NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
DELIVERY ASSURANCE COMMITTEE
WEDNESDAY 4TH SEPTEMBER 2019
CROSLAND SUITE, GRIMSBY TOWN HALL, GRIMSBY

PRESENT: Laura Whitton, Chief Finance Officer, NELCCG (Chair)
Martin Rabbetts, Performance Development & Assurance Manager, NELCCG
Bev Compton, Director of Adult Services, NELCCG
Geoff Barnes, Deputy Director of Public Health, NELC
Lisa Hilder, Assistant Director, Strategic Planning, NELCCG

APOLOGIES: David Walker, Community Member, NELCCG
Dr Mathews, GP Rep
Lydia Golby, Nursing Lead for Quality
Eddie McCabe, Assistant Director Contracting & Performance, NELCCG

IN ATTENDANCE: Sue Ward, Assurance and Delivery Manager, NHSE
Rob Walsh, Chief Executive NELC/NELCCG
Caroline Reed, PA to Executive Office, NELCCG - Note Taker
Levi Clements-Pearce, Service Manager Disability and Mental Health/Emergency Preparedness (Item 5)
Sarah Dawson, Service Lead Primary Care and Long Term Conditions Service Planning and Re-design (Item 6)
Jo Horsfall, Finance Support Officer (Item 6)
Andy Ombler, Service Lead - Unplanned Care (Item 7)
Lynne Popplewell, Head of Finance (Health Commissioning & Corporate) (Items 8, 9)
Simon West, Finance Manager (Financial Strategy & Assurance) (Items 8,9)

	Item	**Action**
1.	**Apologies**	
	Apologies were as noted above.	
2.	**Declaration of Interest**	
	There were no declarations of interest from those in attendance.	
3.	**Notes From Last Meeting – 26.06.2019**	
	The notes from the last meeting were agreed as an accurate record subject to the following agreed amendment: Sue Ward and Neil Smaller to be noted as Attendees rather than Members.	**C Reed**
4.	**Matters Arising – 26.06.2019**	
	Outstanding actions from the updated matters arising document were discussed. Item 5 - Mental Health and Disabilities Update Members experienced difficulty in opening the embedded document from L Holton – C Reed to circulate the document to the Committee. *There is increasing concern from NHSE regarding the non-delivery of IAPT. An update will be brought to the next meeting to provide the Committee with assurance around this standard*. N Smaller provided an update advising that there was an issue with reconciling the national and local data during 2018-19 and that Q1 2019/20 data is required to confirm that the data is back in line. M Rabbetts confirmed that the Q1 data is expected in October and assurance should be received for the October meeting. It was noted that IAPT continues to show as not achieving at the current time.	**C Reed**

	Item 9 - Integrated Assurance Report *Quality – Provision of high quality care –. It was agreed that it would be useful to set something more achievable. Quality team were discussing this at meeting arranged for 12th August 2019. JH / JB and LG to feedback* L Golby to provide feedback to the Committee. *Continuing Healthcare (CHC) – It was agreed that KPIs need to be agreed in order to receive assurance as this is a critical area with a significant amount of spend. M Rabbetts to discuss with B Bradshaw.* M Rabbetts and B Bradshaw to join a WebEx on 9th September which will include recommendations on reporting re CHC. This will be fed back to the Senior Team with recommendations being submitted to the next meeting of this Committee.	**L Golby** **M Rabbetts**
	FOR RATIFICATION	
5.	**Emergency Preparedness, Resilience and Response (EPRR)**	
	A report was circulated for consideration. L Clements-Pearce provided a summary: • In 2018, the CCG was fully compliant with 38/43 core standards. Due to work completed following last year's self-assessment process around pandemic flu preparedness (pandemic flu plan has been created), availability of loggists (full cohort of loggists have been trained) and media strategy (training for all on call directors has been completed), the CCG is now fully compliant with 41/43 core standards resulting in "Substantial Compliance". • Infectious disease preparedness and AEO attendance at LHRP continue to achieve "partial compliance". Significant progress has been made in relation to infectious disease (2 internal exercises and attendance at one external session). Work is ongoing to establish how attendance at LHRP meetings can be improved as H Kenyon (AEO) is unable to attend the required 75% of meetings. It is proposed that Lisa Hilder be named as "appropriate director" and deputise for H Kenyon. It was noted that a CCG representative is sent to every LHRP and provides feed back to the AEO. • Collaborative working has increased between CCG Emergency Planning Staff and NELC's emergency planners (Humber Emergency Planning Service). The CCG now shares the Council's emergency co-ordination centre and held the most recent exercise at the centre. • Emergency Preparedness and Resilience Group (EPARG) continues to meet quarterly and has identified new objectives for this year, including: increased resilience against cyber-attacks, increased resilience against supply chain issues in anticipation of EU Exit, increased resilience as a health economy against prolonged periods of hot weather. The September meeting will take the format of a table top exercise based on Operation Wellington. All of the main providers will be in attendance. A similar exercise will be required for smaller providers. L Clements-Pearce and B Compton to follow this up. Feedback from the EPARG meeting to go to the next Leadership Team meeting. *9:13am – Lisa Hilder joined the meeting.* The Committee provided the following feedback: • How does the CCG compare to other organisations? L Clements-Pearce confirmed that performance is similar to other CCGs and that excellence progress has been made this year. Gary Johnson, NLCCG is attending the NEL EPARG sessions to improve mutual learning. The ongoing work plan is better placed than previously.	**L Clements-Pearce** **B Compton**

	Work is required to embed EPRR training onto the ESR system.
	• Is the CCG assured regarding providers' business continuity? Has provider business continuity been tested against a set of risks? L Clements-Pearce confirmed that larger providers, eg, NLaG and CPG have their own dedicated EPRR teams and there is good engagement with the CCG. There are gaps with primary care, Yarborough Clee and smaller residential and domiciliary care.
	  • Primary care - conversations have taken place with Julie Wilson and it is proposed that EPRR champions be identified within PCNs.
	  • Yarborough Clee - Sarah Dawson to liaise with Yarborough Clee in order to try and improve engagement.
	  • ASC – B Compton and L Clements-Pearce to meet to discuss this further. An assurance piece of work will be circulated to smaller providers this week asking providers to consider areas such as potential road closures, severe weather plans etc. A previous exercise regarding Brexit resulted in a good return from providers. There were no significant concerns regarding the workforce as NEL does not have a high rate of EU staff members. The Committee raised concerns regarding potential road closures and the impact on staff travel. It was noted that NHSE are working to try and avoid road closures around Scunthorpe hospital and requests have been made to enable medical and healthcare professionals to travel via emergency lanes. Some areas are looking at electric bikes for staff in the event of fuel shortages. Further discussions are required in NEL.
	• The Committee requested assurance that H Kenyon has reviewed and approved the self-assessment return. L Clements-Pearce to ensure that this has occurred prior to submission to the Governing Body.
	
	The Committee agreed to note and accept the contents of the report and self-assessment return, subject to approval by H Kenyon, prior to sign off at Governing Body on 12th September 2019.
		L Clements-Pearce

	FOR DISCUSSION	
6.	**Primary Care Update**	
	A report was circulated for consideration. S Dawson provided a summary: • Corporate action plan - a lot of work has been undertaken to create and formally establish the PCNs (officially in place since 1st July 2019). Formal monthly meetings have been agreed and timelines for the alignment and integration of other community provider teams agreed. The CCG is supporting the development of local supplementary schemes within the PCNs, which will support local priorities and contribute towards QIPP savings. Initial proposals relating to medicines optimisation and urgent care (emergency admissions and A&E attendances) require further development and support. Good progress is being made around the rollout of online consultation (on track to achieve 75% population coverage by the end of March 2020). Case studies are being gathered to demonstrate the positive impact on patient and practice experience. • Key performance measures – one practice was recently rated "inadequate" following a CQC inspection; this will impact on overall performance. The practice has been put into special measures and will be re-inspected within a year. An action plan has been agreed and additional support from within the PCNs has been put in place. • Financial position - The CCG received a lower than expected uplift to the delegated primary care budget, which created a gap of £550k. This has been addressed through reviewing current spend and ensuring that any	

	expected slippage and underspend against current schemes/services has been accounted for. The result is less flexibility within the primary care budgets this year. • QIPP – medicines optimisation is on track to deliver; however the demand management scheme is not currently in place. Interim support has been offered to PCNs. The QIPP challenge will be submitted to the September CoM meeting for further input. It was agreed that a baseline assessment and revised profile is required in order to understand the risk and gain assurance on what can be achieved. Julie Wilson to be asked to action this. • Risks – key risks to delivery include: CCG staff capacity (weekly team meetings are taking place to review and reprioritise), GP and primary care management capacity to support the development of PCNs and transformational change (actions are in place to support GP recruitment and to free up GP time and additional funding of £1.50 per head has been provided to support the management of PCN work), pace of demand management QIPP delivery (support from the CCG is provided and monthly meetings are taking place chaired by the LMC). The Committee provided the following feedback: • Some periods within KPI information are not current, eg, Patient experience of GP services 2017/18; is there more up to date information available? M Rabbetts confirmed that these are the latest figures available. Is assurance on user outcomes available via other indicators? Are providers and practices collating information? It was noted that work is underway by the Quality team around provider quality profiles and feedback is also received via PALS and complaints. • PCNs are key enablers in terms of transformation. Is there anything that can be done to move the pace forward or refocus efforts? What are the implications for CPG with the changes in the system? S Dawson confirmed that discussions are ongoing with CPG to discuss community nursing, rapid response etc. Monthly meetings with the LMC are scheduled in order to get the formal processes in place. The focus for 2019/20 is the integration with providers and the realignment of services in order to be able to deliver the seven core national standards. • Further understanding is required on the financial position as part of the CCG's medium term planning. Lower uplifts to primary care budgets are anticipated in the coming years which will limit the flexibility within the overall primary care allocation. The CCG needs to be clear that resources are being used in the most efficient and effective way to maximise outcomes. • What powers can the CCG exercise to intervene if a GP practice is rated inadequate? S Dawson confirmed that contractual action could be taken if a practice did not try to meet the improvement plan. **The Committee noted the update.**	
7.	**Urgent and Emergency Care Update**	
	A report was circulated for consideration. A Ombler provided a summary: • A&E performance remains the focus of Northern Lincolnshire and NHS regional concern due to not meeting the national target or the local planning trajectory. A NHSE/NHSI summit with the Trust is taking place on 6th September in order to identify a way forward. Recent performance has improved; further work is required to understand this improved performance and whether it is sustainable. Overnight staffing of A&E remains a problem at a clinical level, which impacts on the following day's performance. • Emergency Transport ARP measures - EMAS met 2 of the 6 ARP measures in June and did not meet any of the measures in July 2019. E McCabe is doing a piece of work on local transport services in order to establish if there is an alternative way of providing local transport. E McCabe to confirm the timeframe for this piece of work. • Hospital Handover Performance – the pre-clinical handover performance	**E McCabe**

	at DPoW is close to meeting the 15 minute target (against a county average of 25 minutes); however the post clinical handover performance attributable to EMAS is above target. It was noted that good work has been carried out at the hospital to ensure that people exit ambulances quickly. The Committee provided the following feedback: • How does the roll out of the Urgent Treatment Centre (UTC) link to the A&E performance target and what are the expectations on the impact on the target? A Ombler reported that a large cohort of patients presenting at A&E do not need to be seen by an acute led service. The aim is for those patients to be seen in a timelier manner at the UTC. It is difficult to confirm whether this will have a positive impact on A&E performance as the more complex cases will still be dealt with in A&E. It was noted that counting guidance has changed and direct appointments in the UTC will not count towards performance. • Concerns were raised that the UTC might not be in place by the December deadline due to delays and gaps in the workforce. A Ombler acknowledged the issues relating to gaps in the rotas and leadership and advised that this issue is likely to be picked up at the summit on 6th September. • What are the expected outcomes from the summit? S Ward advised that summits in other areas focused on identifying priorities and issues and pressure points in the overall system. Action plans were agreed at the summits. A Ombler advised that the system is looking at all mechanisms that can be used to manage demand, eg, community service transport for conveyances. The challenge will be getting providers to work better together. • EMAS performance is comparatively better in NEL than other areas; however does not compare favourably with YAS performance; therefore Yorkshire and Humber is an outlier overall. • Are there critical barriers to rightsizing the community urgent care response? What do we need to do as a system if there are gaps? A Ombler advised that the principle of the Alliance is to take out efficiencies as a result of better collaborative working and that further work is needed to formalise pathways, eg, primary care to have direct access to a rapid response nurse. Has direct booking via 111 been factored in? A Ombler confirmed that this is in place and has been factored in. • Will the system cope with flu season? A Ombler advised that this has been picked up at the Delivery Board. • Concerns that improvement in Discharge to Assess could have a detrimental impact on long term placements and therefore impacts the overall system. The Committee agreed that a deep dive would be helpful to look at this issue, eg, is a more detailed pathway regarding home care required?; emphasis to be placed on therapy; more collaborative working re care at home etc. This will be picked up outside of the meeting. **The Committee noted the update.**	**B Compton** **A Ombler**
	STANDING ITEMS	
8.	**Finance Update**	
	A report was circulated for consideration. S West provided an update: • In month 4, the CCG under traded by £57k; however is expected to achieve its planned operating position and its NHSE/I mandated surplus. • St Hugh's - the significant overtrade has started to slow down. • CHC – an underspend is anticipated due to a slowdown in activity related to people over 65 with a physical disability. • Potential risk value has increased since the last report and is now at £4.7m. Key movements include a £67k increase for prescribing linked to Cat M pressures and a £500k increase in the risk share relating to delivery of the Northern Lincolnshire system £2m QIPP. • Better Payment Practice – as reported at the last meeting performance	

	dipped below the target for the number of invoices paid. This was linked to delays in Adult Social Care invoices paid by focus on the CCG's behalf, this was due to staffing issues within the focus Community Care Finance team. New staff are now in post and have been trained; therefore an improvement in performance is anticipated. The CCG has also performed some data validation checks (correct dates etc) and are awaiting responses. The Committee provided the following feedback: • L Whitton reiterated that the current financial position is very tight and emphasised the need to ensure that budgets are contained within their envelopes and QIPP schemes are delivered. • Recent benchmarking data on SBS (accounting system) has been published. It would be helpful to consider how NEL compares with other areas to get some context and areas of good practice. S West to incorporate this into a future report. **The Committee noted the update.**	**S West**
9.	**QIPP Update**	

9.1	A report was circulated for consideration. L Popplewell provided an update:
	• The CCG is anticipating that the planned savings for the year will be achieved in full.
	• Unidentified QIPP - in the last report there was unidentified QIPP of £17k this has now been reduced to zero.
	• 2 schemes have been RAG rated red:
	  • Demand management via the Alliance/PCNs – plans are being worked on with the PCNs and training organised. This will be discussed at CoM on 5th September and J Wilson will attend the next DAC meeting in order to provide an update.
	  • NLaG Gastroenterology - activity has increased. Work is underway with NLaG to understand the increase.
	• Pressure sores (scheme that cross cuts the NL system) is rated as red. A meeting is scheduled on 6th September to look into this.
	• Total QIPP risk is £ 3.5m. Mitigations are in place.
	
	The Committee noted the update.
		Forward plan

9.2	**Adult Social Care Savings**	
	B Compton provided a verbal update: • Collaborative working with the ICP – the £200k savings have been delivered via ICP efficiency. • Reduction of high cost residential care placements – work is underway regarding the scheme. £100k of savings have been identified, however the aspiration is to overachieve on this figure. The scheme is not delivering at this stage but is on track to deliver by March 2020. A working group has been established to lead the review and some of the work done in children's services is being mirrored. The CCG is working with children's services to look at the supply chain of high cost placements; there are a small number of very high cost placements that will feed into adult care. Work is ongoing to try to meld the two systems together. A formal process is to be agreed for social workers to review cases, including supported living and CHC. It is estimated that there are 89 placements that each cost over £50k p.a. The group is also looking at opportunities to develop different options for people with very specialist needs who currently need to go out of area. The work around fees and cost of care will support the review. Reviews of formal packages will commence in October; this will start to deliver the efficiencies. • ASC savings renegotiate via the Union arrangements for the NHS contribution to ASC services (£1m) – data exercise to be carried out; NEL is a higher placer of individuals from residential care into A&E than the national norm and individuals tend to stay in the system longer than nationally. The system needs to work better together in order to improve	

	this position. The next step is to utilise the data to review planning assumptions, eg, if performance was 10% better than currently. Are there some focused pieces of work that can be done on a while system approach, eg, reduction in ambulance conveyance? A key element is to ensure that the rehab pathway is fully functioning – this work is in its infancy. **The Committee noted the update and requested that a formal update be submitted to a future meeting to detail the timescales and quantifiable outcomes.**	**Forward plan**
10.	**Integrated Assurance Report**	

	A report was circulated for consideration. M Rabbetts provided a summary:
	• Unplanned Care - 2 NEW measures around ARP Category 1T (Transported)
	• Mental health and disabilities - 8 NEW measures around MH SMI Health Check, Reliance on inpatient care commissioned by NHSE, MH Crisis Provision, IAPT Trainees and Therapists and MH Data Quality.
	• Prescribing
	  • Reduction in the number of antibiotics prescribed in primary care – performance has improved but the target has not yet been met.
	  • Reduction in the proportion of broad spectrum antibiotics prescribed in primary care – performance has deteriorated slightly; however the target continues to be met.
	• Planned Care
	  • Cancer waiting times – access to diagnostics and reporting – not achieving the 62 day standards. This links to NLaG's focus on the current long waiters in order to try and improve the overall waiting time position. The poor performance is anticipated to continue; however it will improve the overall positon. Most of the breaches have occurred when patients are seen at NLaG and then move to Hull.
	  • RTT and diagnostic waiting times – these areas have seen the highest level of activity which is resulting in a significant impact on performance. Actions plans are in place to address the issues.
	  • 52 week breaches – there were two at the end of July which is an improvement; however the target was zero. Both patients are due to be treated by the end of September.
	• Women and Children
	  • The information provided for the two measures relating to Eating Disorders requires further investigation as there appear to be data issues.
	• Mental Health
	  • Proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period – performance has dropped below the target. This is anticipated to improve and will be monitored.
	  • IAPT recovery rate – still below the 50% target.
	• Community Care - Percentage of children waiting less than 18 weeks for a wheelchair - dropped below the target in Q1. This relates to one patient and the target is anticipated to be met once the issue is rectified.
	
	The Committee noted the update.	

11.	**Corporate Business Plan 2019/20**	
	A report was circulated for consideration. L Hilder provided an update: • Progress against plan as at the end of August was 27% against the planned trajectory of 29%. • Outstanding actions and milestones are highlighted in the report. • Updates are being received in a timely manner. Leads are aware that they are required to provide assurance to this Committee regarding any slippage.	

	The Committee provided the following feedback: • Are there any concerns regarding meeting the trajectory? L Hilder confirmed that the trajectory is set at a measured pace and there is no current cause for concern. **The Committee noted the update.**	
12.	**Internal Audit Survey**	
	A report was circulated for information. L Whitton provided a summary: • An effectiveness survey of the CCG's main committees was carried out by Internal Audit. Committee members were asked to provide feedback on roles and remits, timeliness and appropriateness of papers etc. • Overall feedback was positive. • The importance of dedicating the appropriate time to updates and enabling confirm and challenge was emphasised The Committee provided the following feedback: • R Walsh fed back that he had found the meeting useful and positive. • Need to ensure appropriate crossover with the Senior Team. How do we ensure that colleagues who do not attend DAC are aware of the discussions and issues raised? L Whitton confirmed that escalations are discussed at the Leadership Team and other critical issues are picked up at Operational Leadership Team. The Committee were asked to provide any additional suggestions or feedback to L Whitton. **The Committee noted the update.**	**ALL**
13.	**Escalation to the Governing Body**	
	It was noted that the papers for the Governing Body have already been finalised. M Rabbetts to provide any additional updates to E McCabe for a verbal update at the meeting.	**M Rabbetts**
14.	**Any Other Business**	
	S Ward reported that the NHS Oversight Framework for 2019/20 has been published and includes additional indicators. Further guidance will follow.	
	FOR INFORMATION	
15.	**Risk Register and BAF** – circulated for information.	
16.	**Financial Appeals Report** – circulated for information.	
17.	**Quarterly Incident Report** - deferred.	
18.	**Serious Incident Report** – deferred.	
	Date and time of next meeting **Wednesday 30th October, 12-2pm, Bremerhaven Room, Grimsby Town Hall, Grimsby**	