. They intend to meet monthly.

**SFH**

- Communication to go out to public to encourage patients to complete a response
- Ensure multiple collection methods are well publicised
- Implement 'you said, together we did' to show feedback makes a difference
- Themes fed back to ED teams and discussed in combined speciality divisional governance meetings
- Working with volunteers to understand how family liaison can support communication

**NHT**

- FFT score rates within the 3 clinical divisions (Forensics, Mental Health and Community) are usually quite different and so a subgroup analysis was carried out to understand the change in rates.
- The trust transitioned onto the new FFT question set by NHSE in April 2020, however, there has been substantially less data being collected over the past 17 months than there was before (particularly in Community services in contrast to Mental Health services). Given that scores tend to be lower in Mental Health services (patient population and clinical need/expectations of care), this may at least partly explain the lower scores.
- April 2020 was also the start of the COVID pandemic lockdown and therefore it would appear that patients and service users may not have had the opportunity to provide feedback. However, the trust is embarking on new ways of collecting feedback and this includes innovative work such as the use of SMS/text messaging as a tool to gather feedback

**Assurances (CCG)**

The Quality Assurance team monitors this standard through Trust Board reports and links in with the CCG's Patient Experience Team to check if there is any correlation between complaints received into the CCG and serious incidents reported on STEIS.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Responsive | Long stay patients Number of Inpatients >21 days | Prolonged stay in acute hospitals increases the risk of hospital-acquired infections in older patients, and disrupts patient flow and access to care due to bed shortages. | Sandy Smith | CCG Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | National target of 209 | 202 | 207 | 199 | 212 | 198 | 234 | 260 | 250 | 279 | 230 |
| SFH | Standard ≤ 65 | 61 | 55 | 51 | 50 | 54 | 51 | 51 | 56 | 65 | |

**Current issue/risk**
**NUH**
The number of long lengths of stay (LOS) patients (>=21 days) in hospital reduced during the early phase of the pandemic, moving in alignment with the reduction in the number of medically safe patients in hospital awaiting a supported discharge. NUH have always experienced a relationship between this national performance metric and the locally set medically safe for transfer metric.
During November, NUH experienced an increase in discharge delays with the number of medically safe for transfer (MSFT) patients requiring a supported discharge at an elevated level. This has placed further pressure on the long LOS metric. Long LOS because of patients having COVID-19 also remains a factor.

**SFH**
The worsening position is a direct link to workforce issues within adult social care, and to a degree, community partners and closed care homes. In part annual leave cycles exacerbate the gap.
Complex Discharges are high, and partners are having challenges in staffing onward care with packages of care. Care homes capacity is also affected. Long stay patients-number of Inpatients >21 days are no longer reported within the Trust's SOF report

**Mitigating Actions (Provider)**
**NUH**
NUH continue to escalate and seek support for system partners to reduce the number of medically safe patients in hospitals, following a significant increase in discharge delays through the Autumn and into the Winter period. Notwithstanding this, they continue to deviate from the system agreed target of less than or equal to 37 patients (a position which has not been met since Summer 2020). The system ambition to eliminate the discharge delays will support the reduction of medically safe backlog and an associated reduction in the number of LOS patients. System partners have a number of actions in place to increase capacity to expediate discharge for medically safe supported patients over the coming weeks/months- these plans are reviewed and agreed by the ICS discharge cell.

Divisions remain focused on internal actions to reduce long LOS patients that do not have a clinical reason to reside. The Trust does operate rehabilitation units for Stroke and Neurology that will account for some of the very long LOS patients (this is an entirely appropriate clinical pathway). Recently, the regional team have advised that for the purposes of external reporting that the Trust's rehabilitation units can be omitted; the Trust is in the process of agreeing the detail around the reporting changes to ensure that they remain sighted and focused on all areas across the Trust whilst also reporting in a manner in line with NHSE/I advice.
The fortnightly emergency pathway taskforce oversees performance against this metric at divisional-level and facilities the airing of cross-divisional issues and the sharing of best practice.

**SFH**
There is an identified increase in the number of patients who are medically safe for discharge awaiting home care. This issue has maintained the deteriorated position seen and is driven by severe workforce capacity issues in the homecare market. To manage this, additional beds have been opened as well as additional staffing for ED. A recovery plan has been developed across the ICS. The ED expansion project continues and the first phases of increased capacity in ambulatory care are now open. Although this is not reported within the SOF, this is still monitored by the CCG through QA meetings.

**Assurances (CCG)**
The Quality Assurance Team receive notes from the System Call at which numbers of medically fit patients for discharges are discussed and assurance obtained that these numbers are being reviewed by the providers with support from the CCG Urgent Care Team. CCG Urgent Care and Care Homes team colleagues take part in the daily discharge meetings to support providers with escalation of issues when patient flow is reduced. The messaging of 'Why Not Home?' is reiterated in any discharge situation.

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Responsive | Ambulance handover | Ambulance handover delays can be a symptom of system-wide issues, a mismatch of capacity and demand and inadequacy of patient flow | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH (completed within 15 minutes) | National target of 100% | 67.0% | 68.0% | 66.0% | 59.0% | 55.0% | 49.0% | 46.0% | 47.0% | 51.0% | YTD Actuals 55.5% |
| SFH (Percentage of Ambulance Arrivals > 30 minutes) | <10% | 2.9% | 2.1% | 3.3% | 3.7% | 3.5% | 3.4% | 6.6% | 4.1% | 2.4% | YTD Actuals 3.9% |

**Current issue/risk**
**NUH**
The recent deterioration in this metric has been driven by record level of attendances to Emergency Department (ED). High 'majors' demand combined with poor outflow from ED for patients requiring hospital admission results in overcrowding. Overcrowding is causing ambulance handover delays as there is no space to move patients out of 'first contact' and into the major's department. As a result, the number of patients waiting in 'first contact' frequently goes above the capacity for the area (3 patients). Whilst performance continues to be below target, there has been a small improvement in the last month and the relative performance for ambulance handover in the region remains strong. The proportion of handovers greater than 1 hour has reduced to 1.2% in November (strongest position for 5 months) after peaking at a yearly high of 3.6% in October 2021.

The heightened demand is meaning that providing timely access to urgent and emergency care is an on-going challenge in a frequently overcrowded ED. This overcrowding is resulting in ambulance handover delays.
Hospital flow challenges also contribute to crowding in ED because of constrained flow into assessment areas (patients waiting in ED whilst 'fit for ward'). The challenge in the assessment areas relates to timely flow into the base wards due to lack of timely base ward bed availability. The maximum ED occupancy is also constrained by infection prevention and control measures as the Trust operates in the 'loving with Covid-19' era.

**SFH**
Ambulance handovers remained within target

**Mitigating Actions (Provider)**
**NUH**
Ambulance handover performance oversight takes place within ED and the site operations team daily. Continued joint working with EMAS is underway to improve turnaround times, including work to develop a live feed of ambulance handover performance to be part of the command centre. In the last month they have developed a live feed on their internal command view which details ambulance numbers arriving in to trolley first contact. This is helping with oversight and the ability to quickly address when trolley first contact goes over capacity. The fortnightly Emergency Pathway Taskforce oversees performance and facilitates the airing of issues and agreement of actions.
In ED, the team adopt a process of 'reverse-queuing' to try and complete handovers on arrival to release ambulance crews when the 'first contact' area becomes busy. This has been exceptionally challenging to deliver as the major's department has been so crowded there has not been the staff available.

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| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | 12 hour trolley breaches | | Sandy Smith | Acute Providers |

Nottingham and Nottinghamshire Clinical Commissioning Group

| Organisation | Standard | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Performance Direction |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NUH | National target of 0 | 8 | 0 | 5 | 0 | 74 | 134 | 147 | 117 | 430 | ↓ |
| SFH | | 1 | 0 | 1 | 3 | 0 | 1 | 6 | 1 | 23 | ↑ |

**Current issue/risk**
**NUH**
In November, high numbers of patients continued to experience long waits for admission in the ED department, leading to a very high number of 12-hour breaches. The breaches were spread across the month whilst the ED remained almost constantly over capacity. Hospital flow challenges contribute to crowding in ED because of constrained flow into and out of the assessment areas. The challenge in the assessment areas relates to timely flow into the base wards, due to a lack of bed availability. The challenge in the assessment. The challenge in the assessment areas relates to timely flow into the base wards, due to lack of base ward bed availability. The non-elective bed base has been under pressure to high non-elective demand alongside high numbers of supported patients waiting in hospital after being declared medically safe. The number of medically safe patients waiting in hospital has surged from September to the highest levels in the post-pandemic era and at times exceeded the equivalent of 5 hospital wards. High Covid-19 demand, pathway segregation (including IPC and control measures) and staffing issues are also factors that are exacerbating bed challenges.

**SFH**
There were 23 x 12-hour trolley breach reported by SFH in November 2021.

**Mitigating Actions (Provider)**
**NUH**
Robust escalation processes are in place operationally to track, communicate and try to avoid patients experiencing 12-hour trolley waits however, significant operational bed pressures limit availability to prevent waits. During the reported period, NUH have implemented OPEL 3 & 4 actions in line with the management of patient flow policy.
NUH focused on improving the utilisation of the bed base. To do so they: (1) secured additional divisional resource to support internal bed meetings; (2) increased the risk appetite for patient outlying; and (3) reviewed and balanced risk decisions around bed and ward closures due to infection. To expedite discharge, the Matrons and leadership teams joined board rounds to assess and resolve blockages to discharge and reviewed patients identified as home today or tomorrow. During September, they worked with system partners to (1) ensure full awareness of the hospital flow challenges; (2) disseminate communications to encourage the appropriate use of the urgent care services; and (3) seek support to reduce the number of medically safe patients in the hospitals. In early September, as a last resort after sustained pressure, NUH made the difficult decision to curtail further the elective programme and converted Harvey 2 from an elective ward to accommodate medically safe patients – this ward has subsequently been converted back to elective care after a reduction in the number of medically safe patients in the hospitals

**Assurances (CCG)**
**NUH & SFH**
The Quality Assurance team receives the notes from the daily System Call where any 12-hour trolley breaches are declared. The QA team follows up with the CCG's Urgent Care Team and Head of Operational Planning and Assurance at NUH and SFH to obtain details of the breach and review the Breach Incident Response Template. The QA Team and the Urgent Care Team also have monthly meetings to discuss any breaches that happened during the month. RCAs once completed are reviewed by the QA team who request for further assurance as needed.

| Theme | Indicator | Indicator | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | C-Diff | | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| C-Diff 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 21-22 | TOTAL 21-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS Nottingham and Nottinghamshire CCG | Plan | 20 | 18 | 19 | 24 | 21 | 21 | 21 | 20 | 20 | 20 | 20 | 21 | 184 | 245 |
| | COCA | 6 | 3 | 6 | 3 | 8 | 3 | 3 | 0 | 8 | | | | 40 | 40 |
| | COIA | 1 | 5 | 1 | 2 | 5 | 5 | 7 | 2 | 5 | | | | 33 | 33 |
| | COHA | 8 | 4 | 6 | 8 | 8 | 3 | 5 | 8 | 4 | | | | 54 | 54 |
| | HOHA | 5 | 6 | 6 | 11 | 13 | 11 | 12 | 9 | 9 | | | | 82 | 82 |
| | Total acquired | 20 | 18 | 19 | 24 | 34 | 22 | 27 | 19 | 26 | 0 | 0 | 0 | 209 | 209 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 13 | 14 | 20 | 19 | 25 | 5 | -15 | -36 | 25 | -36 |
| Sherwood Forest Hospital NHS Trust | Plan | 9 | 6 | 6 | 8 | 13 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 43 | 57 |
| | COHA | 5 | 4 | 4 | 4 | 5 | 1 | 3 | 3 | 1 | | | | 30 | 15 |
| | HOHA | 4 | 2 | 2 | 4 | 8 | 6 | 8 | 1 | 1 | | | | 36 | 13 |
| | Total acquired | 9 | 6 | 6 | 8 | 13 | 7 | 11 | 4 | 2 | 0 | 0 | 0 | 66 | 66 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 0 | 6 | 11 | 4 | 2 | -2 | -1 | -1 | 23 | 9 |
| Nottingham University Hospitals NHS Trust | Plan | 7 | 4 | 10 | 17 | 9 | 12 | 10 | 10 | 10 | 11 | 11 | 11 | 89 | 122 |
| | COHA | 4 | 0 | 3 | 6 | 4 | 2 | 2 | 6 | 5 | | | | 32 | 18 |
| | HOHA | 3 | 4 | 7 | 11 | 5 | 10 | 5 | 9 | 13 | | | | 67 | 30 |
| | Total acquired | 7 | 4 | 10 | 17 | 9 | 12 | 7 | 15 | 18 | 0 | 0 | 0 | 99 | 99 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 0 | 0 | -3 | 5 | 8 | -11 | -11 | -11 | 10 | -23 |

**Current issue/risk**
SFHT have breached the year- end target 66/57
NUHT breached plan in December 18/10

**Mitigating Actions (Provider)**
There has been a noted increase in COHA and HOHA cases and system meetings are in place to support reviews. SFHT rates have improved but NUHT reported an increase in HOHA cases December.

**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<br>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 21-22 | TOTAL 21-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS Nottingham and Nottinghamshire CCG | 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 | | | | 4 | 4 |
| | Hospital-onset | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | | 1 | 1 |
| | Total | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 5 | 5 |
| | Cumulative Variance | 1 | 2 | 3 | 4 | 4 | 4 | 4 | 4 | 5 | 5 | 5 | 5 | 5 | 5 |
| Sherwood Forest Hospital NHS Trust | 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 | | | | 1 | 1 |
| | Total | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 |
| Nottingham University Hospitals NHS Trust | 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 | | | | 0 | 0 |
| | Total | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Current issue/risk**
There is a zero target for MRSA BSI. SFHT reported 1 BSI Dec

**Mitigating Actions (Provider)**
A post infection review (PIR) will be completed and any learning will be shared

**Assurances (CCG)**
System RCA group in place to share learning. PIR will be submitted

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

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

| 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 Nottm and Nottinghamshire CCG | Plan | 76 | 76 | 76 | 76 | 76 | 76 | 76 | 76 | 76 | 76 | 76 | 75 | 684 | 911 |
| | COCA | 55 | 38 | 39 | 54 | 56 | 51 | 49 | 45 | 37 | | | | 424 | 484 |
| | COHA | 14 | 17 | 14 | 17 | 11 | 14 | 16 | 12 | 10 | | | | 125 | 119 |
| | HOHA | 16 | 11 | 13 | 13 | 12 | 14 | 12 | 11 | 13 | | | | 115 | 134 |
| | Total acquired | 85 | 66 | 66 | 84 | 79 | 79 | 77 | 68 | 60 | 0 | 0 | 0 | 664 | 664 |
| | Cumulative Variance | 9 | -1 | -11 | -3 | 0 | 3 | 4 | -4 | -20 | -96 | -172 | -247 | -20 | -247 |
| Sherwood Forest Hospital NHS Trust | Plan | 6 | 4 | 0 | 2 | 1 | 4 | 15 | 15 | 15 | 15 | 16 | 16 | 62 | 109 |
| | COHA | 5 | 9 | 6 | 7 | 7 | 3 | 8 | 2 | 1 | | | | 48 | 48 |
| | HOHA | 6 | 4 | 0 | 2 | 1 | 4 | 4 | 3 | 3 | | | | 27 | 27 |
| | Total acquired | 11 | 13 | 6 | 9 | 8 | 7 | 12 | 5 | 4 | 0 | 0 | 0 | 75 | 75 |
| | Cumulative Variance | 5 | 14 | 20 | 27 | 34 | 37 | 34 | 24 | 13 | -2 | -18 | -34 | 13 | -82 |
| Nottm University Hospitals NHS Trust | Plan | 14 | 7 | 16 | 14 | 12 | 16 | 37 | 37 | 38 | 38 | 38 | 38 | 191 | 305 |
| | COHA | 10 | 10 | 11 | 12 | 5 | 14 | 8 | 10 | 10 | | | | 90 | 90 |
| | HOHA | 14 | 7 | 16 | 14 | 12 | 16 | 15 | 14 | 14 | | | | 122 | 122 |
| | Total acquired | 24 | 17 | 27 | 26 | 17 | 30 | 23 | 24 | 24 | 0 | 0 | 0 | 212 | 212 |
| | Cumulative Variance | 10 | 20 | 31 | 43 | 48 | 62 | 48 | 35 | 21 | -17 | -55 | -93 | 21 | -183 |

**Current issue/risk**
New reduction objectives were released in July 21. CCG on plan year to date.

| Theme | Indicator | Indicator | 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 Nottm and Nottinghamshire CCG | Plan | 18 | 18 | 18 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 18 | 168 | 224 |
| | COCA | 10 | 16 | 6 | 16 | 9 | 7 | 16 | 7 | 5 | | | | 92 | 92 |
| | COHA | 6 | 2 | 4 | 9 | 3 | 7 | 7 | 5 | 4 | | | | 47 | 47 |
| | HOHA | 6 | 6 | 8 | 9 | 8 | 8 | 5 | 6 | 11 | | | | 67 | 67 |
| | Total acquired | 22 | 24 | 18 | 34 | 20 | 22 | 28 | 18 | 20 | 0 | 0 | 0 | 206 | 206 |
| | Cumulative Variance | 4 | 10 | 10 | 25 | 26 | 29 | 38 | 37 | 38 | 19 | 0 | -18 | 38 | -18 |
| Sherwood Forest Hospital NHS Trust | Plan | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 2 | 2 | 3 | 3 | 2 | 12 | 20 |
| | COHA | 2 | 1 | 0 | 2 | 0 | 1 | 3 | 2 | 1 | | | | 12 | 12 |
| | HOHA | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 1 | 0 | | | | 9 | 9 |
| | Total acquired | 2 | 2 | 2 | 2 | 0 | 4 | 5 | 3 | 1 | 0 | 0 | 0 | 21 | 21 |
| | Cumulative Variance | 2 | 1 | 0 | 2 | 0 | 1 | 3 | 1 | -1 | -3 | -3 | -2 | 9 | 1 |
| Nottm University Hospitals NHS Trust | Plan | 7 | 4 | 8 | 12 | 12 | 12 | 12 | 14 | 16 | 16 | 16 | 15 | 97 | 144 |
| | COHA | 6 | 2 | 5 | 9 | 3 | 6 | 7 | 4 | 5 | | | | 47 | 47 |
| | HOHA | 7 | 4 | 8 | 12 | 12 | 8 | 7 | 6 | 10 | | | | 74 | 74 |
| | Total acquired | 13 | 6 | 13 | 21 | 15 | 14 | 14 | 10 | 15 | 0 | 0 | 0 | 121 | 121 |
| | Cumulative Variance | 6 | 2 | 5 | 9 | 3 | 2 | 2 | -4 | -1 | -16 | -16 | -15 | 24 | -23 |

**Current issue/risk**
New reduction objectives were released in July 21. CCG over monthly plan 206/224 cases. SFHT have breached year-end plan 20/21 cases

**Mitigating Actions (Provider)**
This is new work and 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

| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Pseudomonas | | Sandy Smith | CCG<br>Acute Providers |

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| Pseudomonas<br>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<br>2021-22 | TOTAL<br>2021-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS Nottm and Nottinghamshire CCG | Plan | 6 | 6 | 7 | 7 | 7 | 7 | 6 | 6 | 6 | 6 | 6 | 6 | 58 | 76 |
| | COCA | 0 | 1 | 1 | 4 | 3 | 3 | 3 | 3 | 6 | | | | 24 | 24 |
| | COHA | 1 | 1 | 2 | 2 | 2 | 1 | 0 | 2 | 0 | | | | 11 | 11 |
| | HOHA | 2 | 1 | 1 | 6 | 5 | 2 | 2 | 2 | 4 | | | | 25 | 25 |
| | Total acquired | 3 | 3 | 4 | 12 | 10 | 6 | 5 | 7 | 10 | 0 | 0 | 0 | 60 | 60 |
| | Cumulative Variance | 3 | 2 | 3 | 8 | 7 | 3 | 2 | 4 | 4 | 0 | 0 | 0 | 2 | 36 |
| Sherwood Forest Hospital NHS Trust | Plan | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 4 |
| | COHA | 0 | 0 | 0 | 0 | 1 | 0 | 0 | **0** | **0** | | | | 1 | 1 |
| | HOHA | 1 | 0 | 0 | 0 | 1 | 2 | 1 | **0** | **1** | | | | 6 | 6 |
| | Total acquired | 1 | 0 | 0 | 0 | 2 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 7 | 7 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 0 | 1 | 0 | -1 | -1 | 5 | 3 |
| Nottm University Hospitals NHS Trust | Plan | 2 | 3 | 2 | 8 | 9 | 2 | 4 | 4 | 4 | 5 | 6 | 6 | 38 | 55 |
| | COHA | 1 | 2 | 3 | 1 | 1 | 2 | 0 | 2 | 1 | | | | 13 | 13 |
| | HOHA | 2 | 3 | 2 | 8 | 9 | 2 | 6 | 3 | 4 | | | | 39 | 39 |
| | Total acquired | 3 | 5 | 5 | 9 | 10 | 4 | 6 | 5 | 5 | 0 | 0 | 0 | 52 | 52 |
| | Cumulative Variance | 0 | 0 | 0 | 0 | 0 | 0 | 2 | -1 | 0 | | | | 14 | -16 |

**Current issue/risk**
New reduction objectives were released in July 21. SFHT have breached year-end target 7/4 cases and CCG and NUHT are over monthly plan.

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

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

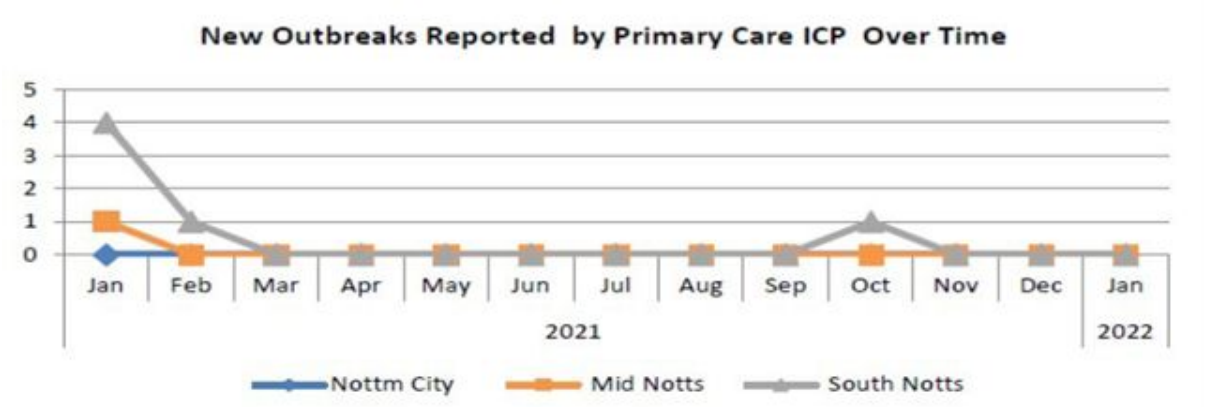
| Theme | Indicator | Indicator Overview | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | COVID-19 | | Sandy Smith | CCG Acute Providers |

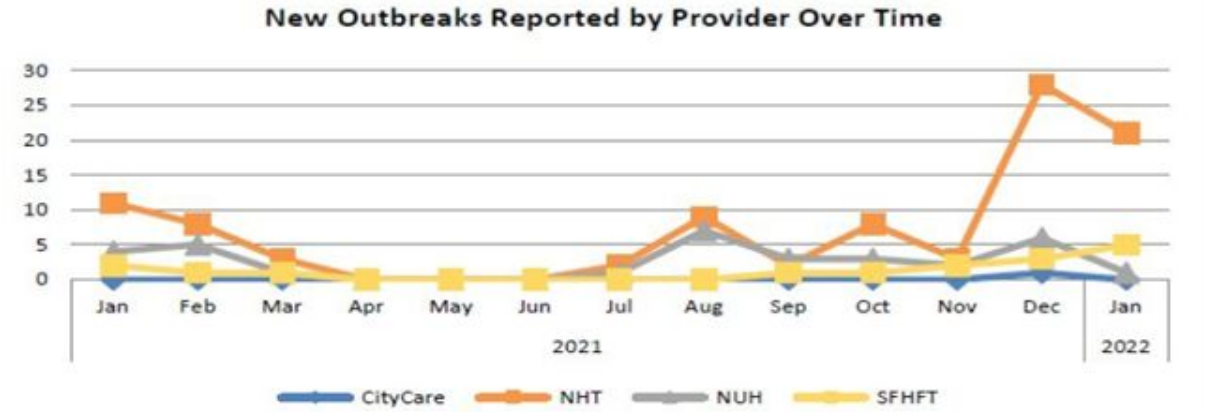
NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

| 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 | | | | 34 |
| Nottm University Hospitals NHS Trust | 5 | 0 | 0 | 6 | 14 | 8 | 10 | 1 | 18 | | | | 62 |

| 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 | | | | 61 |
| Nottm University Hospitals NHS Trust | 15 | 1 | 0 | 3 | 13 | 10 | 7 | 0 | 26 | | | | 75 |

| 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 | Data not available | | | | 122 |
| Nottingham University Hospitals NHS Trust | 7 | 6 | 2 | 21 | 39 | 61 | 42 | 47 | | | | | 225 |



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**Current issue/risk**
COVID-19 related outbreaks have dramatically escalated due to the new Omicron variant. W/c 12.1.22 there were 235 outbreaks in care homes and supported living services, 2 primary care, 6 NUHT,7 SFHT, 47 NHCT. Issue raised re access to national testing and long delays in reporting of results during December.
This has increased system and IPC pressures.
National and local COVID-19 rates remain high but are slowly decreasing.

**Mitigating Actions (Provider)**
Provider BAF in use for action planning
Implementation of IPC advice, guidance and training support. Increased testing,
Co-horting/zoning positive cases, contact cases from those currently negative.
Enhanced cleaning schedules.; Monitoring PPE use with audits and 'spot checks' of compliance;
Monitoring of safe staffing levels ; Adherence to guidance re reduced visitor access.
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 secondary care and NHCT

**Assurances (CCG)**
- Weekly/Monthly IPC system assurance meetings with escalation to ICS Quality Group,
- Public Health COVID-19 outbreak meetings 3 x week. Daily care homes taskforce meetings

| Theme | Indicator | Indicator | CCG Lead | Focus |
|---|---|---|---|---|
| Safe | Individual Funding Requests & Service Restricted Procedures | | Sandy Smith | CCG Acute Providers |

Nottingham and Nottinghamshire Clinical Commissioning Group

| 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 consisted meeting the 100% target from last month and so no exception reporting is required.

Nottingham and Nottinghamshire Clinical Commissioning Group

# 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 Serv | 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 Trus |
| 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 |

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| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |
| **Paper Title:** | Highlight report from the (virtual) meeting of the CCG's Audit and Governance Committee | **Paper Reference:** | **GB 21 130** |
| **Chair of the meeting** | Sue Sunderland, Non-Executive Director | **Attachments/ Appendices:** | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Purpose:** | Approve | ☒ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Summary of the Meeting**

The Audit and Governance Committee met on the 13 January 2022. Due to the current Coronavirus (Covid-19) restrictions, the meeting was held virtually.

At the meeting, the Committee:

- **RECEIVED ASSURANCE** from two reports on key areas of risk assurance:
  - The annual Fraud Risk Assessment
  - A review of the strategic risks identified within the CCG's 2021/22 Governing Body Assurance Framework and of the actions identified to remedy any identified gaps in controls and assurances.
- **RETROSPECTIVELY APPROVED** invoice payments and credit notes transacted outside of delegated limits. Since beginning to monitor this issue in June 2021, the Committee noted that a continued focus on this issue had resulted in a significant decrease in the number of instances where transactions had been approved outside of limits set in the CCG's Standing Financial Orders and had agreed a reporting by exception approach going forward.
- **NOTED** the issuance of the Stage Two Head of Internal Audit Opinion Report, which had not highlighted any concerns: and the final Internal Audit Report on Continuing Healthcare, which had provided an opinion of 'significant' assurance.
- **NOTED** a new risk relating to cyber security, which would continue to be monitored via the Committee's Risk Register.

The Audit and Governance Committee met 'in common' with the Audit Committee of Bassetlaw CCG on the 13 January 2022.

At the meeting 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 required amending and an update on this would be presented at

the next meeting. It was noted that the revised target date of 1 July 2022 for the ICB's establishment meant that the CCG would be responsible for signing off the Annual Report and Accounts 21/22 in June.

- **NOTED** the External Audit Plans for both CCGs.

| **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.**

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| | | | |
|---|---|---|---|
| **Meeting Title:** | Governing Body (Open Session) | **Date:** | 02 February 2022 |

| | | | |
|---|---|---|---|
| **Paper Title:** | Corporate Risk Report | **Paper Reference:** | **GB 21 131** |

| | | | |
|---|---|---|---|
| **Sponsor:** | Rosa Waddingham, Chief Nurse | **Attachments/ Appendices:** | N/A |
| **Presenter:** | Lucy Branson, Associate Director of Governance | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approve | ☐ | Endorse | ☐ | Review | ☐ | Receive/Note for:<br>• Assurance<br>• Information | ☒ |

**Executive Summary**

The purpose of this paper is to present the Governing Body with the major (red) operational risks from the CCG's Corporate Risk Register. This paper is a standing agenda item, presented to each meeting to ensure that the Governing Body is kept informed of the key risks facing the CCG and assured that robust management actions are in place to manage and mitigate them.

**Relevant CCG priorities/objectives:**

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

**Conflicts of Interest:**

☒ No conflict identified

**Completion of Impact Assessments:**

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

**Risk(s):**

The paper details the current major (red) risks in the Corporate Risk Register.

| **Confidentiality:** |
| --- |
| ☒No |
| **Recommendation(s):** |
| **1.** **NOTE** the major risks shown at Section 2.1 and comment on whether sufficient controls and actions are in place. |
| **2.** **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 **ten** major (red) operational risks in its Corporate Risk Register. This is a reduction in one major risk since the last meeting.

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 | | | | **1** |
| | 4 – High | | 1 | 7 | **8** | **1** |
| | 3 – Medium | | 3 | 5 | 4 | |
| | 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** *(July 2019)* | The risk of over reliance on non-recurrent (one-off) funds / mitigations to temporarily offset recurring (year on year) pressures may result in:<br>• Deterioration in the CCG's recurrent underlying financial position.<br>• Depletion of non-recurrent funds available.<br>• Over-reliance becoming a substitute for not needing to take recurrent corrective actions.<br>• Adverse impact on overall financial position in the medium to long term.<br><br>***Update:*** *The CCG is forecasting a breakeven year-end position for 2021/22, however, given the continued reliance on underspends and non-recurrent solutions, it is considered appropriate for the risk score to remain at 16.* | Overall Score 16: **Red** (I4 x L4) | Finance & Resources Committee |
| **RR 116** *(Oct 2019)* | 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. | Overall Score 16: **Red** (I4 x L4) | Quality & Performance Committee |

| Risk Ref | Risk Narrative | Current Risk Score | Responsible Committee |
|---|---|---|---|
| | ***Update:*** *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.*<br>*The Quality Team continues to work with the Trust as part of their organisational-wide Improvement Plans (e.g. attendance at Trust-wide Improvement Boards), which includes those relating to Priory Hospital, Specialised Services and Lings Bar Hospital. 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. There may be further challenges arising from the Omicron variant (e.g. staff absences) and the incident response.*<br>*Following discussions with the Chief Nurse, it was agreed that the risk should remain at 16 until such time as a dedicated 'deep dive' review can be undertaken by the Quality and Performance Committee, when a full assessment of the risk will be completed.* | | |
| **RR 129**<br>*(May 2020)* | There is a potential risk of increased morbidity and/or mortality for the CCG's population, both directly and indirectly, as a result of the COVID-19 pandemic.<br>The indirect factors include, but are not limited to, changes in patient behaviours (e.g. reluctance to seek health advice from primary and secondary care), limited access to services and longer waiting times for elective and planned care.<br><br>***Update:*** *Day-to-day operational waiting list management includes validation and clinical prioritisation of waiting lists. Both providers (Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust) work closely together with the CCG to maximise all available capacity with excellent engagement with the independent sector providers. This enables a system-wide view to ensure that surgery is in appropriate order of clinical priority and length of overall wait. However, the impact of the Omicron variant is having a significant impact on waiting lists and providers' ability to undertake elective activity.*<br>*The Planned Care Transformation Board oversees the development and delivery of system-wide transformation plans relating to planned care, cancer and diagnostics. It also oversees the Elective and Outpatient Transformation Programme and achievement of elective recovery fund (ERF) gateways. This is currently overseen by the CCG's incident management governance.*<br>*Given the current impact of Omicron, it has been agreed that* | Overall Score 16:<br>**Red**<br>(I4 x L4) | Quality & Performance Committee |

| Risk Ref | Risk Narrative | Current Risk Score | Responsible Committee |
|---|---|---|---|
| | *the risk should remain at 16.* | | |
| **RR 130** *(May 2020)* | COVID-19 may exacerbate health inequalities across the CCG's population if robust processes are not in place to ensure the prompt restoration of services.<br><br>***Update:*** *Mitigations to this risk largely link to the work that is being undertaken as described against risk RR 129.The Planned Care Transformation Board continues to oversee progress with elective recovery, supported by the Elective Hub. In response to the latest NHS critical incident (level 4), these structures now form part of the incident response governance, overseen by the Health and Social Care Emergency Tactical Coordinating Group (HSCETCG).*<br>*The ICS Health Inequalities Group continues to meet; reporting to the System Executive Group. Work is underway to develop a Health Inequalities Plan, which will be in place by March 2022.* | Overall Score 16:<br>**Red**<br>(I4 x L4) | Prioritisation & Investment Committee |
| **RR 151** *(Sept 2020)* | There is a risk that the CCG may incur increased costs of service provision due to COVID related requirements and the resulting reduction in productivity. This may manifest in increased prices for services that the CCG seeks to procure in the future, as well as increased costs to the NHS provider cost base. This, in turn, would have a cost pressure on the system.<br><br>***Update:*** *2021/22 planning submissions for H2 have been co-produced by system partners and submitted to Regulators. Contracts have been put in place with the independent sector providers for 2021/22, however, the financial regime put in place during COVID continues for NHS providers during H2.*<br>*Given H2 continues to be based on 2019/20, a true assessment of spend will need to be undertaken as part of planning for 2022/23, which will then help determine an accurate cost base. Work is underway to determine the 'true' underlying position of the system, in part, to determine which COVID related costs are expected to result in ongoing cost pressures.*<br>*The risk score is to remain at 16 until the full assessment has been completed.* | Overall Score 16:<br>**Red**<br>(I4 x L4) | Finance & Resources Committee |
| **RR 156** *(Nov 2020)* | 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.<br><br>***Update:*** *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* | Overall Score 25:<br>**Red**<br>(I5 x L5) | Quality & Performance Committee |

| Risk Ref | Risk Narrative | Current Risk Score | Responsible Committee |
|---|---|---|---|
| | *partners.*<br>*A comprehensive briefing in relation to NUH Maternity Services was provided at the January meeting of the Quality and Performance Committee; although assurances were provided around the work being undertaken through the 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.* | | |
| **RR 158**<br>*(April 2021)* | 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)).<br>This risk may be further exacerbated given the underlying, deficit position across the system.<br><br>***Update:*** *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 (as outlined within NHSEI 2022/23 Operational Planning Guidance).*<br>*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 Finance meeting during November 2021 to reaffirm some of the principles contained within.*<br>*Work has also been undertaken to develop a formal financial 'risk sharing' agreement as part of planning for 2022/23; this is currently in draft and awaiting agreement.* | Overall Score 16:<br>**Red**<br>(I4 x L4) | Finance & Resources Committee |
| **RR 160**<br>*(Oct 2019)* | 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'. | Overall Score 16:<br>**Red**<br>(I4 x L4) | Primary Care Commissioning Committee |

| Risk Ref | Risk Narrative | Current Risk Score | Responsible Committee |
|---|---|---|---|
| | ***Update:*** *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 PCCC 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. Primary Care Network workforce planning and 'roving' workforce support is also in place.*<br>*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. Further discussions are being held with the Associate Director of Primary Care and the Associate Director of PCN Development in relation to mitigations for this risk.* | | |
| **RR 162**<br>*(May 2021)* | A number of potential, and actual, complex and significant quality issues have been identified at Nottingham University Hospitals NHS Trust (NUH).<br>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.<br>***Update****: An action plan is in place which is being monitored by the ICS Quality Assurance and Improvement Group (QAIG); key themes within the action plan relate to organisational culture, patient experience, patient safety and clinical effectiveness. Resource from the CCG continues to support NUH in relation to delivery of the actions. However, there may be challenges arising from the Omicron variant (e.g. staff absences) and the incident response, impacting the required actions that need to be taken.*<br>*Following discussions with the Chief Nurse, it was agreed that the risk should remain at 20 until such time as a dedicated 'deep dive' review can be undertaken by the Quality and Performance Committee, when a full assessment of the risk will be completed.* | Overall Score 20:<br>**Red**<br>(I4 x L5) | Quality & Performance Committee |
| **RR 171**<br>*(Oct 2021)* | 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.<br>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. | Overall Score 16:<br>**Red**<br>(I4 x L4) | Quality & Performance Committee/ Primary Care Commissioning Committee |

| Risk Ref | Risk Narrative | Current Risk Score | Responsible Committee |
|---|---|---|---|
| | ***Update**: The CCG's Communication Team is doing a significant media focus on the COVID booster campaign, flu campaign, respiratory syncytial virus (RSV), mental health support and how the public should access urgent care services. There is also continuing effort to boost the public's confidence in the use of community pharmacy services.*<br>*Work is also continuing to respond to ongoing media and MP enquiries. Further updates and mitigations are being sought from relevant CCG lead officers.* | | |

2.2 The likelihood score for risk **RR 172** (*insufficient H2 funding*) has been reduced from 4 to 3, resulting in an overall score of 12 (I4 x L3), since the last meeting. This is in response to further assurances being provided regarding the efficiencies and mitigations identified to deliver a balanced financial position and the CCG continuing to report a breakeven position for 2021/22.

## 3. Workforce Risks

3.1 Following discussions at the December 2021 Governing Body meeting, an assessment has been undertaken on the workforce related risks currently held within the CCG's Corporate Risk Register. There are five 'live' operational workforce risks contained within the Register and these largely relate to the CCG's own workforce (i.e. capacity, wellbeing and the impact of COVID and agile working), alongside risk **RR 160** which relates to primary care workforce.

3.2 Secondary care workforce does not feature as an explicit risk within the Corporate Risk Register, however, is a contributing factor to a number of risks which have been identified in line with the CCG's statutory duty around quality improvement. Examples include quality risks (i.e. poor patient experience, patient safety and/or outcomes) due to failure to achieve EMAS performance targets, lack of pace in maternity service improvements, inability to meet mental health demand and increasing elective backlog. Workforce is a fundamental issue which contributes to all these risks.

3.3 When the Integrated Care Board is established, with its duties relating to the implementation of the People Plan, it will be key to ensure any risks associated with the primary, community, secondary and social care workforces are collectively considered and captured within the ICB's risk register. At present, risks associated with the 'one workforce' are held by the ICS People and Culture function.

3.4 It is also important to note that the CCG's Governing Body Assurance Framework does include a strategic risk relating to workforce which is jointly owned by the ICS. The detail of this will be reported as part of the year-end Governing Body Assurance Framework, scheduled to be presented to the April 2022 meeting of the Governing Body.

## 4. Recommendations

4.1 The Governing Body is requested to:

a) **NOTE** the major risks shown at Section 2.1 and comment on whether sufficient controls and actions are in place.

b) **HIGHLIGHT** any risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

**Siân Gascoigne**

**Head of Corporate Assurance**

Nottingham and Nottinghamshire Clinical Commissioning Group

# Minutes of the Nottingham and Nottinghamshire Patient and Public Engagement Committee held virtually on Tuesday 26 October 2021 2 pm to 4 pm

**Attendees;**
Sue Clague, Chair
Jasmine Howell, Vice Chair
Chitra Acharya, Patient Leader/Carer
Colin Barnard, Patient Leader/Diabetes
Gilly Hagen, Patient Leader/Sherwood Patient Participation Groups
Jane Hildreth, Community Voluntary Sector representing Mid Nottinghamshire PBP
Amdani Juma, African Institute for Social Development
Emma Lucas, My Sight Nottinghamshire
Roland Malkin, Nottinghamshire Cardiac Support Group
Paul Midgley, Rushcliffe
Helen Miller, Healthwatch Nottingham and Nottinghamshire
Carolyn Perry, Community Voluntary Sector representing, South Nottinghamshire PBP

**In attendance (NHS Nottingham & Nottinghamshire Clinical Commissioning Group's Staff/ICS):**
Julie Andrews, Engagement Manager
Alex Ball, Director of Communications and Engagement
Sasha Bipin, Engagement Officer
Amy Calloway, Assistant Director of Quality, Transformation and Oversight
Andrew Fearn, Digital Lead for the ICS
Prema Nirgude, Head of Insights and Engagement
Becky Sutton, Programme Director, Community Transformation Programme
Steven Smith, Programme Manager, Community Transformation Programme

**Apologies for absence were received from;**
Teresa Burgoyne, Nottingham West
Kerry Devine, Improving Lives
Daniel Robertson, Nottingham and Nottinghamshire Refugee Forum
Jules Sebelin, Community Voluntary Sector representing City PBP

| NN/196/10/21 | Welcome and introductions |
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| | Sue Clague welcomed everyone to the Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) meeting and extended a warm welcome to Prema Nirgude, Head of Insights and Engagement, who had recently taken up post and was attending her first PPEC meeting.<br><br>In addition, Alex Ball, Amy Calloway, Andrew Fearn, Becky Sutton and Steven Smith who would be presenting items on the agenda were welcomed. |
| **NN/197/10/21** | **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. |

Nottingham and Nottinghamshire Clinical Commissioning Group

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| **NN/198/10/21** | **Minutes of the last meeting** |
| | The minutes of the last PPEC meeting held on 28 September 2021 were discussed and these were agreed as an accurate record of the discussion that took place at that meeting. |
| **NN/199/10/21** | **Matters arising including Action Log** |
| | An updated copy of the Action Log had been circulated to PPEC members prior to the meeting and was noted.<br><br>Julie Andrews confirmed that the items in the action log recorded as complete had been completed to PPEC members satisfaction and it was agreed these could be closed.<br><br>Julie Andrews highlighted some of the ongoing actions within the action log as follows;<br><br>**NN/190/09/21 Dementia Well Pathway**<br>During discussion regarding Dementia Well Pathway engagement at the last meeting PPEC members had requested details of the planned feedback webinar. Julie Andrews advised that a provisional date of 24 November from 12 15 pm to 1 45 pm was subject to confirmation and further information would be circulated.<br><br>**Action; Julie Andrews to circulate further details of the Dementia Well Pathway feedback webinar.**<br><br>**NN117/08/21 Interpretation and Translation Services**<br>Julie Andrews explained to PPEC members that planning for further engagement was pending availability of the outcome of desktop research being undertaken by a subject matter expert. PPEC members agreed that a further update should be provided at the November meeting to include progress against key milestones.<br><br>**Action: Julie Andrews to include an update regarding Interpretation and Translation Services on PPEC forward programme for November 2021**.<br><br>**NN/157/06/21 and NN/168/07/21 – Engaging with ethnically diverse communities in Mid Nottinghamshire**<br>Julie Andrews referenced concerns raised by PPEC members that minority ethnic communities in Mid Nottinghamshire may be feeling isolated due to their inability to access their usual support networks in the City during the pandemic. Diane Carter agreed to follow this issue up at end June 2021. PPEC members agreed that Diane Carter should be invited to provide an update at November/December meeting on progress made to identify communities and to share any issues and barriers they are experiencing and how these would be addressed.<br><br>**Action: Julie Andrews to include an update regarding engagement with ethnically diverse communities in Mid Nottinghamshire in the PPEC forward programme for November/December 2021.**<br><br>**PPEC Virtual Membership**<br>With regard to the action relating to virtual PPEC membership Julie Andrews explained that the action had been partially completed and the outstanding issues would be addressed through the work taking place regarding working with people and communities as part of the ICS transition. PPEC members agreed that this action could be removed from the action log. |

Nottingham and Nottinghamshire Clinical Commissioning Group

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| | **Action: Julie Andrews to remove the action relating to PPEC membership from the action log.** |
| **NN/200/10/21** | **ICS Transition** |
| | **a) Working with people and communities**<br>Copies of a paper entitled Working with People and Communities prepared for presentation to the ICS Board on 4 November 2021 had been circulated to PPEC members prior to the meeting.<br><br>Alex Ball, Director of Communications and Engagement provided a brief introduction to this paper explaining that it summarised a high level approach to involving people and communities and had been shared with PPEC members in advance of it being presented to the ICS Board. PPEC members had been involved in previous discussions and workshops to inform the development of the paper. PPEC members were invited to provide input to navigate and accelerate implementation of an ambitious programme as quickly and effectively as possible and to help identify critical success factors.<br><br>Sue Clague referenced the detail in the paper and acknowledged the work that had gone into its development by the Engagement Team.<br><br>PPEC members highlighted the following points;<br>• The Citizens Panel appears to have the potential to be something that is big, cumbersome and expensive. This point was noted and it was confirmed that the citizens panel would form part of a spectrum of activity that would be agile and lean.<br>• A greater emphasis should be included regarding the influence of engagement which would be a critical success factor and increase belief that it can work.<br>• Community and voluntary sector are an important part of the engagement approach and mapping would help identify any gaps in representation. Adequate resources would be required to support engagement through the sector. The richness and diversity of the community and voluntary sector was acknowledged and is being progress through a parallel programme of work to support leadership and integration within the ICS.<br>• Social prescribers have much valuable insight that could be used to inform local approaches.<br><br>Clarification was requested regarding the Advisory Committee and whether or not this would incorporate the transition of PPEC. Alex Ball acknowledged the need to clarify this but explained that the governance arrangements would be different and were still evolving. The ICS would wish to maintain the intelligence and enthusiasm of PPEC members but this would need to fit with other elements of the governance structures.<br><br>Alex Ball also referred to governance at place and neighbourhood level and the need to be flexible and shape what is required providing broad principles to support places and neighbourhoods to develop their approach.<br><br>Alex Ball agreed to reference the above comments when presenting to the ICS Board on 4 November 2021. The ICS Board would be asked to endorse the approach following which there would be a significant amount |

of work to progress implementation. Several things would need to be in place by 1 April 2022 to ensure the organisation was legally compliant. Overall the approach could take between 12 and 18 months to fully implement.

**Action: Alex Ball to incorporate PPEC members comments when presenting to the ICS Board on 4 November 2021.**

**b) Co-production**

Copies of an overview of the work taking place to develop an ICS Co-Production Strategy together with a presentation had been circulated to PPEC members prior to the meeting and were noted.

Amy Calloway, Assistant Director of Quality, Transformation and Oversight, provided PPEC members with an overview of the programme of work to develop system wide co-production across the ICS in readiness for new governance arrangements that would take effect from April 2022. Co-production would be embedded in all areas of the new organisation including commissioning, service development, service change and key decision making.

Nottingham and Nottinghamshire was one of 10 sites to secure funding and peer mentoring from NHSE/I to develop and embed strategic co-production across the system.

In addition to a strategy, other key deliverables include:

- A co-production toolkit for staff
- Toolkit materials and training package
- Strategic co-production group to report into the Integrated Care Board
- Culture change across the system

The approach complements the engagement work happening across the system and forms part of the system approach to working with people and communities.

Paul Midgley welcomed this approach and suggested the East Midlands Academic Health Science Network (EMAHSN) PPI Senate would be a good group to engage with to obtain feedback on the Co-Production Strategy.

Gilly Hagen suggested engaging with partners at a place and neighbourhood level for example District/Borough Councils. Amy Calloway confirmed that engagement had taken place at place and neighbourhood level and whilst an overarching umbrella strategy would be developed there would be an expectation that key partners would sign up to it and for their own strategies to align with it.

Sue Clague looks forward to seeing a worked through example of co-production and suggested this could relate to a patient pathway, for example emergency care.

Sue Clague welcomed the presentation and the embedding of the concept of co-production across the system.

Nottingham and Nottinghamshire Clinical Commissioning Group

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| **NN/201/10/21** | **Community Transformation Programme** |
| | Copies of a paper providing an update on the Community Transformation Programme had been circulated to PPEC members prior to the meeting.<br><br>Becky Sutton, Programme Director, Community Transformation Programme, presented the update and referred to the huge role community services play in service delivery across the system. The vision is to optimise people's independence by addressing their physical and mental health and social care needs. The programme began in May 2021 to define good services and outcomes and is currently in Phase 2, the strategy and development phase will explore in more detail what the vision should look like including best practice and key principles for neighbourhoods to adopt. During Phase 3, work will take place with neighbourhoods to co-produce community services in response to health inequalities and differing needs. Citizen engagement and co-production would be key at neighbourhood level and would build on existing community assets and incorporate integration with social care. The plan is to identify early adopters and work through a 100 day improvement cycle to test and co-produce a local approach.<br><br>Sue Clague noted that the work had been ongoing since May 2021 and queried the timeline for implementing change, requested outputs of the workshops and principles to test. This was one of the biggest transformation programmes that would happen in the next 2 – 3 years and it is important to understand the citizen perspective to inform service transformation.<br><br>Becky Sutton responded that stakeholder engagement to date had focused on securing a commitment from partners to a high level ambition to do something fundamentally different across the system. Becky Sutton provided assurance to PPEC members that citizen engagement through co-production would be applied across the system from January 2022.<br><br>Sue Clague suggested that citizen engagement would need to take account of the state of maturity of the neighbourhoods and this should be taken into consideration when identifying early adopter sites. In addition, consideration should be given to developing metrics that would identify improvements in the quality of community services.<br><br>PPEC members noted the update on the Community Transformation Programme and the commitment to meaningful citizen engagement within the programme that could deliver a different offer in response to the differing needs of an area. PPEC members agreed that a further update should be provided in January 2022.<br><br>**Action: Julie Andrews to include an update regarding the Community Transformation Programme in PPEC forward programme for January 2022.** |
| **NN/202/10/21** | **Digital Solutions** |
| | Andrew Fearn, Digital Lead for the ICS, provided PPEC members with an overview of the national context and referenced Government policy document Data saves lives: reshaping health and social care with data supported by NHSx leading body for digital services What Good Looks Like framework that sets out a common vision for good digital practice and the Unified Tech Fund that has released nationally £634 million to bid against to spend predominantly by March 2022. |

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| | In addition, the ICS Design Framework provides eight key elements that an ICS should have from a digital perspective. This includes a clear ICS digital strategy that covers five key areas;<br>1. Public facing digital services<br>2. Population health management to steer and design services<br>3. Digitilisation of providers<br>4. Single care record<br>5. Digital literacy of staff and service users with a focus on the NHS App and Patient Knows Best (PKB) to provide access to information through one gateway and then to start to capture information. For example, a patient may self identify as housebound via PKB and this information could be used to inform delivery of appropriate services.<br><br>A lengthy discussion took place that covered three key areas, digital exclusion, NHS app and use of NHS app to help alleviate system pressures particularly in primary care;<br><br>1. With regard to addressing digital exclusion, Gilly Hagen shared an example of a community hub in place in Mid Nottinghamshire that offers free tablets and digital health champions to support people who don't have access to their own resources and need support and training. A further example was shared whereby hospital out-patient appointments had taken place in local GP practices to enable the patient to connect via video link to avoid a long journey time to hospital.<br><br>Andrew Fearn advised the ICS was keen to explore how across Nottingham and Nottinghamshire 'safe pods' could be provided in libraries or healthcare settings to allow people to access their healthcare provision and have access to facilities that enable them to talk to the people they need to talk to.<br><br>Emma Lucas suggested consideration be given to the siting of safe pods in community and voluntary sector settings and would welcome a conversation about provision for people with visual impairment. Andrew Fearn acknowledged the importance of involving community groups in the design of this and agreed to have follow up conversations with Gilly Hagen and Emma Lucas.<br><br>Jane Hildreth reminded everyone not to forget those citizens who do not wish to be digitally enabled but still need to access information and appointments.<br><br>2. Paul Midgley referenced the NHS app and PKB and how well it is embraced by Sherwood Forest Hospitals Foundation Trust (SFHFT) compared to Nottingham University Hospitals Trust (NUH). It was suggested the Unified Tech Fund could support further developments at NUH.<br><br>Andrew Fearn acknowledged the need for all partners to change attitude and opinions regarding the sharing and more effective use of information across the system.<br><br>Helen Miller highlighted the data security risks posed by having several NHS related apps available to patients and asked for clarification as to how this could be brought together in a single gateway to reduce security risks. |

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| | Andrew Fearn responded that over the last 18 months due to Covid-19 the way healthcare is delivered had radically changed through the use of technology. This was an issue to be addressed and favoured the use of the NHS app with PKB sitting behind this.<br><br>Further clarity regarding the plans to grow the 275,000 citizens already signed up to the NHS app was requested.<br><br>3. Paul Midgely asked that consideration be given to developing communication plans that could be put in place relatively quickly to help alleviate pressures in general practice, through encouraging use of NHS App to reduce telephone calls into practices for repeat prescriptions, insurance reports, sharing results.<br><br>Andrew Fearn confirmed that this is an area that is being explored to alleviate pressures across the system.<br><br>Sue Clague thanked Andrew Fearn for an extremely informative presentation that had generated a great deal of discussion.<br><br>**Action: Andrew Fearn to arrange follow-up conversations with Gilly Hagen and Emma Lucas.** |
| **NN/203/10/21** | **Covid Update** |
| | Alex Ball, Director of Communications and Engagement provided a brief update on the Covid-19 and the vaccination programme as follows:<br><br>• Covid-19 infection rates are steadily increasing and there was concern regarding pressures on the NHS during the winter period.<br>• Vaccination programme is not optimal but progress is being.<br>• Booster doses are available to those eligible to walk-in and access at any one of three sites.<br>• To access a booster dose at a GP site, invitations will be sent out by letter.<br>• Eligible people (190 days since second vaccination) may also book online to go to any one of the three sites and community pharmacy.<br>• Vaccinations for 12 to 15 year olds would continue after the half term break and appointments could be booked at the larger vaccination sites.<br>• People can continue to walk- in to access first and second vaccinations. Number of people over age of 80 years have attended for their first dose.<br><br>In response to a question, it was confirmed that the regular community briefings on Covid-19 would continue if they were helpful. PPEC members confirmed that they are helpful. |
| **NN/204/10/21** | **PPEC Terms of Reference** |
| | Copies of an updated version of the PPEC Terms of Reference had been circulated to PPEC members prior to the meeting.<br><br>Sue Clague highlighted to PPEC members that Section 8, 'Conduct of business and members' of PPEC's Terms of Reference have been updated to clarify the purpose of recording meetings and to provide an etiquette for PPEC members to follow when attending virtual meetings.<br><br>PPEC members noted the changes to the Terms of Reference. |

Nottingham and Nottinghamshire Clinical Commissioning Group

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| **NN/205/10/21** | **Governing Body Feedback & Key Messages from PPEC** |
| | Sue Clague provided feedback from the Governing Body meeting held on 6 October 2021 when discussion had focused on:<br>• The provider collaborative involving Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Foundation Trust and Sherwood Forest Hospitals Foundation Trust, working together on elective recovery. An update on progress would be brought to PPEC next month.<br>• A new framework to improve accountability of primary care performance.<br>• Community care transformation and the measurement of outcomes using the expertise within the newly established System Analytical Unit.<br>• Workforce issues with a focus on staff shortages.<br><br>**Sue Clague summarised the key messages from PPEC that would be highlighted at the next Governing Body meeting on 1 December 2021 as;-**<br>1. PPEC members welcomed the progress made to date to develop a framework for working with people and communities as part of the ICS transition. It was noted that there was a significant amount of work to do to implement the framework and that supporting the establishment of robust arrangements at place and neighbourhood level remain a key challenge to its successful implementation.<br>2. The development of a co-production strategy for implementation across the ICS was welcomed. PPEC members look forward to understanding more about the practical application of co-production and suggested this could be applied to a patient pathway, for example emergency care.<br>3. A presentation on the Community Transformation Programme provided PPEC members with details of the stakeholder engagement undertaken to date to agree high level principles for all partners to sign up to. PPEC members noted that citizen engagement would take place at neighbourhood level to facilitate co-production of community services that are responsive to health inequalities and differing needs. PPEC members requested further detail regarding plans for citizen engagement in January 2022.<br>4. PPEC members welcomed the details shared regarding digital transformation across the ICS and highlighted the need for a single gateway to NHS digital applications to improve accessibility and data security. |
| **NN/206/10/21** | **Any Other Business** |
| | There were no further items for discussion. |
| **NN/207/10/21** | **Date of Next Virtual Meeting** |
| | The next PPEC meeting will be held virtually on Tuesday 30 November 2021 from 2 pm to 4 pm via Microsoft Teams. |

Nottingham and Nottinghamshire Clinical Commissioning Group

# Minutes of the Nottingham and Nottinghamshire Patient and Public Engagement Committee held virtually on Tuesday 30 November 2021 2 pm to 4 pm

**Attendees;**
Sue Clague, Chair
Jasmin Howell, Vice Chair
Chitra Acharya, Patient Leader/Carer
Colin Barnard, Patient Leader/Diabetes
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
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 Sebelin, Community Voluntary Sector representing City ICP
Mary Spencer, Bassetlaw PPGs
Becky Law, Community Voluntary Sector representing Bassetlaw

**In attendance (NHS Nottingham & Nottinghamshire Clinical Commissioning Group's Staff):**
Julie Andrews, Engagement Manager
Alex Ball, Director of Communications and Engagement
Sasha Bipin, Engagement Officer
Lucy Dadge, Executive Team representative
Lisa Durant, System Delivery Director; Planned Care, Cancer and Diagnostics
Karen Foulkes, Deputy Head of Children's Commissioning
Jane Hufton, Engagement Assistant (minute taker)
Prema Nirgude, Head of Insights and Engagement

**Apologies for absence were received from;**
Deb Morton, Healthwatch
Amdani Juma, African Institute for Social Development
Mike Deakin, Nottinghamshire County Council

| NN/208/11/21 | Welcome and introductions |
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| | Sue Clague welcomed everyone to the Nottingham and Nottinghamshire Patient and Public Engagement Committee (PPEC) meeting and extended a warm welcome to two new members representing Bassetlaw, Mary Spencer and Becky Law recognising that Bassetlaw would be part of the new Nottingham and Nottinghamshire Integrated Care Board from April 2022. |
| **NN/209/11/21** | **Declarations of interest** |
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| | 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/210/11/21** | **Minutes of the last meeting** |
| | The minutes of the last PPEC meeting held on 26 October 2021 were discussed and agreed as an accurate record of the discussion that took place at that meeting. |
| **NN/211/11/21** | **Matters arising including Action Log** |
| | An updated copy of the Action Log had been circulated to PPEC members prior to the meeting and was noted.<br><br>Julie Andrews confirmed with PPEC members that the completed actions could be closed. Julie Andrews continued by highlighting the outstanding actions for discussion which included:-<br><br>**NN/202/10/21 –** Following on from the previous meeting Andrew Fearn had agreed to contact PPEC members, Gilly Hagen and Emma Lucas to discuss digital transformation. This had not taken place, therefore, Julie Andrews agreed to follow up with Andrew Fearn.<br><br>**Action: Julie Andrews to contact Andrew Fearn to remind him to contact PPEC members to follow up conversations about digital transformation.**<br><br>**NN/199/10/21** and **NN/142/05/21 –** It was agreed email updates regarding engagement with ethnically diverse communities in Mid Nottinghamshire and preventative programme information would be shared with PPEC members.<br><br>**Action: Julie Andrews to request updates regarding engagement with diverse communities in Mid Nottinghamshire and ICS Prevention Programme**.<br><br>**NN/133/04/21**- Community Diagnostic Hubs. Paul Midgely and Teresa Burgoyne both expressed interest in joining the working group. The development of an engagement plan to wrap around the Community Diagnostic Hubs would be progressed. Simon Oliver had offered to attend a future PPEC meeting to provide a further update on Community Diagnostic Hubs.<br><br>**Action: Julie Andrews to confirm representation on the Community Diagnostic Hubs Working Group with Lisa Durant and Simon Oliver.**<br><br>**Action: Julie Andrews to develop an engagement plan to wrap around the Community Diagnostic Hub programme.** |
| **NN/212/11/21** | **Covid Update** |
| | Alex Ball, Director of Communications and Engagement provided an update on the Covid 19 vaccination programme and this was noted by PPEC members.<br><br>Alex Ball confirmed that cases had risen in Nottingham and Nottinghamshire of patients testing positive for Covid. Whilst there has been a lower impact on |

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| | hospitalisation and deaths due to the vaccination programme it is continuing to create pressure and considerable challenges in hospitals. The Omicron variant had led to the Government putting in place new restrictions including the use of face coverings, international arrivals being subject to PCR tests and anyone in contact with someone with Omircron having to isolate for 10 days.<br><br>Alex Ball updated members that in the UK almost 100 million vaccinations had been administered and reminded PPEC members of the current eligibility criteria for boosters that is available on the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) website https://nottsccg.nhs.uk/covid-19/covid-19-vaccinations/groups-being-vaccinated/.<br><br>PPEC members highlighted issues regarding long queues at specific sites. Alex Ball acknowledged this and advised that across Nottingham and Nottinghamshire a booking only model had been implemented and encouraged everyone to book their appointments. Further clarification was requested regarding provision in Newark. It was confirmed that provision was subject to ongoing review and changes would be implemented as required.<br><br>PPEC members thanked Alex Ball for the update around the Covid-19 Vaccination programme. It was agreed that this should continue to be a standing PPEC agenda item for the foreseeable future. |
| **NN/213/11/21** | **Children and Young People's Holistic Healthy Lifestyle Service** |
| | Karen Foulkes, Deputy Head of Children's Commissioning and Sasha Bipin, Engagement Officer shared a presentation on the outcome of engagement to inform the development of a new Children and Young People's Holistic Healthy Lifestyle Service (weight management service for children and young people who are significantly above a healthy weight without other healthcare issues). The preparatory work undertaken, methodology and key points arising from the engagement undertaken were highlighted.<br><br>Engagement took place during July and August 2021 with children and young people, parents and carers and professionals. Valuable insight was gathered by promoting surveys, attending groups virtually and in 1:1 interviews.<br><br>Subsequently a detailed report had been published outlining the key recommendations arising from the engagement. Key recommendations included;<br>• The need for this service to offer support to all under the age of 18, who are over a specific Body Mass Index (BMI).<br>• The need for friendly staff, who know how to communicate well with children and young people, and who offer a non-judgemental approach to support.<br>• The need for the service to adopt a tailored approach to support by offering a range of support options that are delivered from community settings.<br>• The need for the service to be staffed with Doctors, Nurses, Exercise Specialists, Peer Support Workers, Mental Health Support, Dietitians and Key Workers who are skilled in working with families with weight management needs.<br>• The service should provide holistic family support and offer positive advice and tips to help children and young people make positive changes. |

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| | • The service should measure change in the young person's behaviour, overall confidence levels, confidence levels in maintaining a healthy lifestyle and overall wellbeing to understand how effective the service has been.<br><br>Karon Foulkes advised that the engagement report would be shared with those who had participated in the engagement and others and they would be invited to join a Steering Group to be held on 15 December 2021 to help inform the design of this service.<br><br>PPEC members commended the approach to engagement and were particularly pleased that engagement had been undertaken at a stage when it could be used to inform the service specification.<br><br>PPEC members raised following questions;<br>• Would it be possible to incorporate everything that has been asked for in the business case or will it be necessary to prioritise?<br>• What will be the approach regarding transition to adult services?<br>• How many young people will benefit from the new service?<br>• How will emotional and psychological aspects feature in new services?<br><br>In response, Karon Foulkes explained that this was a new service that the CCG had a responsibility to provide and it would be supported financially. The development of services for adults is also taking place simultaneously and this provides an excellent opportunity to incorporate transitional arrangements in the planning. It was confirmed that the National Child Measurement Programme provided data regarding numbers of children who would require this service that would incorporate a multi-disciplinary approach to provide holistic support including emotional and psychological support.<br><br>It was agreed that this programme of work should be reviewed using the PPEC Effectiveness Framework.<br><br>**Action: Julie Andrews to schedule a review of this programme of work using the PPEC Effectiveness Framework and bring back to PPEC in March 2022.** |
| **NN/214/11/21** | **ICS Transition; working with people and communities** |
| | Prema Nirgude, Head of Insights and Engagement delivered a presentation on 'Integrated Care System (ICS): Working with people and communities'.<br><br>Prema Nirgude reported that the paper entitled, 'Working with People and Communities' providing a high level approach to engagement, had been presented at the ICS board meeting on 4 November 2021. Overall, the proposal had been endorsed with a few areas identified for further development including incorporating the involvement of Foundation Trust Governors and wider memberships, expert patient groups and alignment to Health and Wellbeing Boards in the City and County.<br><br>Subsequent discussion focused on the engagement structures required to deliver some components of the high-level approach that would deliver continuous and consistent listening to citizens moving away from a model of episodic and discrete periods of asking people about changes the NHS would like to make to health services. |

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| | PPEC members were reminded of current sources of insight and engagement structures at neighbourhood, place and system level and alignment of PPEC to the Governing Body. The ten principles for how ICSs work with people and communities that featured in the detailed guidance were shared.<br><br>PPEC members were asked to consider a proposed engagement structure for the ICS/ICB. The structure would provide a clear link between a Strategic Citizen Engagement Advisory Group, and Integrated Care Board (ICB) and Integrated Care Partnership (ICP). The structures also included a VCSE Alliance. There was an expectation that a formal agreement for engaging and embedding the VCSE in system level governance and decision-making arrangements would be in place by April 2022, ideally working through a VCSE Alliance. Work is underway with VCSE colleagues from our four places, Self Help UK and Citycare to co-produce this formal arrangement.<br><br>Prema Nirgude invited PPEC members to share their expertise and learning to support the establishment of the Strategic Citizen Engagement Group and to develop ideas for bringing together insight from a wide range of sources within our four places. Jane Hildreth and Paul Midgely expressed an interest in being involved in a working group. Any further expressions of interest should be sent to Prema Nirgude.<br><br>Discussion ensued about citizen engagement at a place and neighbourhood level. There was some concern about the maturity of place and neighbourhood infrastructure to deliver effective citizen engagement. There was strong support for PPG involvement but recognition that not all areas have strong PPGs and that inclusive citizen (not just patient) engagement is necessary to ensure diverse populations have a voice.<br><br>**Action: PPEC members to email Prema Nirgude to register interest in participating in a working group to further develop engagement structures.** |
| **NN/215/11/21** | **Interpretation and Translation Services Update** |
| | Julie Andrews, Engagement Manager updated PPEC members on a planned programme of engagement to inform the procurement of Interpretation and Translation Services that would be commissioned to meet the needs of the population in Nottingham and Nottinghamshire. The service would provide access to interpretation and translation services for people for whom English is not their first language accessing GP services.<br><br>PPEC members were reminded that a programme of engagement had been completed during Spring 2021 involving a range of advocacy groups to define what good looks like in terms of service provision. Primary Care Commissioning colleagues presented a proposal to the Primary Care Commissioning Committee in July 2021 and following consideration a more comprehensive analysis was requested to include:<br><br>• A desk top review of service provision in other areas<br>• Further stakeholder engagement<br>• Options appraisal<br><br>The outcome of the comprehensive analysis referenced above will be considered by the Primary Care Commissioning Committee, a procurement process would be undertaken with a new service to be in place by 1 July 2022. |

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| | With regard to engagement, PPEC members were informed of plans to engage with a range of stakeholders including faith groups, Black and Asian Minority Ethnic groups, community groups, advocacy groups, staff working in General Practice and the Nottingham Together Board. Engagement would be undertaken through a survey to gather broader views, focus groups during December 2021 to January 2022. PPEC members were invited to share details of any further groups to include on the stakeholder list.<br><br>Sue Clague welcomed the thorough engagement process that was planned.<br><br>**Action**: **PPEC members were asked to contact Julie Andrews with any further suggestions of stakeholders to engage with**. |
| **NN/216/11/21** | **Elective Recovery Update** |
| | Lisa Durant, System Delivery Director; Planned Care, Cancer and Diagnostics shared a presentation that provided an update on the elective recovery programme developed in response to significant backlog of patients waiting for elective care as a result of Covid 19. The key points highlighted were;<br><br>• Despite ongoing urgent pressures the system benchmarks well in comparison to the region and nationally<br>• Patients are priorities clinically appropriately<br>• In parallel the system has plans to deliver the national requirements to eliminate waits of longer than 104 weeks by March 2022 and to stabilise waiting lists. Majority of patients waiting over 104 weeks are Ear Nose and throat (ENT) patients.<br>• There is a significant level of risk over winter of increased urgent care demand and Covid related admissions, therefore all system partners are working together to enable safe timely access to care for patients<br>• Risks are exacerbated by workforce constraints and system partners are working together to support our staff<br>• Oversight of elective recovery is underpinned by a system wide approach to clinically led service transformation and earlier diagnosis<br><br>Lisa Durant advised that Nottingham University Hospitals and Sherwood Forest Hospitals Trusts had reached out to patients waiting for surgery in June/July 2021 apologising for the wait and providing a broad average wait as an indication. Guidance was provided about keeping well, receiving the Covid vaccination, controlling longer term conditions and remaining fit for surgery. A central contact point was given to enable patients to raise any questions/concerns but minimal feedback had been received.<br><br>Lisa Durant confirmed that the system had submitted a plan mid-November to stabilise waiting lists and to ensure that no patient would wait over 104 weeks by March 2022. Cancers are being diagnosed earlier and in parallel the system aims to improve cancer 62 day performance.<br><br>Lisa Durant highlighted the many risks impacting on elective care provision including workforce, winter pressures, critical care capacity Covid 19 and flow out of hospital remains challenging. However, the system would build on its successes which include |

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| | a successful bid for 'Elective Accelerator' funding, planned care transformation programme and pathway redesign.<br><br>In response to a question about plans for clinical pathways to be streamlined and pharmacists, optometrists and dentists to be part of primary care networks, Lucy Dadge confirmed that from April 2023 responsibility for commissioning Pharmacy, Optometry and Dentistry (PODs) would be delegated to the ICB who would support the development of such clinical pathways and integrated working.<br><br>In response to a request from PPEC members, Lucy Dadge agreed to attend a future PPEC meeting to explore opportunities for pathway redesign at place level in relation to PODs but asked that PPEC members consider and share any opportunities they identify for such pathway development.<br><br>In response to a query about hospital discharge, Lisa Durant confirmed that the system is working collaboratively on this and the flow out of hospital is due to a number of reasons including lack of capacity to assess patients and availability of home care services.<br><br>**Action: PPEC members to provide examples of opportunities for pathway redesign at place level utilising the expertise of PODs.**<br><br>**Action: Julie Andrews to include an item on PODs pathway redesign opportunities at place level on the PPEC forward programme.** |
| **NN/217/11/21** | **Governing Body and Committee Feedback** |
| | Sue Clague provided feedback from the Governing Body development session that had focused on ensuring patients are treated in appropriate health care settings to avoid inappropriate attendances at the Emergency Department.<br><br>Discussion at the Prioritisation and Investment Committee had focused on the Community Transformation Programme and service redesign for musculoskeletal and pain management services.<br><br>**Key messages from PPEC to highlight at the next Governing Body meeting on 1 December 2021 were;-**<br><br>1. 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 to be known as the Holistic Healthy Lifestyle Service. The thoroughness of the engagement and report was commended. PPEC members were particularly pleased that the engagement had been undertaken at a stage that it could be used to inform the service specification. In addition, it would be aligned to the development of a new service for adults and that this would support transition arrangements between children and young people and adult services. PPEC members will review this programme of work using the PPEC effectiveness framework to identify any good practice or learning.<br>2. With regard to the ICS Transition; Working with people and communities, PPEC members received an update following discussion of this at the last ICS Board meeting. PPEC members' discussion focused on citizen engagement at a place and neighbourhood level. There was some concern about the maturity |

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| | of place and neighbourhood infrastructure to deliver effective citizen engagement. There was strong support for PPG involvement but recognition that not all areas have strong PPGs and that inclusive citizen (not just patient) engagement is necessary to ensure diverse populations have a voice.<br>3. An update was provided regarding Interpretation & Translation Service in relation to the planned engagement and PPEC members noted a thorough process was planned.<br>4. 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. However, it was noted that increasing pressures continue across the system in particular challenges regarding flow out of hospital that impacts on the ability to offer elective care to patients. |
| **NN/218/11/21** | **Any Other Business** |
| | No further business was raised. |
| **NN/219/11/21** | **Date of Next Virtual Meeting** |
| | The next PPEC meeting will be held virtually on Tuesday 21 December 2021 from 2 pm to 4 pm. |

Nottingham and Nottinghamshire Clinical Commissioning Group

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group**

**Quality and Performance Committee**

**Ratified minutes of the meeting held on**

**25/11/2021 9:00-12:00**

**MS Teams Meeting**

**Members present:**

| | |
|---|---|
| Eleri de Gilbert | Non-Executive Director (Chair) |
| Jon Towler | Non-Executive Director |
| Rosa Waddingham | Chief Nurse |
| Stuart Poynor | 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 |
| Sarah Bray | Associate Director of System Assurance |
| Mindy Bassi | Chief Pharmacist |
| Caroline Nolan | System Delivery Director - Urgent Care |
| Danni Burnett | Deputy Chief Nurse |

**In attendance:**

| | |
|---|---|
| Louise Espley | Corporate Governance Officer (minutes) |
| Sian Gascoigne | Head of Corporate Assurance |

**Apologies:**

| | |
|---|---|
| Sue Clague | Non-Executive Director |
| Maxine Bunn | Associate Director of Commissioning |

| **Cumulative Record of Members' Attendance (2021/22)** | | | | | |
|---|---|---|---|---|---|
| **Name** | **Possible** | **Actual** | **Name** | **Possible** | **Actual** |
| Dr Manik Arora | 08 | 06 | Eleri de Gilbert | 08 | 08 |
| Mindy Bassi | 08 | 04 | Andy Hall* | 06 | 06 |
| Hazel Buchanan | 08 | 07 | Dr Hilary Lovelock | 08 | 06 |
| Maxine Bunn | 08 | 06 | Caroline Nolan | 08 | 06 |
| Danni Burnett | 08 | 07 | Stuart Poynor | 08 | 06 |
| Lisa Durant | 08 | 08 | Dr Richard Stratton* | 06 | 04 |
| Sue Clague | 08 | 07 | Jon Towler | 08 | 06 |

| | | | | | |
|---|---|---|---|---|---|
| Rosa Waddingham | 08 | 07 | Sarah Bray* | 02 | 02 |

** Dr Stratton left 24/09/2021*

** Andy Hall left 25/10/2021*

** Sarah Bray joined 28/10/2021*

**Introductory Items**

**QP 21 123** **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 21 124** **Confirmation of Quoracy**

The meeting was confirmed as quorate.

**QP 21 125** **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 21 126** **Management of any real or perceived conflicts of interest**

No management action required.

**QP 21 127** **Minutes from the meeting held on 28 October 2021**

The minutes were agreed as an accurate record of proceedings.

**QP 21 128** **Action log and matters arising from the meeting held on 28 October 2021**

The action log includes a number of actions with future dates for completion. Other actions were updated on the action log or addressed as part of the agenda.

There were no matters arising.

**Strategy and Performance**

**QP 21 129** **Update on Quality in the Integrated Care System (ICS)/Integrated Care Board (ICB)**

*Danni Burnett left the meeting during this item.*

Rosa Waddingham presented the item highlighting the following points:

a) A presentation was shared detailing; the shared system approach to quality, the development of quality principles and commitments, how quality will be implemented at system, Place and Primary Care Network (PCN) level.

b) The presentation articulated ten shared quality system principles for 2022/23. The priorities take account of population health needs and will be reviewed annually to ensure they remain fit for purpose.

c) The realignment of roles and changes to delivery were shared.

The following points were raised in discussion:

d) Members noted that the Quality Assurance report following the Grant Thornton review will be important in terms of quality system design. The report will be presented to the Committee in January 2022.

e) Concerns from system Quality Chairs were shared, they include capacity demands on Executive Directors and senior teams to operate in the new system, an absence of clarity regarding the future role of NHS England/Improvement (NHS/I) and the Non-Executive Director role at Place level.

f) Guidance on the regional role and system role from a quality perspective is expected from NHSE/I in December 2021.

g) Discussion followed regarding quality indicators at Place level and the need to ensure consistency across the four Places whilst at the same time recognising their different stages of maturity.

h) A readiness to operate statement will be prepared in January 2022, followed by a system quality strategy by March 2022.

The Quality and Performance Committee:

- **NOTED** the update and upcoming activities.

**QP 21 130 Winter planning**

Rosa Waddingham and Caroline Nolan delivered a presentation, highlighting the following points:

a) The presentation focused on the quality perspective of managing winter pressures.

b) The winter plan follows an unprecedented 18 months due to the Covid-19 pandemic. System partners undertook a listening event with staff from across the system to frame and focus planning for winter, elective activity and the financial position.

c) Key themes have been identified and system agreement reached to ensure a collaborative response to pressures.

d) Principles have been agreed and four working groups established to progress the work. The four groups are; Risks, thresholds and triggers (proactive planning), Front door (managing demand), Back door (managing discharge and flow) and Workforce.

The following points were raised in discussion:

e) Members noted the significant amount of work underway and the different approach to planning for winter this year.

f) Concern was expressed regarding continued workforce pressures both in terms of staffing levels and stress experienced by staff. In response the Chief

Nurse informed members that quality impact assessments and service change processes are being used to capture risks and issues. The system is working in a very different way in the face of unprecedented pressure and is challenging to staff whose drive remains to provide high quality, comprehensive and safe care. A programme of communication with the public is required to generate greater visibility and openness about the changing landscape and expectations.

g) Members supported the plans and approach outlined, noting the need to avoid duplication of effort and to ensure actions align with the elective recovery programme. The involvement of ESIST was seen as a positive initiative.

The Quality and Performance Committee:

- **NOTED** the update and upcoming activities.

**Quality and Performance**

**QP 21 131** **Integrated Performance Report**

Sarah Bray presented the item and highlighted the following points:

a) A small deterioration has occurred in the elective care RTT. The number of CCG registered patients on the waiting list is 87,506, which is a small reduction of 262 patients since the July 2021 position was reported.
b) The shape of the waiting list continues to be challenging although there is a reduction (since March 21) in the number of very long-waiting patients i.e. those over 52-weeks.
c) Diagnostic services show an improvement in performance against the August 2021 position with respect to the number of patients waiting against the 6-week national standard.
d) Cancer services overall continue to show relatively good levels of performance compared to similar populations across the country. Referral volumes are 15-20% higher than the equivalent pre-COVID period. Performance is marginally below the national standard (92.31% against the 93% standard).
e) Performance in respect of the 31-day standard remains stable. The 62 day performance increased from July to August 2021 and has remained stable into September 2021. As a result the number of patients waiting more than 62-day has increased and the backlog position remains challenging.
f) Attendance volumes to A&E departments continue to increase and are now at pre-pandemic levels. A total of 149 12 hour breaches were reported in September 2021, of which 140 were at NUH.
g) Increased numbers of patients continue to require mental health services. The acuity of patients is increasing.
h) The report includes the overall position of the H2 plan submitted to NHSE/I. Plans are in place against the six national priorities (five priorities to tackle health inequalities and continued delivery of the Long Term Plan).
i) The ICS H2 plan is compliant with the majority of national performance

ambitions for elective care, outpatients, cancer, learning disability and autism and primary care.

j) The ICS H2 NHS plan meets national ambitions to eliminate 104 week waits (except for patients choosing to wait longer), stabilise 52 week waits and stabilise/reduce the overall waiting list by March 2022.

k) Cancer 62 day performance remains non-compliant with the national performance ambitions in the H2 plan.

l) Work is underway to benchmark outpatient virtual consultations and develop methods to increase utilisation.

m) A national deep dive is underway in relation to physical health checks for patients with severe mental illness (SMI).

The following points were made in discussion:

n) Members noted the difference in performance between to two acute provider Trusts in relation to 12 hour A&E breaches. Concern was expressed about the risk of harm as a result of long waits and potential to exacerbate inequalities. Delayed ambulance handovers were also identified as a concern. . In response members were informed that Ben Owens from SFH/ECIST is involved in reviewing pathways at NUH, this was considered a positive initiative.

o) Concern was expressed with regard to the impact of continued pressure on the workforce across all systems.

p) Members raised concern around waiting lists creeping up; elective capacity and whilst performance against cancer targets was relatively good the impact on 62 day cancer target was now worrying.

The Quality and Performance Committee:

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

**QP 21 132** **Nursing and Quality Quarter 2 report**

Danni Burnett presented the item and highlighted the following points:

a) The Quarter two (2021/2022) report provides assurance in relation to the activity of the Quality Team and its statutory duties. It also highlights the main quality and safety issues faced by providers and the impact of this on the wider system.

b) There continues to be extra ordinary pressures experienced across the whole system.

c) Delays in access to care and discharge between settings has been highlighted as a system-wide area for focus.

d) The CCG Quality, Commissioning and Contracting Teams continue to work closely with NUH in a monitoring and supporting role.

e) The quality Team is working with the Local Authority and the CCG Care Homes and Home Care Team to support several providers to address quality and workforce challenges. The January 2022 meeting will focus on the Care Home and Home Care sector.

f) Seven providers are currently under enhanced surveillance.

g) The CCG is working with partners to support the Asylum Seeker & Afghanistan Resettlement Programme to ensure that people have access to appropriate health care services.

h) As part of the NHS response to the Norfolk Safeguarding Adults Review (SAR) concerning the deaths of three patients at Cawston Park Hospital, NHSE/I 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 January 2022. The CCG is responsible for carrying out the reviews. The IMPACT provider collaborative will undertake reviews for patients in low & medium secure services.

i) The CCG continues to co-ordinate the maternity element of the COVID-19 vaccination programme, extending to all pregnant women.

j) The CCG Safeguardinig team is supporting CityCare to address backlogs. An insight visit to CityCare is planned for early 2022.

k) NHT QAG meetings continue. There will be a focus on workforce and culture at a future meeting. There is greater assurance from a CCG perspective in terms of the Trusts progress.

l) The backlog with serious incidents continues to be a challenge for all providers. The main challenge being the capacity to undertake investigations. The January 2022 meeting will receive an update on CCG compliance with the duty of candour.

m) There will be a focus in quarter three on enhancing systems for the SEND agenda by closer working with the System Analytics and Intelligence Unit (SAIU).

n) Healthcare acquired Infections (HCAI) have increased. Thematic reviews are underway in respect of Pseudomonas BSI and clostridium difficile cases at Sherwood Forest Hospital (SFH).

o) A shortage of capacity in the homecare market in both adults and children's care is resulting in delays in commissioning care packages for adults eligible for CHC and children eligible for continuing care.

p) The CCG has completed a Section 11 Self-Assessment Form. The return is conducted bi-annually, although was subject to delay as a result of the Covid-19 pandemic. Two areas within the self-assessment require further assurance.

q) A SEND local area inspection took place in Nottingham City during November

2021. Good practice was identified along with some areas of learning.

r) In respect of Learning Disabilities and Autism an 'Escalation and Executive Oversight' group has been established and is developing a system-led action plan to improve inpatient performance.

The following points were made in discussion:

s) Members acknowledged the extensive range of issues requiring support from the quality team and the resultant pressure this puts on the team. This will be picked up at the next meeting as part of the independent review of quality assurance systems

t) Members were encouraged to see that there will be a focus on CityCare during the next quarter.

u) Additional assurance was received regarding NHT safe staffing levels following the recent QAG meeting. NHT have agreed to undertake a deep dive into staffing and culture.

The Quality and Performance Committee:

- **REVIEWED** the report and the actions outlined.

**QP 21 133 NUH Maternity update and NUH update**

Danni Burnett presented the item and highlighted the following points:

a) There has been a refresh in oversight arrangements following publication of the CQC NUH Well Led Review. The NUH Oversight & Quality Assurance Group will broaden its focus to extend across NUH as a whole. A new Maternity sub group has been established to maintain focus and will report into the overarching group.

b) Maternity services continue to experience operational pressures. Data quality and analytic support is improving with a greater understanding of data being evident by NUH.

c) A quality, risk and safety framework is under development. Alignment with corporate governance processes will be monitored.

d) The escalation policy is having a positive impact with a reduction in the number of diverts between units reported. Further assurance is required to embed the policy.

e) A number of maternity mutual aid system actions are in place although there is some reluctance in women taking the opportunity to give birth at Sherwood Forest Hospital (SFH).

f) There is a maternity case going to the Coroner in early 2022 that is likely to prompt media interest.

g) The independent maternity review is underway. Phase one of the review will conclude in February 2022, emerging themes will be addressed at that time.

The following points were made in discussion:

h) Members noted that there is some improvement since the last report but concern remains in relation to the pace and scale of change. Whilst there is evidence of greater acceptance of the issues by NUH members were concerned that NUH will become overwhelmed by the sheer volume of change required. Capacity, operational demands and gaps in the senior leadership team are all contribute to ongoing concerns.

i) Discussion ensued in relation to midwifery recruitment. The Deputy Chief Nurse confirmed that there has been no net increase in midwives over the last 12 months despite an active recruitment campaign. The national pipeline for midwives was cited as an issue, with the Midlands being an outlier in this regard. Different solutions are being considered to address the workforce issue, for example rotational posts with SFH. The system nursing and midwifery cabinet are looking at how to attract nurses and midwives to Nottingham.

j) With regard to wider NUH performance the Committee noted that the improvement plan following the CQC well led report has not yet been signed off by NUH. An update will be provided to the January 2022 meeting.

The Quality and Performance Committee:

- **NOTED** the update and upcoming activities in relation to NUH and NUH maternity services.

**QP 21 134 External review of Quality Assurance**

*This item was taken out of sequence to aid the flow of the meeting.*

Rosa Waddingham presented the item and highlighted the following points:

a) The report is currently going through the Grant Thornton assurance process. The final report will be presented to the Committee in January 2022.

b) Sue Cordon from Grant Thornton had shared with Rosa a summary of the report highlights. Initial findings confirm that on the whole quality assurance processes are good and the committee is working effectively. The report will include recommendations for improvement that will influence the new system quality assurance process.

The following points were made in discussion:

c) Members were encouraged by the report headlines and will receive the final report in January 2022.

The Quality and Performance Committee:

- **NOTED** the update.

**QP 21 135 Patient and Public Engagement update**

*Prema Nirgude joined the meeting for this item*.

Prema Nirgude presented the item and highlighted the following points:

a) Plans are progressing to move to a system wide ICS function for engagement, informed by guidance from NHSE/I.

b) Nottingham and Nottinghamshire has been awarded additional funding to establish a citizens panel. This will inform one method of engagement alongside a suite of other options and will be in place by April 2022.

c) Community groups and service users have informed recent work on the Dementia pathway. A link to the webinar where the outcomes were discussed will be shared with members following the meeting.

d) A twelve week public consultation will take place during 2022 related to 'Tomorrows NUH' and will be a focus for engagement.

The following points were made in discussion:

e) Members welcomed the report and hearing about the many ways in which engagement is taking place, particularly the establishment of a citizens panel.

f) Members requested further information regarding the Hucknall development and engagement activity. An update will be shared following the meeting.

**ACTION:**

- Link to the webinar on the Dementia pathway will be shared following the meeting.
- Detail of engagement activity related to the Hucknall development will be shared following the meeting.

The Quality and Performance Committee:

- **NOTED** the update for assurance purpose.

*Prema Nirgude left the meeting.*

**QP 21 136 Infection Prevention and Control (IPC) Annual report**

*Wendy Walker joined the meeting for this item.*

Wendy Walker presented the item and highlighted the following points:

a) Reducing and preventing infections and antimicrobial resistance remains a high priority for NHS Nottingham and Nottinghamshire CCG. The annual report outlines the work of the Nottinghamshire Community Infection Prevention and Control Team (CIPCT) and Nottingham CityCare Infection Prevention and Control Team during 2020/21.

b) This year has seen the emergence of a global pandemic, the infection prevention and control teams across the County and the City were required to focus all their efforts on COVID-19 with the majority of routine work being suspended.

c) At the height of the pandemic the IPC teams were managing in excess of 100

COVID-19 outbreaks and moved to seven day working.

The following points were made in discussion:

d) Members recognised the immense challenge the team has and continues to face as a result of the Covid-19 pandemic and formally recorded their thanks to the team in recognition of the incredible job they have done since the start of the pandemic. This was valued across the system.

e) The reference to securing funding in the report was raised. It was confirmed that this is less of a funding issue and relates to the contracting arrangement for IPC in the system space.

The Quality and Performance Committee:

- **APPROVED** the Infection Prevention and Control Annual Report 2021/22.

*Wendy Walker left the meeting.*

**Corporate Assurance**

**QP 21 137** **Risk report**

Sian Gascoigne presented the item and highlighted the following points:

a) There are ten risks on the risk register an increase of two risks since the October 2021 meeting. Five risks are rated red.

b) The two new risks were presented for approval. RR 171 has a score of 16 and relates to the potential loss of public confidence in health care services. It was noted that this risk is also included in the PCCC risk register. The second new risk, RR 174 relates to the potential risk associated with responding to an emergency and/or mass casualty event. The risk score is 10 reflecting low likelihood but high impact.

The following points were made in discussion:

c) It was agreed that the narrative of RR 174 will be reviewed following the major incident planning event that is due to take place in December 2021.

**ACTION:**

- Narrative of RR 174 to be reviewed in December 2021.

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.
- **APROVED** the inclusion of RR 171 and RR 174 in the risk register. The narrative of RR 174 will be reviewed in December 2021.

| Closing Items | |
|---|---|
| **QP 21 138** | **Any other business**<br>No further business was raised. |
| **QP 21 139** | **Key messages to escalate to the Governing Body**<br>The Committee:<br>• **RECEIVED** an update on Quality in the ICS.<br>• **RECEIVED** detail of winter plans from a quality perspective.<br>• **RECEIVED** the Integrated Performance report and Nursing and Quality report.<br>• **RECEIVED** an update on NUH Maternity services and wider NUH performance**.**<br>• **NOTED** that the report on Quality Assurance from Grant Thornton will be presented to the Committee in January 2022. |
| **QP 21 140** | **Date of next meeting**:<br>**27/01/2022** via MS Teams meeting |

Nottingham and Nottinghamshire Clinical Commissioning Group

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group**
**Finance and Resources Committee**

**Ratified minutes of the meeting held on**
24/11/2021 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 |
| Dr James Hopkinson | Joint Clinical Leader |
| Andrew Morton | Operational Director of Finance |
| Caroline Nolan | System Delivery Director (Greater Nottingham) |
| Stuart Poynor | Chief Finance Officer |
| Dr Stephen Shortt | Joint Clinical Leader |
| Amanda Sullivan | Accountable Officer |
| Sue Sunderland | Non-Executive Director |
| Jon Towler | Non-Executive Director |

**In attendance:**

| | |
|---|---|
| Siân Gascoigne | Head of Corporate Assurance |
| Chloe Skeavington | Graduate Trainee (Observing) |
| Marcus Pratt | Programme Director – Finance and System Efficiency |
| Rob Taylor | Deputy Director of Performance and Information |
| Shannon Wilkie | Corporate Governance Officer (Minutes) |

**Apologies:**

| | |
|---|---|
| Maria Principe | Director of System Analytics and Intelligence Unit |
| Jonathon Rycroft | Associate Director of Financial Recovery (Operations) |

| **Cumulative Record of Members' Attendance (2021/22)** | | | | | |
|---|---|---|---|---|---|
| **Name** | **Possible** | **Actual** | **Name** | **Possible** | **Actual** |
| Shaun Beebe | 08 | 07 | Caroline Nolan | 08 | 07 |
| Lucy Branson | 08 | 08 | Stuart Poynor | 08 | 06 |
| Maxine Bunn | 08 | 07 | Jonathan Rycroft | 08 | 07 |
| Michael Cawley | 08 | 08 | Stephen Shortt | 08 | 07 |
| Lisa Durant | 08 | 08 | Amanda Sullivan | 08 | 07 |
| Andy Hall | 06 | 06 | Sue Sunderland | 08 | 07 |

| | | | | | |
|---|---|---|---|---|---|
| James Hopkinson | 08 | 05 | Jon Towler | 08 | 06 |
| Andrew Morton | 08 | 06 | Maria Principe | 2 | 0 |

## Introductory Items

**FR 21 104** **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 Maria Principe and Jonathan Rycroft. Marcus Pratt and Rob Taylor were in attendance to deliver the Cross Provider Report on Maria's behalf.

**FR 21 105** **Confirmation of Quoracy**

The meeting was confirmed as quorate.

**FR 21 106** **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 21 107** **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 21 108** **Minutes from the meeting held on 27 October 2021**

The minutes were agreed as a correct record.

**FR 21 109** **Action log and matters arising from the meeting held on 27 October 2021**

All actions on the action log were marked as completed. A briefing was attached at Appendix 1 to satisfy action FR 21 096.

## Financial Position and Contract Management

**FR 21 110** **Finance Report Covering 2021/22 Position and H2 Planning Update**

Michael Cawley, Stuart Poynor and Andrew Morton presented the item and highlighted the following points:

a) The report described a forecast breakeven position for the financial year.
b) Unlike 2020/2021, the financial plan does not reset at month seven and instead the financial position is year to date (YTD).
c) The greatest area of pressure remains Continuing Healthcare Costs (CHC). There has been a slight benefit since the previous report which has resulted in a deficit reduction.
d) Financial pressures are being mitigated using non recurrent measures.

e) Performance against the capital plan is positive and the CCG is on track to deliver the full capital plan for the year. There are some delays with spend being charged to the plan and conversations with NHS England/Improvement (NSHE/I) are ongoing to gain assurance that this will be resolved.

f) Delivery of efficiency plans is positive in most areas. There is £3.38m of unidentified opportunities remaining.

g) An update was provided on the COVID-19 vaccination programme financial position. As explained at the previous meeting, the CCG had put forward a case for an additional £1.5m funding to NHSE/I; this has now increased to £1.7m. NHSE/I responded to the request with a number of queries and thus far it is unknown whether the claim will be successful.

h) The updated H2 plan was presented for Committee approval.

The following points were made in discussion:

i) Members acknowledged that surrounding systems are reporting a surplus position whereas the local system is reliant on non-recurrent measures to achieve a balanced position. Members queried the reason for this. It was explained that this is due to the budget setting process, as non-recurrent measures were used to achieve the control total in 2019/20 and the temporary financial regime is based on 2019/20 figures. Reassurance was provided that over the coming years the NHS will steadily move back towards the 'usual' budget setting process.

j) Members noted the level of risk involved in the 2020/21 financial position and debated whether the Committee had sufficient oversight of the various streams of work to mitigate financial risks and deliver efficiency savings.

k) Assurance was provided that there is a Financial Savings Group which meets to focus on the delivery of internal efficiency savings.

l) Members queried whether 'driving activity to increase revenue' was an appropriate message to be sending to the local system, in light of the work undertaken in recent years to move away from this culture. It was explained that the drive to increase activity is motivated by the national priority to recover from COVID-19.

m) It was noted that the paper described £5m of unspent primary care monies. Members queried the reason for this as primary care would welcome any additional investment. It was stressed that these monies are reserved purposefully to mitigate unforeseen risk and reassurance was provided that all primary care services had been fully funded in line with the plan.

n) Members discussed the transition to the Integrated Care Board (ICB) and stressed the importance of ensuring that the quality of conversation and challenge within assurance Committees is upheld.

o) It was agreed that a presentation would be given at the next Committee meeting to provide assurance around the actions being taken to manage the financial position and the risks to delivery of the 2021/22 financial position.

The Committee:

- **NOTED** the report and **APPROVED** the report for onward submission to the Governing Body.

- **APPROVED** the H2 Financial Plan.

**Action:**

- **A presentation to be given to the next Finance and Resources Committee meeting to provide assurance surrounding the ongoing actions to manage the CCG financial position and transition arrangements for oversight of the CCG and system financial position as we approach the end of the current governance arrangements.**

**FR 21 111** **Cross Provider Report**:

Marcus Pratt and Rob Taylor were in attendance to present the report. The following points were raised:

a) The 120% activity target had not been achieved. This target had not been achieved by any system in the NHS.

b) Current activity levels mirror those from early summer 2021, however due to the changes in thresholds; the income received is less.

c) There is internal focus on managing day case activity. Patients are presenting with greater acuity and complexity than experienced before the pandemic. This is having a negative impact on the already growing waiting list.

d) Elective activity levels had in recent weeks reached pre COVID-19 levels.

e) There was a significant increase in urgent referrals during September 2021 which subsequently has a negative impact on performance against targets for Cancer services.

f) Outpatients performance has exceeded levels in the H1 Plan and the number of virtual appointments has gradually reduced throughout the year.

g) Waiting times vary significantly between specialties and across providers. For the areas with the greatest challenges, mutual aid is being discussed. MRI is an example of this.

h) The system continues to operate with a reduced bed base in order to maintain increased Infection Prevention and Control standards due to the COVID-19 pandemic.

The following points were made in discussion:

i) Members discussed the current waiting list case mix and agreed that the most appropriate way forward is to tackle a mixture of high volume low complexity cases with high complexity cases to ensure the waiting list is being worked through, whilst also triggering Elective Recovery Funding (ERF).

j) Members noted that the increase in Cancer waiting lists is a positive indicator that patients with suspected cancers are presenting, which has been a goal during the recovery from COVID-19.

k) Members queried whether activity trends are discussed in greater detail in other forums. It was confirmed that these conversations take place at a programme level and it was explained that the Committee receive a high level overview of the position. It was noted that there is ongoing analytical work at the Right Place First Time Group surrounding behavioral insights, which have a direct impact on

activity.

The Committee:

- **NOTED** the update.

## Risk Management

**FR 21 112** **Risk Report**

Siân Gascoigne presented the item and highlighted the following points:

a) There were nine risks pertaining to the Committee's responsibilities.

b) Section four of the report proposed that RR 165 'Insufficient H1 Funding' be archived as this risk is no longer relevant.

c) Section five of the report proposed the addition of a new risk RR 172 'Insufficient H2 Funding'.

The following points were made in discussion:

d) Members discussed the likelihood rating for RR 172 and agreed that the rating would remain unchanged and would be considered at the next Committee meeting.

The Committee:

- **COMMENTED** on the risk report **HIGHLIGHTING** risks discussed throughout the course of the meeting.
- **APPROVED** the archiving of RR 165 'Insufficient H1 Funding'.
- **APPROVED** the addition of RR 172 'Insufficient H2 Funding'.

## Closing Items

**FR 21 113** **Any other business**

The Committee AGREED to hold an additional Finance and Resources Committee meeting during the month of December 2021.

**Action:**

- **A suitable date for an additional Committee meeting during the month of December 2021 to be identified and a diary appointment circulated.**

**FR 21 114** **Key messages to escalate to the Governing Body**

The Committee:

- **AGREED** to update the Governing Body on the progress of H2 Plans.

**FR 21 115** **Date of next meeting**: 22/12/2021.

Nottingham and Nottinghamshire Clinical Commissioning Group

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group**
**Primary Care Commissioning Committee (Public Session)**
**Ratified minutes of the meeting held on**
**17/11/2021 09:00-10:40**
**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 |
| Lucy Dadge | Chief Commissioning Officer |
| 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 |
| Louise Espley | Corporate Governance Officer (minute taker) |
| Michael Wright | Nottinghamshire Local Medical Committee |
| Sian Gascoigne | Head of Corporate Assurance |
| Esther Gaskill | Head of Quality |

**Apologies:**

| **Cumulative Record of Members' Attendance (2021/22)** | | | | | |
|---|---|---|---|---|---|
| **Name** | **Possible** | **Actual** | **Name** | **Possible** | **Actual** |
| Shaun Beebe | 08 | 08 | Joe Lunn | 08 | 08 |
| Michael Cawley | 08 | 06 | Dr Richard Stratton* | 06 | 04 |
| Lucy Dadge | 08 | 08 | Sue Sunderland | 08 | 08 |
| Eleri de Gilbert | 08 | 07 | Dr Ian Trimble | 08 | 08 |
| Helen Griffiths | 08 | 06 | Danielle Burnett | 08 | 07 |

** Dr Stratton left 24/09/2021*

| | |
|---|---|
| | **Introductory Items** |
| **PCC/21/153** | **Welcome and Apologies**<br>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. No apologies were received. |
| **PCC/21/154** | **Confirmation of Quoracy**<br>The meeting was confirmed as quorate. |
| **PCC/21/155** | **Declaration of interest for any item on the shared agenda**<br>There were no identified conflicts of interest. |
| **PCC/21/156** | **Management of any real or perceived conflicts of interest**<br>No management action was required. |
| **PCC/21/157** | **Questions from the public**<br>No questions had been received. |
| **PCC/21/158** | **Minutes from the meeting held on 20 October 2021**<br>The minutes were agreed as an accurate record of proceedings, subject to the following amendment:<br>- Page 3, item PCC 21 141 amend DDG to CCG. |
| **PCC/21/159** | **Action log and matters arising from the meeting held on 20 October 2021**<br>Two actions have future dates for completion. one action is on-going and one complete.<br>There were no matters arising. |
| | **Commissioning, Procurement and Contract Management** |
| **PCC/21/160** | **Monthly contract update**<br>Lynette Daws presented the item and highlighted the following key points:<br>a) The public contract update provides the latest information on contractual actions in respect of individual providers' contracts across Nottingham and Nottinghamshire.<br>b) There were no specific actions on the contract report to highlight this month.<br><br>No further points were raised in discussion.<br><br>The Committee:<br>• **RECEIVED** the public contract update. |
| **PCC/21/161** | **PCN DES – Unclaimed fund 2021/22 – outcome report**<br>Helen Griffiths presented the item and highlighted the following key points:<br>a) The paper provides details of contractual requirements for the Primary Care Networks (PCNs) Unclaimed Fund process for the Additional Roles Reimbursement (RES) for 2021/2022, as documented in the 'Network Contract Directed Enhanced Service Contract specification 2021/22 – PCN Requirements and Entitlements'.<br>b) PCNs completed workforce plans detailing their recruitment plans for 2021/22 in |

August 2021. Plans were shared with the Committee in October 2021.

c) During October 2021 PCNs were invited to submit workforce bids against the unclaimed funds. A review panel was established to assess the bids against the criteria detailed within the PCN specification.

d) The value of the Additional Roles Reimbursement Scheme (ARRS) System Unclaimed Fund Pot was £526,283. Bids amounting to £1,073,991 were received.

e) 15 PCNs submitted bids. All that met the criteria received a portion of the fund. Detail of the approved bids was provided in appendix 2. The key challenge/risk faced by PCNs relates to the ability to recruit to the new posts funded.

The following points were raised in discussion.

f) Members commented on the Nottingham City allocation, noting that it appears low comparative to their contribution. It was felt that this may be due to the City practices not having the capacity to develop bids. It is hoped this gap will be addressed by the additional funding for leadership and management to be discussed at item 13 PCC 21 165.

The Committee:

- **NOTED** the proposed process as per the PCN DES specification to utilise the projected underspend of the ARRS allocation.
- **NOTED** the allocations of the ARRS unclaimed funding.
- **NOTED** the risks associated with the implementation and delivery of the unclaimed funding.

**Quality Improvement**

**PCC/21/162** **Primary Care Quality report**

Esther Gaskill presented the item and highlighted the following points:

a) The paper provides detail in relation to; quality dashboard ratings for quarter two, an update on the activity of the Primary Care Quality Groups and Primary Care Quality Team, a summary of current CQC ratings and an overview of practices receiving enhanced support from the Quality Team.

b) In respect of the quality dashboard, three practices received a ‘green’, three star rating meaning they comply with all measures. Overall, 95 practices are rated green, 25 amber with no practices having a red rating.

c) This quarter there was a focus on two childhood immunisation indicators; vaccinations for under two’s and pre-school vaccinations. The quality team will follow up with practices where further support is required to increase the uptake of vaccinations.

d) Primary Care Quality groups at place level have merged to create one overarching Quality Group. The Quality Group reviews each quality dashboard, patient experience information and patient safety incident reports. The patient experience report highlighted that the most contacts were from patients seeking additional clarification following receipt of a letter informing them about their transfer to a different practice following closure. As a result the content of such letters will be reviewed.

e) During quarter two, 47 patient safety incidents were received by the CCG relating to primary care. None of the incidents reported met the national serious incident framework threshold.

f) The report detailed the CQC ratings for all practices; 19 practices are rated outstanding, 98 good, one requires improvement and none are rated inadequate. Six practices are yet to be rated by the CQC.

g) The CQC have introduced a new monitoring approach to help prioritise activity. This involves a monthly review of practice information resulting in a risk assessment for each practice. If the review indicates a high/very high risk an inspection will follow.

h) Covid-19 continues to have an impact in practices and a number of practices are supporting the phase three Covid-19 vaccination programme in addition to the flu vaccination programme.

The following points were made in discussion:

i) Members were encouraged to see the positive results detailed in the report. JRB Healthcare were commended following their recent 'good' rating from the CQC. JRB Healthcare took on the contract and this rating represents a significant improvement for this practice.

The Committee:

- **NOTED** the Primary Care Quality report for November 2021.

*Michael Wright joined the meeting during this item.*

**Strategy, Planning and Service Transformation**

**PCC/21/163 National Primary Care Patient Survey report – 2020/21**

Esther Gaskill presented the item and highlighted the following points:

a) The GP Patient Survey (GPPS) is an England-wide survey providing practice level data about patients' experiences.

b) 44,211 questionnaires were sent out, and 15,710 were returned completed. This represents a response rate of 36%, an improvement on the previous year.

c) CCG overall GP experience of satisfaction results range from 76% to 87%. 35 practices score 90% or above. The lowest practice is rated 55% in terms of experience.

d) In Mid Nottinghamshire, Sherwood Medical Partnership had the poorest results flagging as outliers ten times. This practice also flagged up eight times in 2020.

e) In Nottingham City, Greendale Primary Care Centre and Queens Bower Surgery both flagged nine times. Lime Tree Surgery eight times, John Ryle Medical Practice and Bilborough Medical Centre seven times. Bilborough has been top of the worst performing practices for the last three years.

f) In South Nottinghamshire, Highcroft Surgery flagged nine times with Oakenhall Medical flagging six times.

g) Use of online bookings is below the national average in all localities although Nottingham City has seen an improvement during the last year. Mid Nottinghamshire performance has declined against this measure. Repeat prescription usage sees South Nottinghamshire in line with the national average but Mid Nottinghamshire and Nottingham City is 5-6% below the national average.

h) With regard to the ease of getting through to a practice by phone, Nottingham City and South Nottinghamshire scored well whilst Mid Nottinghamshire requires slight improvement.

i) Overall experience of the GP Practice sees the CCG surpass the national average. South Nottinghamshire exceeds the national average by 5% with Mid

Nottinghamshire and Nottingham City 1% below the national average.

j) New to the survey is a question associated with COVID-19; 'have you, at any time in the last 12 months, avoided making a general practice appointment for any reason. The results show South Nottinghamshire 5% below the national average and Mid Nottinghamshire and Nottingham City in line with the national average.

k) The number of patients who have responded as shielding due to being vulnerable to COVID-19 highlights MMid Nottinghamshire 3% above the national average and Nottingham City 3% below.

l) A reduction in performance with respect to the management of long term conditions as a consequence of the COVID-19 pandemic is evident from the survey results.

The following points were made in discussion:

a) Members noted the results and were encouraged to see some high performing practices, although it was acknowledged that the response rate of 36% is low.

b) Results that were of concern were discussed, particularly in relation to access to practices via the telephone. It was noted that some practices have recently implemented new phone systems and it was hoped this would have a positive impact. The importance of patients being able to make contact with a practice via telephone was emphasised and would be addressed further at item PCC 21 164.

c) Practices reporting poor results, for example Highcroft are currently receiving a higher level of support from the CCG.

d) Michael Wright informed members of a patient choice project that the LMC and Healthwatch will be undertaking and agreed to bring the outcome to the Committee at a future meeting.

The Committee:

- **NOTED** the National Primary Care Patient Survey summary for 2020/21.

**PCC/21/164 Improving access for Patients and Supporting General Practice**

Joe Lunn presented the item and highlighted the following points:

a) On 14 October 2021, NHS England & Improvement (NHSE/I) published the guidance "Our plan for improving access for patients and supporting general practice" with additional funding of £250m nationally to support delivery.

b) Each CCG/ICS area was asked to develop plans to deliver the requirements detailed in the guidance in order to secure funding to support the system over winter.

c) Nottingham and Nottinghamshire CCG worked with colleagues in Primary Care to develop plans. The plans submitted include a mixture of centralised hub and PCN solutions to improve access and include a greater number of face to face appointments, increased availability of urgent appointments and increased staffing levels during peak times of activity. Conversations are underway with LMC colleagues to discuss flexible pools to address workforce requirements.

d) In addition, work is underway to review some of the underpinning operational and Infection Prevention and Control (IPC) requirements.

e) The national cloud based telephony (national) solution was highlighted as a route to improving access for patients although the proposals from NHSE/I only offer a software solution and do not address hardware requirements. It was also

noted that many practices are committed to existing contracts with regard to their telephone systems, therefore change would take some time to be implemented.

f) The plans submitted are for a budget of £4.6 million for the CCG. Funds must be utilised between November 2021 and March 2022.

g) As part of the process NHSE/I asked for confirmation of how the plans would support elective, urgent care and long-term condition management.

h) Formal feedback from the national team is awaited but the CCG has been advised to progress the plans with immediate effect.

The following points were made in discussion:

a) Members noted the plans and the national project in respect of telephony systems. Discussion followed specifically related to telephony and the importance of back office functions and management strategies at PCN level. Members agreed that this would be important to incorporate into the developing ICS Primary Care Strategy.

b) Confidence in being able to deliver the plans was discussed along with how accessible the various options will be for patients. In confirming ease of access for patients members were informed that patients would access the additional support via their usual practice.

c) The time limited nature of the funding was noted and a level of concern raised that public/patient expectations will be raised that will not be able to be fulfilled beyond March 2022.

d) Members noted the significant amount of work that had been done to produce the plans in a short timeframe. Following discussion members were assured that the hub and PCN models described will ensure the whole area will benefit from the investment and meet the requirements as described by NHS England /Improvement (NHSE/I).

The Committee:

- **NOTED** the update in relation to plans for Improving Access for patients and supporting general practice.

**PCC/21/165 PCN Leadership and Management Funds 2021/22**

Helen Griffiths presented the item and highlighted the following points:

a) The paper provides details of additional funding that has been provided by NHS England to the Primary Care Networks (PCNs) to support leadership and management capacity within the PCN for the remainder of this financial year.

b) NHSE/I has not specified how this funding should be used other than stating '*It is up to Clinical Directors to recommend how the funding is best deployed across the PCN to create additional leadership and management capacity'.*

c) The Nottingham and Nottinghamshire allocation of £778k is to be reimbursed to PCNs as a monthly payment. All PCNs have been asked to inform the CCG of their plans and intentions for the use of the funds.

d) Five PCNs have submitted plans to date.

No further points were made in discussion.

The Committee:

- **NOTED** the additional allocation and distribution of funding available to PCNs to support leadership and management capacity for the duration of 2021/22.

**Covid-19 Recovery and Planning**

**PCC/21/166** **Covid-19 Practice level update: Operational Pressures Escalation Levels (OPEL)**

Joe Lunn presented the item and highlighted the following 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) daily. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice each day.

b) The paper provides an overview of OPEL reporting for the four weeks to 29 October 2021. 32 of 124 practices reported days at OPEL level three having previously reported amber or green. 97 practices reported days at OPEL level 2 and 25 practices reported consistently at OPEL level one.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL reporting overview for General Practice for the four weeks to 29 October 2021.

**Financial Management**

**PCC/21/167** **Finance report – month seven**

Michael Cawley presented the item and highlighted the following points:

a) The paper reported the financial position for the month seven 2021/22 and has been prepared in the context of the revised financial regime implemented by NHSE/I in response to the COVID-19 pandemic.

b) The year to date (M1-7) position shows a £3.34 million underspend (3.44% of year to date budget). This is primarily due to the underspend of primary care reserves forming part of the position (£3.18 million, 3.27% of the 3.44% total underspend). [As previously reported, £2.64m of the underspend representing the PCCC reserves held at month six, were released into the CCG's final H1 position.]

c) Other factors driving the variances are the reversal of prior year accruals in relation to Alternative Provider Medical Service's (APMS) Caretakers (£0.25m) alongside favourable variances in areas such as Dispensing / Prescribing Drs and Premises Cost Reimbursement. This month there are additional charges in relation to two rent reviews for practices; backdated to 2017 totalling £0.28m and final caretaking charges of £0.05m.

d) The CCG in conjunction with the ICS, is currently working on the H2 Financial Plan that is due to be submitted to NHSEI on 18 November 2021. For H2 a comparable level of PCCC reserves is planned to be set aside. By adopting this approach, the risk of the PCCC's balanced position target being compromised is minimised.

No further points were made in discussion.

The Committee:

- **NOTED** the contents of the Primary Care Commissioning Finance Report.
- **APPROVED** the Primary Care Commissioning Finance Report for the period ending October 2021.

## Risk Management

**PCC/21/168** **Risk Report**

Sian Gascoigne presented the item and highlighted the following points:

a) There are currently six risks relating to the Committee's responsibilities, the same number of risks that was presented to the last meeting.
b) There is one high risk, RR 160 related to pressure on Primary Care workforce with a score of 16. The register also includes a related risk, RR 032 scored at 12 addressing workforce capacity.

No further points were made in discussion.

The Committee:

- **NOTED** the Risk Report and did not highlight any further risks for inclusion in the risk register.

## Closing Items

**PCC/21/169** **Health Scrutiny Committee Papers – Nottingham and Nottinghamshire**

The papers were provided for information in order that members are aware of information shared with the Scrutiny Committees. Members were informed that the City Scrutiny Committee had recorded their thanks to Nottingham City practices for their on-going work during an extended time of significant pressure.

**PCC/21/170** **Any other business**

No further business was raised.

**PCC/21/171** **Key messages to escalate to the Governing Body**

The Committee:

- **RECEIVED** the Quality report for quarter two. 95 practices are rated green, 25 are amber with no practices having a red rating. In terms of CQC ratings, 19 practices are rated outstanding, 98 good, one requires improvement and none are rated inadequate. Six practices are yet to be rated by the CQC.
- **RECEIVED** the patient survey report. Across the CCG the response rate to the survey was 36%. Overall experience of the GP Practice sees the CCG surpass the national average. South Nottinghamshire exceeds the national average by 5% with MidMid Nottinghamshire and Nottingham City 1% below the national average.
- **RECEIVED** the report on utilisation of funds to improve primary care access from November 2021 to March 2022 following the NHSE/I publication 'Our plan for improving access for patients and supporting general practice'. The plans submitted are for a budget of £4.6 million for the CCG and offer a PCN and centralised hub model to improve availability and access.

**PCC/21/172** **Date of next meeting**:
**15/12/2021**
MS Teams meeting

**NHS Nottingham and Nottinghamshire Clinical Commissioning Group**
**Primary Care Commissioning Committee (Public Session)**
**Ratified minutes of the meeting held on**
**15/12/2021 09:00-10:00**
**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 |
| Lucy Dadge | Chief Commissioning Officer |
| 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 |
| Louise Espley | Corporate Governance Officer (minute taker) |
| Michael Wright | Nottinghamshire Local Medical Committee |
| Jo Simmonds | Head of Corporate Governance (part meeting) |

**Apologies:**

| | |
|---|---|
| Sian Gascoigne | Head of Corporate Assurance |
| Esther Gaskill | Head of Quality |

| **Cumulative Record of Members' Attendance (2021/22)** | | | | | |
|---|---|---|---|---|---|
| **Name** | **Possible** | **Actual** | **Name** | **Possible** | **Actual** |
| Shaun Beebe | 09 | 09 | Joe Lunn | 09 | 09 |
| Michael Cawley | 09 | 07 | Dr Richard Stratton* | 06 | 04 |
| Lucy Dadge | 09 | 09 | Sue Sunderland | 09 | 09 |
| Eleri de Gilbert | 09 | 08 | Dr Ian Trimble | 09 | 09 |
| Helen Griffiths | 09 | 07 | Danielle Burnett | 09 | 08 |

** Dr Stratton left 24/09/2021*

| | |
|---|---|
| | **Introductory Items** |
| **PCC/21/173** | **Welcome and Apologies**<br>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. No apologies were received. |
| **PCC/21/174** | **Confirmation of Quoracy**<br>The meeting was confirmed as quorate. |
| **PCC/21/175** | **Declaration of interest for any item on the shared agenda**<br>There were no identified conflicts of interest. |
| **PCC/21/176** | **Management of any real or perceived conflicts of interest**<br>No management action was required. |
| **PCC/21/177** | **Questions from the public**<br>Four questions had been received related to the Springfield Medical Centre practice merger from members of the public. Committee Members received the questions ahead of the meeting. Responses will be provided at item PCC 21 182. |
| **PCC/21/178** | **Minutes from the meeting held on 17 November 2021**<br>The minutes were agreed as an accurate record of proceedings. |
| **PCC/21/179** | **Action log and matters arising from the meeting held on 17 November 2021**<br>Discussions are ongoing regarding a replacement for Dr Stratton. An update will be provided in January 2022.<br><br>There were no matters arising. |
| **PCC/21/180** | **Actions arising from the Governing Body meeting held on 01 December 2021**<br>The Governing Body supported the work of the Committee in developing metrics to understand PCN performance and variation. |
| | **Commissioning, Procurement and Contract Management** |
| **PCC/21/181** | **Monthly contract update**<br>Lynette Daws presented the item and highlighted the following key points:<br>a) The public contract update provides the latest information on contractual actions in respect of individual providers' contracts across Nottingham and Nottinghamshire.<br>b) There were no specific actions on the contract report to highlight this month.<br><br>No further points were raised in discussion.<br>The Committee:<br>• **RECEIVED** the public contract update. |
| **PCC/21/182** | **Springfield Medical Centre – merger update**<br><br>Joe Lunn presented the item and highlighted the following key points:<br>a) The paper provides an update on progress following the decision in August 2021 |

to approve the merger.

b) Dr and Mrs Mohindra hold the GMS contract at Springfield Medical Centre. They have taken the decision to add the partners of the St Albans/Nirmala to their partnership to enable them to retire and exit from the contract, in line with GMS contract regulations. The merger retains the practice under a new partnership.

c) The paper details the communication of the merger to patients and stakeholders. All Springfield Medical Centre patients have received a letter informing them of the merger and briefings shared with stakeholders. Due to the close proximity of the two practices all support services will continue to be provided in the same way as currently.

d) Meetings have taken place with staff at both practices.

e) Patient Participation Groups from both practices have been informed of the merger and posters providing further information are displayed in both practices.

f) The patient experience team has received two enquiries letters were sent to patients, both enquiries related to Dr and Mrs Mohindras' other practice in Hucknall which is not subject to this merger.

g) A follow up letter will be issued to all patients reminding them of the changes from 01 April 2021.

The following points were raised in discussion:

h) The Chair reiterated that Dr and Mrs Mohindra, under their GMS contract are able to go into partnership with the practice St Albans/Nirmala to secure the continuation of primary medical services for their practice population and allowing them to retire. Under the GMS regulations this does not require approval by the CCG or a procurement process. The CCG are therefore unable to pause this process as it is permitted within the regulations of the GMS contract and frequently occurs across general practice when partnerships change. That decision is not under review and was indeed recognised and supported at a previous meeting. The focus of today's discussion is on engagement and the cascade of information to patients and stakeholders.

i) Members were assured that engagement with patients and stakeholders had been appropriate, with lessons having been learnt from previous partnership changes in terms engaging elected members and scrutiny committees

j) The role of the CCG in monitoring the quality of services provided by practices was described by way of providing further assurance.

k) The four questions from members of the public were shared in full and responses provided.

l) Question from Peter Kirker – "Should the decision to merge Springfield's patients into an Operose practice be paused for further consideration, given that Operose is owned by a company notorious for seeking to maximise profit at the expense of service delivery - a potential factor in, for instance, the withdrawal of walk-in access to a Birmingham urgent treatment centre since the centre was last CQC'd; and in the CQC finding (after concerns had been raised) that staff at a Balderton practice now felt unappreciated and understaffed?" In response it was confirmed that this merger does not require the approval of the CCG as it is a decision for the practice Partners therefore the CCG has no authority to pause the merger. as previously discussed. With respect to Balderton Primary Care Centre, the CQC carried out an unannounced inspection in March 2021 due to concerns raised about the practice, particularly in relation to staff and staff numbers. The only area identified that improvements needed to be made related to effective systems and processes to ensure good governance. Both the CCG and CQC continue to offer support to the practice to address these issues, as well as monitoring progress with recruitment and the management of staffing

rotas and to respond to media, MP and stakeholder attention. Following a series of meetings stakeholders have issued a statement in support of the changes the practice is making. The Committee is unable to respond to the issue raised about a Walk in Centre in Birmingham as it has no information or jurisdiction relating to this.

m) Question from Karen Stainer – "I am aware of much patient dissatisfaction with the Operose Practices in the Bulwell area. Has there been a review/ inspection of the practices operated by Operose? If not, could you reassure me that this will be done before Springfield patients are transferred?" In response it was confirmed that St Albans/Nirmala is the only practice run by Operose in the Buwell area. A CQC inspection of that practice took place in August 2019 and the overall rating was good. The CQC on 09 December 2021 undertook a data review of the practice and found no evidence that any further inspection or re-assessment of the 'good' rating was required. In addition, a review of patient experience contacts over the last two years has not raised any concerns.
n) Question from Pauline Sault – "With regard to the planned transfer of patients from the Springfield practice in Bulwell to the St Albans and Nirmala practice in March 2022, how has the CCG consulted patients at both practices? Have the Patient Participation Groups (PPGs) at both practices been included in the consultation?" In response it was confirmed that the detail of patient and stakeholder engagement was presented in the report. Patient Participation Groups (PPGs) at both practices have been included in the engagement process.
o) Question from Richard Buckwell – "In view of a Judicial Review due to be heard in January/February 2022 about how Operose acquired practices in London in 2021, will the CCG review its decision to support the transfer of patients from Springfield Medical Practice to the Operose run St Albans and Nirmala practice at the end of March 2022? "In responding, the CCG was unable to confirm whether the requested judicial review will take place. If it does take place the CCG will ensure the findings and any implications for Nottingham and Nottinghamshire are considered.
p) The Chief Executive of the LMC shared his views on the absence of succession plans and options for GPs wanting to retire.
q) The CCG confirmed that all practices run by Operose are actively encouraged to engage in their Primary Care Network.

The Committee:

- **NOTED** the update.

**PCC/21/183 Winter access fund update**

Joe Lunn presented the item and highlighted the following points:

a) The paper provides an update to members following submission of plans to NHSE/I. Plans have received support and delivery has commenced.
b) Work is now focused on the funding flows and claiming process.
c) A further update will be provided to the Committee in January 2022 to review any further requirements associated with the Covid-19 vaccination programme.

The following was raised in discussion:

d) Members requested the detail of the different approaches adopted by the different localities to use of the winter access fund. It was confirmed this information will be shared following the meeting.

e) In respect of the funding it was confirmed that plans are predicated on finding additional staff.

f) Assurance was provided that the differentiated approach to delivery will not adversely impact on the availability of face to face appointments nor drive further inequalities in access. Delivery of appointments will be monitored in order that areas of pressure are identified if and when they arise. The different approaches reflect population health needs and infrastructure/estate issues.

g) A wider discussion followed regarding the CCG's role as strategic commissioner versus provider. It was confirmed that the winter access fund requirements for access are not a contractual requirement and as such powers of enforcement are not in place. The CQC do have powers of intervention although they have suspended visits until the end of December 2021 due to the Covid-19 situation.

h) Winter access will remain as an agenda item each month until the end of March 2022, particularly as the national position regarding Covid-19 evolves.

**ACTION:**

- Detail of the different approaches to use of the winter access fund across localities to be shared with Members.

The Committee:

- **NOTED** the update and will receive monthly reports on utilisation of the winter access fund.

**PCC/21/184 Temporary GP contract changes to support COVID-19 Vaccination Programme**

*Jo Simmonds joined the meeting.*

Joe Lunn presented the item highlighting the following points:

a) On 03 December 2021, NHS England & Improvement (NHSE/I) circulated a letter outlining flexibilities introduced to support GP practices to deliver the Covid-19 vaccination programme.

b) A second letter was received on 08 December 2021 providing more detail on the temporary GP contract changes to support COVID-19 vaccination programme.

c) To provide additional clarity in relation to the flexibilities and requirements of general practices across Nottingham and Nottinghamshire, a letter from Stephen Shortt, James Hopkinson and Amanda Sullivan was circulated 09 December 2021.

The following points were made in discussion:

d) Members noted the letters from NHSE/I and recognised the significance in terms of further pressure on primary care services and staff. At the same time there was concern that patients who require care are able to access it in timely way. In

response it was confirmed that the latest guidance from NHSE/I does not mean general practice can stop Quality and Outcomes Framework (QOF) activity. There is an adjustment to the work rather than a suspension of services.

e) Further correspondence has been received from NHSE/I related to services that need to remain and will be shared with members.

**ACTION:**
- Further NHSE/I correspondence regarding primary care to be shared with Members.

The Committee:

- **NOTED** the documents circulated and the temporary change to GP contracts to support the COVID-19 vaccination programme.

**Strategy, Planning and Service Transformation**

**PCC/21/185 Review of Primary Care Network NHSE/I Maturity Matrix**

Helen Griffiths presented the item and highlighted the following points:

a) The paper provides an update on the progress of Primary Care Network (PCN) development across the ICS in line with the NHSE/I PCN Maturity matrix. The most recent self-assessment was completed in quarter two 2021.
b) The PCN Maturity Matrix is designed to support Network leaders, working in collaboration with system partners and other local leaders within neighbourhoods to work together to understand the development journey both for individual Networks and Places over the five year journey of the PCN contract.
c) PCNs have made significant progress in their development over the last two years despite the impact of the pandemic.
d) The paper includes a summary of system wide recommendations aligned to the five core matrix domains to support PCN development.

The following points were made in discussion:

e) Members were encouraged by the progress and development of PCNs and were pleased that an outcome dashboard continues to be developed.

The Committee:

- **NOTED** the current position of the PCNs against the NHSE/I PCN Maturity matrix
- **CONSIDERED** the support that the ICS can provide to the PCNs to enhance their development and support the delivery of care at Place and across the System.

**Covid-19 Recovery and Planning**

**PCC/21/186 Covid-19 Practice level update: Operational Pressures Escalation Levels (OPEL)**

Joe Lunn presented the item and highlighted the following 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 paper provides an overview of OPEL reporting for the four weeks to 26 November 2021. Report includes the comparator data for the prior reporting period.

c) 25 of 124 practices reported days where they were at OPEL Level 3 during the four week period (177 days across those practices), 97 practices have reported OPEL Level 2 for the period and 26 practices reported they were consistently OPEL Level 1.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL overview report for General Practice for the four weeks to 26 November 2021.

**Financial Management**

**PCC/21/187** **Finance report – month eight**

Michael Cawley presented the item and highlighted the following points:

a) The paper reported the financial position for the month eight 2021/22 and has been prepared in the context of the revised financial regime implemented by NHSE/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 £3.30 million underspend (2.96% of year to date budget). This is primarily due to the reserves forming part of the position (£3.18 million, which is 2.84% of the 2.96% total underspend). The reserves are designed to manage any in-year unforeseen pressures that may arise on those budgets delegated by the CCG to PCCC. For accounting purposes, the total PCCC reserves position remains reported as part of the overall PCCC position.

c) The current forecast position is £1.37m underspend against budget however, within the overall forecast position the PCN spend line shows an overspend. This is largely related to a timing delay in ARRS claims.

The following points were made in discussion.

d) Further clarification was provided regarding the ARRS claims. NHSE/I guidance requires them to be reported in this way.

The Committee:

- **NOTED** the contents of the Primary Care Commissioning Finance Report.
- **APPROVED** the Primary Care Commissioning Finance Report for the period ending November 2021.

| | Risk Management |
|---|---|

**PCC/21/188** **Risk Report**

Jo Simmonds presented the item and highlighted the following points:

a) There are currently eight risks relating to the Committee's responsibilities, an increase in two risks since the last meeting.
b) Risk RR 160 reflects the significant burden on the primary care workforce due to the high level of sustained pressure in general practice.
c) RR 169 and RR 171 have been added to the register since the last meeting. RR 169 reflects the potential risk that Primary Care Networks (PCNs), PCN Clinical Directors and/or GP Member Practices may become disengaged due to the increasing expectations of PCNs. RR 171 articulates the risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports related to access and waiting times.

No further points were made in discussion.

The Committee:

- **NOTED** the Risk Report and did not highlight any further risks for inclusion in the risk register.

| | Closing Items |
|---|---|

**PCC/21/189** **Any other business**

No further business was raised.

**PCC/21/190** **Key messages to escalate to the Governing Body**

The Committee:

- **RECEIVED** an update on the winter access fund following NHSE/I approval of the CCGs plans. Implementation of plans will be monitored through to the end of March 2022.
- **RECEIVED** an update on the Springfield Medical Centre merger and addressed the four questions received by members of the public in relation to this item.
- **RECEIVED** an update on temporary GP contract changes to support COVID-19 Vaccination Programme.
- **RECEIVED** the outcome of the Primary Care Network NHSE/I Maturity Matrix review. The outcome demonstrated good progress in PCN development.

**PCC/21/191** **Date of next meeting**:

**19/01/2022**

MS Teams meeting

Nottingham and Nottinghamshire Clinical Commissioning Group

**Audit and Governance Committee**
**RATIFIED minutes of the meeting held on**
02/11/2021, 09.00-11:30
Via MS Teams

**Members present:**

| | |
|---|---|
| Sue Sunderland | Non-Executive Director (Chair) |
| Eleri de Gilbert | Non-Executive Director |
| Jon Towler | Non-Executive Director |

**In attendance:**

| | |
|---|---|
| Craig Bevan Davies | 360 Counter Fraud Specialist |
| Lucy Branson | Associate Director of Governance |
| Hazel Buchanan | Associate Director of Strategic Programmes and EPRR (item AG 21 066) |
| Michael Cawley | Operational Director of Finance |
| Siân Gascoigne | Head of Corporate Assurance |
| Stuart Poynor | Chief Finance Officer |
| Richard Walton | Director, KPMG |
| Sue Wass | Corporate Governance Officer (minutes) |
| Kevin Watkins | Client Manager, 360 Assurance |

| Cumulative Record of Members' Attendance (2021/22) | | | | | |
|---|---|---|---|---|---|
| **Name** | **Possible** | **Actual** | **Name** | **Possible** | **Actual** |
| Eleri de Gilbert | 4 | 3 | Jon Towler | 4 | 4 |
| Sue Sunderland | 4 | 4 | | | |

## Introductory Items

**AG 21 060 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 21 061 Confirmation of quoracy**
The meeting was declared quorate.

**AG 21 062 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 21 063 Management of any real or perceived conflicts of interest**
This item was not required, as no interests were declared.

**AG 21 064 Minutes from the meeting held on 31 August 2021**
The minutes of the meeting held on 31 August were agreed as an accurate record of the discussions held.

**AG 21 065** **Action log and matters arising from meeting held on 31 August 2021**
All actions were noted as completed and there were no matters arising.

**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity**

**AG 21 066** **Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Update**
Hazel Buchanan presented this item and highlighted the following key points:

a) NHS England and Improvement (NHSEI) had a statutory function to seek formal assurance from CCGs and providers of their readiness to respond to emergencies. This was discharged through annual self-assessment assurance against the EPRR Core Standards.
b) Due to the demands on the NHS during 2020, the annual process had been reduced and had focused on the response to the pandemic. However, the process had now resumed and was a much-improved assurance process.
c) Meetings had been held with NHSEI to discuss the CCG's and system partners' compliance and all were substantially compliant with the core standards.
d) The CCG had self-assessed itself as partially compliant with three of the standards, and plans were in place to address these areas. Specifically, a thorough review of the current Business Continuity Plan was being undertaken within individual directorates, ahead of the end of the financial year, in preparation for the transition to the statutory body.
e) Currently the CCG was a category two responder under the Civil Contingencies Act; however, it was likely that the ICB will become a category one responder and the detail of the implications of this were currently being worked through. It was difficult to assess resource and capacity until national guidance became available.

The following points were raised in discussion:

f) Members queried the timescale for the work to become fully compliant and it was noted that the ambition was to be fully compliant by March 2022.
g) Members queried whether there were any plans to re-introduce incident testing. It was noted that the Business Continuity Plan would be tested. Members emphasised the importance of undertaking a test, which was acknowledged.
h) Members queried whether there was any concern from system partners' partially compliant reports. It was noted that all had similar areas of improvement and had plans in place to address the issues.
i) Members queried the likelihood of fit for purpose structures being established by April 2021. It was noted that the CCG had a good working relationship with the Regional NHSEI Team and local providers on EPRR. It was unlikely that there would be many new functions; the debate would be over the management of the functions. No major concerns were noted at this time. Members requested a brief update on readiness for category one status to be given at the January 2022 meeting.

The Committee:

- **NOTED** the CCG self-assessment and responsibilities for the ICB as a category 1 responder.
- **NOTED** the responsibilities and transition of the ICB to a category 1 responder, which includes a system wide assessment of the capacity required to manage this.

**ACTION:**
- **Hazel Buchanan to provide an update to the January 2022 Committee meeting on readiness for moving to category 1 responder status.**

*At this point, Hazel Buchanan left the meeting.*

**Due Diligence**

**AG 21 067 Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close-down**

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

a) Subject to the passage of the Health and Care Bill through the Parliamentary process, it was expected that CCGs will be abolished, and Integrated Care Boards (ICBs) established on 1 April 2022.
b) A due diligence process is required to ensure the safe transfer of staff and property to the new organisation. The report set out the national requirements, the approach taken and progress to date.
c) The predecessor CCGs had undertaken a similar exercise in 2019/20 and learning from this had been incorporated into the processes for this transfer, with emphasis on the preservation of corporate memory and maintaining oversight of the quality of services.
d) The due diligence requirements are key deliverables within the ICB Establishment, Governance and Accountability Workstream of the ICS Transition Programme, with a direct reporting line to the ICS Transition and Risk Committee as the 'receiving' organisation. The Audit and Governance Committee will have a key role to scrutinise the robustness of the approach being taken as one of the 'sending' organisations.
e) The CCG is following nationally prescribed guidance and checklist processes, which are under continual iteration, and include areas of ICB establishment, such as the new constitution and scheme of delegation.
f) A Due Diligence Plan had been developed, with each activity having named operational leads and deadlines, with a task and finish group overseeing progress. This was a joint approach with Bassetlaw CCG, as the other 'sending' organisation.
g) It was noted that the audit committees of the two CCGs may meet in common in January 2022 to oversee the progress of the Due Diligence Plan in detail.

The following points were raised in discussion:

h) Members noted assurance that robust processes were in place and supported the emphasis on the preservation of corporate memory.

The Committee:

- **NOTED** that a plan and delivery infrastructure has been developed to ensure a robust due diligence process, encompassing essential CCG closedown and ICB establishment activities as defined by national guidance.
- **NOTED** that the CCGs are undertaking a joint approach to this work, with signoff of the process to be sought at a meeting 'in common' of the CCGs' Audit Committees in March 2022 (with potential further meetings in common if required).
- **FEDBACK** on any additional assurances required in further reports, noting that updates will now be presented at each of the Committee's scheduled meetings until CCG close-down.

**Information Governance**

**AG 21 068 Information Governance Assurance Report**

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

a) This was a regular assurance report on the CCG's compliance with legislative and regulatory requirements in relation to information governance.
b) Since the last update the Information Governance Steering Group (IGSG) had met

twice. A review of the Group's Terms of Reference had taken place, with confirmation of their continued fitness for purpose.

c) The 2020/21 Data Security and Protection Toolkit (DSPT) had been submitted by the deadline of 30 June 2021 and confirmation was given that it had been fully compliant with all standards.
d) The CCG was currently 70% compliant with the requirements of the 2021/22 DSPT and a plan was in place to ensure full compliance by the deadline. Although the national deadline was June 2022, the ambition was to submit a fully compliant DSPT by 31 March 2022 ahead of CCG disestablishment. Although the DSPT was not a mandated area of assurance for internal audit this year, the internal audit function would be testing evidence and the scope of the audit was currently being agreed.
e) The National Audit Office had recently published guidance for Audit Committees on monitoring cyber risks. This would be discussed at the December 2021 meeting of the IGSG, and the outcome reported to a future Audit and Governance Committee meeting.
f) The Government had recently released a draft data strategy: 'Data Saves Lives: Reshaping health and social care with data' and the National Data Guardian had raised concern of not losing sight of patients' right to own their own data.
g) The Information Governance Management Framework had been reviewed by the IGSG, with only minor changes proposed and was appended to the report for the endorsement of the Committee for onward submission to the Governing Body for approval.

The following points were raised in discussion:

h) The CCG's Deputy SIRO thanked the team for work to submit a fully compliant DPST.

The Committee:

- **APPROVED** the reviewed and updated terms of reference for the Information Governance Steering Group.
- **NOTED** the arrangements in place to ensure compliance with the requirements of the Data Security and Protection Toolkit and other legal and national obligations.
- **ENDORSED**, for onward submission to the Governing Body, the Information Governance Management Framework.

**Financial Stewardship**

**AG 21 069 Transactions Approved Outside Financial Limits**

Michael Cawley presented this item and highlighted the following key points:

a) Following the initial report at the June 2021 meeting; and a request for updated reports to be brought to the Committee on a quarterly basis, this report covered the period July-September 2021.
b) During the period, 1.13% or 52 transactions were approved outside of the delegated limits set out in the CCG's Standing Financial Instructions. A decrease since the last report.
c) Breaches continued to be primarily the result of financial system limitations.
d) The two areas of concern from the last report had been addressed. There was a continued concern regarding the number of credit notes raised in excess of delegated limits. This was noted as an issue with the limitation of the financial system, rather than a concern of potential fraud; and had been raised with the Shared Business Service as an opportunity to address pending the move to a single ledger from April 2022. If it could be remedied, it would improve the overall control environment.

The following points were raised in discussion:

e) Members were supportive of efforts to address the limitations of the financial systems with the Shared Business Service.

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.

**Internal Audit**

**AG 21 070 Internal Audit Progress Report**

Kevin Watkins presented this item and highlighted the following key points:

a) Since the last meeting, the Stage One report for the Head of Internal Audit Opinion had been circulated. No concerns had been raised, with one minor recommendation for action made.
b) Fieldwork on the Continuing Healthcare and ICS operational planning audits had been completed and fieldwork for the safeguarding and ICS transformation and efficiency reviews had commenced.
c) The terms of reference for the review of patient engagement had been agreed and the draft terms of reference for the primary care workforce development and integrity of the general ledger and key financial systems audits had been circulated.
d) The implementation rate of audit actions was 82%, with extensions agreed on two outstanding actions.
e) Following discussions, it was unlikely that the audit on collaborative commissioning would be undertaken in this financial year and time had been transferred to contingency, which would be drawn on as the CCG moved closer to transition.

The following points were raised in discussion:

f) Members queried the scope of the audit on patient engagement. It was noted that it was focused on evaluating the response to the recently issued NHS England publication 'ICS implementation guidance on working with people and communities'. Members requested that thought be given to a wider piece of work in the next financial year to examine how engagement was undertaken, which was agreed.
g) Members also requested that good practice from the existing Public and Patient Engagement Committee should be considered in the audit, which was agreed.
h) Members queried the scope of the financial reporting audit; and it was confirmed that this would not duplicate work undertaken by external audit on closedown and would focus on payroll systems, which was welcomed.
i) Members queried the capacity of Internal Audit colleagues to deliver the audit plan by the end of the financial year and it was confirmed that the plan was fully resourced.

The Committee:

- **RECEIVED** the progress report and **NOTED** the key messages and progress being made with the delivery of planned assurances for 2021/22

**AG 21 071 Head of Internal Audit Opinion – Stage One Report**

Kevin Watkins presented this item and highlighted the following key points:

a) The stage one report had been completed and had demonstrated that robust risk management arrangements continued to be in place.

The Committee:

- **NOTED** the Stage One Head of Internal Audit Opinion report.

**AG 21 072 Internal Audit Update Paper on Transition Assurance Work**

Kevin Watkins presented this item and highlighted the following key points:

a) The report provided a summary of work being undertaken by Internal Audit to provide assurance in respect of transition arrangements being implemented by the CCG.
b) Attendance at the ICS Transition and Risk Committee provided an opportunity to gain assurance on the delivery of the eight workstreams and to assess potential risk through a risk register, which had been developed for the transition. The Committee had proved an effective mechanism to oversee progress.
c) Terms of Reference had been drafted for a deep dive exercise on reporting arrangements to the Committee and the outcome of the work would be reported to the December 2021 Transition and Risk Committee and to this Committee in January 2022.
d) Internal Audit would also attend the task and finish group established to oversee the completion of the due diligence checklist to ensure compliance with NHS England guidance.
e) Attendance had also been requested by the CCG at the Finance Transition Board to provide advice on the setting up of a new general ledger for the ICB.

The following points were raised in discussion:

f) Members welcomed the active role that Internal Audit colleagues were taking in support of the transition; however, were concerned that any additional agreed work was focused to demonstrate that it was adding value. Members asked Internal Audit to be mindful of potential conflicts of interest when agreeing resource to support working groups.
g) Commenting on the huge amount of work that needed to take place ahead of April, members queried whether this had been articulated on the risk register. Jon Towler, as Chair of the Transition and Risk Committee, noted that the risk was reflected fairly on the register. Although the programme was largely on track, the potential risk was significant as many of the workstreams were inter dependent. Workstream leads met on a fortnightly basis and capacity was continually assessed.
h) Members requested that the outcome of the audit on reporting arrangements be shared ahead of the January 2022 meeting, which was agreed.

The Committee:

- **NOTED** work being undertaken by Internal Audit to review the transition process as the CCG prepares for close-down and establishment of the Integrated Care Board statutory body.

**ACTION:**

- **Kevin Watkins to share the outcome of the audit on reporting arrangements for the transition work ahead of the January 2022 meeting.**

## Counter Fraud

**AG 21 073 Counter Fraud Progress Report**

Craig Bevan Davies presented this item and highlighted the following key points:

a) The report summarised the work undertaken in relation to counter fraud work from the CCG's 2020/21 Counter Fraud Plan.

b) The format of the report had been updated to simplify reporting on the Counter Fraud Functional Standard Return (CFFSR). Currently there were no actions noted as red and the report detailed actions in place to meet all requirements by the end of the financial year.
c) Following the request for CCGs to appoint a counter fraud champion, discussions had taken place with the NHS Counter Fraud Authority on the scope of the role; and further guidance would be circulated in due course.
d) Regarding the function standard relating to the management of fraud risks, work has been undertaken to ensure the CCG's risk management arrangements were in line with the Government Counter Fraud Profession's methodology.
e) It was noted that the outstanding action on the Committee's action log relating to case #82303 was an anomaly and had been closed.

The following points were raised in discussion:
f) Members noted that good assurance had been received on the management of fraud risks.

The Committee:
- **NOTED** the Counter Fraud Bribery and Corruption Report.
- **NOTED** the briefing on fraud risk work currently underway to assist the CCG in meeting the requirements of the Government Counter Fraud Functional Standard.

## External Audit

**AG 21 074** **External Audit Progress Report**

Richard Walton presented this item, highlighting the technical update report, which had been shared for information.

The Committee:
- **NOTED** the report.

## Corporate Governance

**AG 21 075** **Statutory and Mandatory Training Mid-Year Compliance Report**

Siân Gascoigne presented this item and highlighted the following key points:
a) The report provided an update on the CCG's current statutory and mandatory training compliance figures for review.
b) The CCG's overall training compliance was high except for GP appointees and work was on-going with GP colleagues to improve compliance rates.
c) Since the last report the CCG had taken steps to strengthen monitoring and reporting processes, particularly in relation to new starters.

The following points were raised in discussion:
d) Members recognised the pressures GP colleagues were under and were supportive of the steps being taken to support them to ensure compliance.

The Committee:
- **NOTED** the CCG's current statutory and mandatory training compliance figures.
- **SUPPORTED** the work completed to date and identified next steps to improving training compliance.

**AG 21 076** **Health and Safety Mid-Year Compliance Report**

Siân Gascoigne presented this item and highlighted the following key points:
a) The report summarised the work of the CCG's Health, Safety and Security Steering

Group and provided a mid-year overview of health and safety compliance requirements for the CCG.

b) Regarding workplace working, the CCG had continued to take a risk averse approach to returning to offices. However, for those staff wishing to return to the workplace, risk assessments had been undertaken and measures had been put in place to ensure staff could work safely from CCG offices.
c) Work had been undertaken during the period to ensure compliance with health and safety and fire regulations and first aid and fire marshal training had been completed for eight staff.
d) Work continued to identify lone workers working in the community within the organisation and to ensure risk assessments were completed and managed appropriately.
e) For workers working from home, it was noted that the management of risk would sit with the line manager; and this would be articulated in the CCG's Agile Working Policy, which was currently in draft. Specific risks associated with display screen equipment (DSE) were being managed via DSE assessments and completion of assessments was currently at 96%.

The following points were raised in discussion:

f) Members emphasised the need to conclude the assessments on lone workers with direct contact with members of the public and to test procedures, which was acknowledged. It was agreed that this work would be prioritised and completed by the end of the calendar year.
g) Discussing any potential resumption of face-to-face meetings, it was concluded that the CCG should document and define its approach, which would take account of factors, such as efficiency and the social benefits of face-to-face meetings. This should be incorporated into the CCG's Agile Working Policy.

The Committee:

- **NOTED** the CCG's position in relation to key health and safety requirements.

**ACTION:**

- **Siân Gascoigne to discuss with the CCG's HR team the need to include reference to a blended approach to face-to-face meetings in the CCG's Agile Working Policy.**

## Risk Management

**AG 21 077 Risk Management Arrangements Mid-Year Update**

Siân Gascoigne presented this item and highlighted the following key points:

a) The report gave a mid-year update on the work undertaken during the first six months of 2021/22 to further embed and maintain the CCG's strategic and operational risk management arrangements.
b) A review of the CCG's Risk Management Policy had been undertaken to ensure it continued to meet current requirements and a new policy was being developed for the ICB.
c) The mid-year position of the Assurance Framework had been presented to the Governing Body at its October meeting and note was taken of the challenges of seeking controls and assurances against the backdrop of evolving system working. A quarter three update report would be brought to the January meeting of this Committee.
d) The Corporate Risk Register currently contained 41 risks that were managed by the CCG's respective committees. An analysis of the risks that had been on the register for a relatively long time had been undertaken to ensure they continued to

present a 'live 'risk.

e) The report detailed work to develop risk management arrangements for the ICB.

The following points were raised in discussion:

f) Members noted the challenges to establish consistent risk management arrangements across all system partners and it was noted that partners were supportive of the approach.

The Committee:

- **NOTED** the full Corporate Risk Register at Appendix A.
- **NOTED** the development of risk management arrangements for the Integrated Care Board (ICB).

**Closing Items**

**AG 21 078** **Any other business**

There was no other business.

**AG 21 079** **Key messages to escalate to the Governing Body**

- Assurance received on EPRR arrangements.
- Assurance received on due diligence arrangements.
- Recommendation for the Governing Body to approve the IGMF.

**AG 21 080** **Date of the next meeting:**

25/01/2022
Via MS Teams