NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
DELIVERY ASSURANCE COMMITTEE
WEDNESDAY 30th OCTOBER 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
David Walker, Community Member, NELCCG
Dr Mathews, GP Rep, NELCCG
Lydia Golby, Nursing Lead for Quality, NELCCG
Eddie McCabe, Assistant Director Contracting & Performance, NELCCG

APOLOGIES:

IN ATTENDANCE: Sue Ward, Assurance and Delivery Manager, NHSE
Caroline Reed, PA to Executive Office, NELCCG - Note Taker
Andy Ombler, Service Lead, Unplanned Care (Item 5)
Julie Wilson, Assistant Director Programme Delivery & Primary Care (Items 5-9)
Rachel Brunton, Finance Manager (Item 7)
Lynne Popplewell, Head of Finance (Health Commissioning & Corporate) (Items 8, 9)
Simon West, Finance Manager (Financial Strategy & Assurance) (Items 8,9)
Lisa Hilder, Assistant Director, Strategic Planning, NELCCG (Item 11)

	Item	**Action**
1.	**Apologies**	
	No apologies were received for the meeting.	
2.	**Declaration of Interest**	
	There were no declarations of interest from those in attendance.	
3.	**Notes From Last Meeting – 04.09.2019**	
	The notes from the last meeting were agreed as an accurate record.	
4.	**Matters Arising – 04.09.2019**	
	Outstanding actions from the updated matters arising document were discussed. *Item 4 - Matters Arising – 26.06.2019 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. L Golby to provide feedback to the Committee*. L Golby reported that, following discussions with J Haxby, it is proposed to agree an aspirational target which could be expected to achieve (the current target continues not to be met and is unlikely to be met for next year). Achievement of this indicator is dependent on CQC inspection outcomes and when they are reported. L Golby advised that future narratives will include additional information to provide assurance or a lack of assurance that improvement is being achieved from providers through their action plans. *Item 7 - Urgent and Emergency Care Update - Emergency Transport ARP measures - 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.* E McCabe reported that an initial meeting has taken place with NELC to review	

	local transport services. The CCG shared information around its transport services and identified future needs/demands as part of this. M Webb agreed to raise this with Rob Walsh and escalate this via the Union Board. Lincolnshire CCG is also looking to do a similar piece of work. *Item 12 - Internal Audit Survey - The Committee were asked to provide any additional suggestions or feedback to L Whitton.* L Whitton advised that no further comments were received. **The Committee noted the update.**	
	12:13pm – S Ward joined the meeting.	
	FOR DISCUSSION	
5.	**Winter Plan**	

	A report was circulated for consideration. A Ombler provided a summary:
	• The A&E Delivery board winter plan is due to be submitted to NHSE by 31st October 2019. A draft was submitted in May and feedback received was incorporated. The revised plan was signed off by the A&E Delivery board on 24th October and will be submitted by the deadline. The success of the implementation of the Plan is monitored by the A&E Delivery Board.
	• The Plan has three elements:
	  • The Seasonal plan – details the planned response to the risk of potential seasonal pressures and outlines how all partners work together to monitor system pressures. There is a weighting element to the acute Trust. The national operational escalation framework (OPEL framework) defines escalation triggers for action. There is an increased number of senior managers who are involved in escalations. Access to Sitreps from all providers is available daily by 10am; this forms part of the monitoring escalation process. The plan includes a communication plan of planned messages for the public, eg, self-care, flu jabs etc. Capacity is planned for known pressure periods, ie, immediately after Christmas. GP practices are open either side of Christmas this year which should have a positive impact. The hospital needs to plan its non-elective work.
	  • Development Priorities – the A&E Delivery Board maintains a transformation plan to consider how the whole system is being developed across urgent and emergency care, ie, emergency transport, community integrated urgent care, A&E and non-elective inpatient care and the discharge and onward care process. The A&E Delivery Board has held workshops to identify the priorities:
	  • Urgent Treatment Centres in DPOW and SGH
	  • Community Conveyance Avoidance schemes for use by EMAS
	  • Frequent A&E attenders review and planning process
	  • Social Worker presence in A&E
	  • Increase in acute short stay capacity
	  • Increase in A&E consultant/senior clinical decision makers overnight in A&E
	  The schemes were presented to the A&E Delivery Board summit. The aim is to have sustainable delivery.
	  • Winter Monies – are released each year for additional capacity in the system and/or initiatives to support winter pressures. Key areas for 2019/20 are flu vaccination clinics to support domiciliary and residential care staff, additional support to the discharge service (early supported discharge/patient transport discharge) and additional capacity in domiciliary care.
	
	The Committee provided the following feedback:
	• How does the winter plan link into social care? A Ombler confirmed that	

	Local Authorities are represented on the A&E Delivery Board. B Compton advised that fortnightly meetings were held in winter 18/19 in order to achieve resolutions. • How does the Quality Team link into the plan? A Ombler confirmed that the links are of an ad-hoc nature; however the escalation process escalates to Directors of Quality when there are concerns relating to quality. • How successful are the communications messages? A Ombler reported that it is difficult to get feedback; however gave examples of the types of communications, eg, messages over loud speaker at Cleethorpes leisure centre and a designated space on the NELC Christmas card circulated to all households. • During the last winter period, the extreme weather protocol failed when the Trust had to support a homeless individual with an overnight stay due to Harbour Place refusing to accept them. This resulted in a Serious Incident. Assurance was sought that NELC are appropriately linked in. A Ombler confirmed that there are appropriate links across the system. B Compton advised that there has been a funding offer facilitating initiatives around support to the homeless during winter. B Compton to pick this up with Sam England. • Is there anything new to address the poor uptake of adult flu immunisation which also links to shingles which has an impact on winter pressures? It was confirmed that a significant number of messages have been used to target the "at risk" under 65s and over 65s and NHS staff. Despite this there has not been much improvement in uptake. It was agreed that a new approach would be helpful based on primary care getting the message out. It was noted that primary care representation at the A&E Delivery Board has not been very strong but that they have started to become more involved. Extended access in primary care and increased locations to receive the flu vaccination should assist in improving performance. The CCG has contacted local providers requesting their plans regarding staff vaccination and emphasising the need to improve on last year's performance (the national target is 80%). If providers do not meet the minimum of 60%, a contract performance notice will be served. G Barnes to share the data with J Wilson once available. • What are the main risks to the CCG in terms of winter monies? A Ombler confirmed that the plan will contain some high level risks, eg, flu combined with bad weather. These risks will be actively managed through the A&E Delivery Board. • Has the move away from an alliance framework increased the risk to the CCG? It was noted that the risk has potentially reduced as there are now one or two lead providers in each area instead of a collective. • Additional assurance is required around how clinical quality is assessed at times of high pressure and how the system remains as safe as it can be. It was noted that the NLCCG Director of Quality is a member of the A&E Delivery Board. A Ombler and L Golby to work outside of the meeting to address this. **The Committee noted the update.**	**B Compton** **G Barnes** **A Ombler L Golby**
6.	**ICP Update**	
	There was no further update on this item.	
7.	**Adult Social Care (ASC) Update**	
	A presentation was circulated for consideration. B Compton and R Brunton provided a summary: Performance exceptions: • Delayed transfers due to ASC; this links to capacity issues in care at home services and will be addressed by the new model. The impact from the move from two handed to single handed care is not yet known. The hospital "in reach" pilot; whereby packages of care are not stepped down should support the capacity issues.	

- Proportion of people still at home aged 65+ 91 days after discharge; this partly links to the shortage of therapists locally. CPG are looking to recruit additional therapists.
- Proportion of people over 65 offered re-ablement services following discharge from hospital; this links to the therapist issue. Consideration to be given to whether therapists are being appropriately deployed and whether there are other skills that could be utilised.
- Permanent admissions to residential care homes aged 65+; there has been a spike in permanent admissions, which has stimulated the work around discharges. N McVeigh led a recent workshop on discharge, which identified that the agreed and aspirational mechanisms are not being routinely applied. The spike occurred despite vacancies at the Beacon, therefore improved monitoring is required. Work is ongoing in this area.

NEL health and care system based on the latest published CQC data/CFO insights data shows:

- Greater use of long term community support and fewer people have a short term services requiring no ongoing support
- Lower users of lower level support
- Insufficient focus on self-help to maximise independence
- Low on people having as much social contact as they would like
- Less nursing care provision
- High A&E attendances but better at avoiding admissions
- Re-enablement is not as effective as it should be
- Emergency re-admissions are deteriorating and re-admissions after 7 days is worsening

Discharge Process

- Two workshops have been held; a working group will follow up the actions identified.

Budgets

- Work around high cost placements is underway. These exceed £50k per year with 152 cases costing £14.2m. One placement costs £0.3m. 3 training workshops have been held with social workers, CHC and MH professionals and a working group will continue to oversee this work. All cases will be allocated for rigorous review. The current review process is also being tested out due to a lack of consistency in the process. Total programme saving needs to deliver at least £1m for ASC.
- The rehabilitation and re-ablement review needs to support a reduction in the number of long term placements to residential care and focus on increasing the number of short term opportunities. It is estimated that approx. £100k could be saved per year by working differently.
- Other areas for potential savings include: reducing off contract spend from care at home, review of specialist and community transport, reduce the cost of voids from supported living, strengthen community hubs to reduce social isolation, preparation for adulthood (long term work between children's and adult services), strengthen social work practice through consolidation – this would reduce duplication and improve case management.
- A lot of the proposed work links to system transformation. It has been agreed that immediate focus should be on the high cost placement work, the work around children's services and the charging review.
- A plan is required around the anticipated target savings; this will be aligned with PCNs etc.

The Committee provided the following feedback:

- High A&E attendance – why are people attending? B Compton confirmed that attendance is predominantly for UTIs, slips and falls, chest infections etc. There are big cost savings around lower levels of admissions.
- Where is the accountability for the system wide discharge issues? It was confirmed as the A&E Delivery Board. It was agreed that a robust and

	cohesive plan is required across the system. This will be picked up at OLT. • High cost placement exercise – are we assured that the anticipated savings will be achieved? B Compton advised that this will not be known until the case review commences as individual best interests will need to be considered. • The end point will need to be articulated, ie, how many years it will take to achieve the desired outcomes/savings. It was agreed that a collective piece of work is required with NELC to understand the current position (where have cash savings been delivered/ what's the current data/ where's the baseline?). • Concerns regarding focusing solely on the financial impact. A good quality impact is also key. It was noted that positive outcome for ASC might result in a negative impact on health outcomes. This was alright so long as there was a "benefit" to the system as a whole. **The Committee noted the update.**	**B Compton** **B Compton**
	STANDING ITEMS	
8.	**Finance Update**	
	A report was circulated for consideration. S West and L Popplewell provided a summary: • All KPIs are currently green. • The CCG is on track to meet its planned operating position and its NHSE/I mandated surplus. A lot of work is taking place in order to maintain this position. • Key pressures are around demand being higher than planned. • £1m of Earmarked Reserves have been released to offset the impact of these pressures. • ASC – there is no significant overall variance; however achievement of a balanced position is reliant on the drawdown of £1.5m earmarked reserves held by NELC. • Risk - The CCG's overall risk has reduced by £737k; £400k of this relates to a reduction in CHC risk (activity has consistently reduced this year) and £360k reduction in the NLaG risk (this risk has now materialised). Confirmed mitigations to address this risk should it materialise are: £1.6m of non-recurrent measures and £900k of confirmed plans. QIPP schemes are being reviewed to see what (if anything) can be brought forward. • The CCG and providers are currently working on their 5 year plans; submissions are due on 1st November. • Better payment practice – the CCG continues to work with focus colleagues in order to address the data issues which have had an impact on overall performance • SBS benchmarking data – NEL ranks 10th out of 193 CCGs. The CCG is marked highly for the use of electronic invoicing and marked low for the lack of purchase orders. The Team is looking at areas of good practice which could help to improve performance. **The Committee noted the update.**	
9.	**QIPP Update**	
	A report was circulated for consideration. L Popplewell provided a summary: • Savings achieved year to date are £13k ahead of plan and the CCG is still anticipating that overall the planned savings for the year will be achieved in full. • Prescribing - the scheme is under achieving year to date. Most of the issues have now been resolved and the scheme is expected to fully deliver its savings. • Continuing Health Care (CHC) - the CHC team has performed a review of high cost packages of care and highlighted where there are opportunities to get better value for money by switching providers and providing the same level of care. There have been some savings as a result of this	

	review but switching providers is taking longer than anticipated. The forecast outturn has been reduced to reflect this delay. It is anticipated that the anticipated savings will be achieved across two years. • Baseline budget review – existing budgets have been reviewed. This resulted in significant in-year non-recurrent savings which will contribute towards the CCG achieving its QIPP target for the year. • NLaG schemes - Advice & guidance is currently underachieving against plan and the forecast outturn has been reduced. Long response times have been cited as the reason for low uptake. The CCG is targeting practices who are low users and are anticipating significant improvements in October, particularly in 3 specialities (ENT, ophthalmology and colo-rectal) due to focused work by NLAG. RightCare Gastro is also currently underachieving despite the implementation of agreed pathways. Work is underway to understand why this is the case. • The total QIPP risk is £2.6m. **The Committee noted the update.**	
9.1	**Demand management schemes linked to PCNs**	
	A report was circulated for consideration. J Wilson provided an update: • A QIPP target relating to demand management and medicines optimisation, equating to £2.25m, was built into the CCG's financial plan for 2019/20. • Progress in developing local schemes has been slower than anticipated due to delays in developing the PCNs. The CCG has now agreed to provide more support to the PCNs in helping to develop their proposals. • The PCNs have agreed two key priority work areas for this year, which will support delivery of this QIPP target, they are: medicines optimisation and community urgent care. A supplementary scheme has been developed to support the PCNs to achieve the current year prescribing target and to go 'further faster'. PCNs are currently discussing this internally. Community Urgent Care Response was previously included as part of the specifications for Integrated Urgent Care, to be delivered by the Alliance. The PCNs have an outline model of how they would work together to better manage urgent / on the day demand, which should result in reduced A&E attendances and hospital admissions. • Other schemes that will impact include – the Urgent Treatment Centre, EMAS conveyance avoidance schemes, frequent attender reviews and social workers in A&E. Work is underway to review the data in order to pinpoint some of the impact. • It is expected that the schemes aimed at non-elective demand management will generate savings of £1m by the end of the financial year. The Committee provided the following feedback: • How has the planning work aligning to the hospital been reflected in the activity trajectories? J Wilson confirmed that the benchmarking data has been used to feed into next year and stressed the importance of the shared ownership in the system. The work around discharge will impact on some of the non-elective costs. Further work is required to understand the implications on health and the costs to the wider system. • The importance of PCNs to the system is reflected in winter plans. Representation of PCNs on the A&E Delivery Board is under discussion. **The Committee noted the update.**	
10.	**Integrated Assurance Report**	
	A report was circulated for consideration. M Rabbetts provided a summary: Key changes in performance • Proportion of the population with access to online consultations moved from Green to Red. The trajectory had increased to 42%; YTD	

	performance is 28%. It is anticipated that the target will be met by year end as all SystmOne practices have signed up to implement by 31st March 2020; EMIS practices are reviewing their options. Feedback from the 4 EMIS practices is that they would like a different online consultation option. Other CCGs have not fed back a similar issue with their EMIS practices. • Prescribing – there are some new measures associated with the new CCG oversight framework. There is no data associated with it at this stage; however it will be included in future reports. It was noted that the old dashboards continue to be available. A new dashboard is being developed to compliment the oversight framework; this has not been shared with CCGs at this stage. • Proportion of older people (65 and over) who were still at home 91 days moved from Amber to Red – feedback is awaited from CPG. This may need to be escalated. M Rabbetts to link in with N McVeigh following the Discharge workshops. • RTT Incomplete Patients: % Seen within 18 Weeks moved from Green to Amber – this continues to improve but is not at the required level to meet the trajectory. There was a dip in performance in August which may have impacted. • RTT size of incomplete waiting list moved from Amber to Green – the waiting list continues to drop significantly. • MRSA Blood Stream Infections moved from Green to Red – this was linked to one incidence; the post infection review confirmed that this was unavoidable. • Proportion of adults in contact with secondary mental health services in paid employment moved from Red to Green. • IAPT 6 weeks CCG moved from Amber to Green – this measure continues to be closely monitored. • Reliance on inpatient care for people with a learning disability and/or autism Care commissioned by CCG moved from Green to Red – this is still anticipated to achieve the year end target. • Wheelchair <18 weeks CCG moved from Amber to Green – quarter two performance has improved but is close to the target; therefore this will be closely monitored. The Committee provided the following feedback: • New oversight framework – concerns that new measures being added at this stage of the year does not give much opportunity to improve if the measure is failing. S Ward advised that retrospective information is expected. J Wilson expressed confidence that the data will be ready. • IAPT recovery rate CCG – "historical data issues are expected to have "worked out of the system" this quarter. Will there be an improvement for the next meeting? M Rabbetts advised that this is dependent on whether it refers to the data. M Rabbetts to confirm. M Rabbetts to check on the progress of the action plan. **The Committee noted the update.**	**M Rabbetts** **M Rabbetts**
11.	**Corporate Business Plan 2019/20**	
	A report was circulated for consideration. L Hilder provided a summary: • As of 23rd October the Corporate Action Plan for 2019/20 was 43% complete against a target of 49%. There are 12 actions and 14 milestones that are overdue. • The plan is 7% off target; however it is anticipated that this is recoverable. • All updates have been provided. The Committee provided the following feedback: • Are there any pressure points looming? L Hilder reported that there was nothing specific to highlight despite the impending period of intense activity for planning. • If a milestone has not been completed and an update provided, it would be helpful to show a new deadline. L Hilder advised that SMT would need	

	to agree an extension to a deadline or a new deadline. SMT would discuss the implications of the milestone slipping and what was being done to address it. • Urgent and emergency care: Integrated urgent care – UTC implementation, urgent community care & 111 / CAS – progress is at 28%. How much of the progress is linked to UTC implementation? L Hilder confirmed that the overall percentage is based on the number of milestones achieved. S Ward queried if the implementation of the UTC is on track. L Whitton confirmed that detailed plans are in place. Performance slipped; however assurance is being received by the A&E Delivery Assurance Board. **The Committee noted the update.**	
12.	**Escalation to the Governing Body**	
	The Committee agreed to escalate the following: • ASC Update • Finance Report, including QIPP information. B Compton to have a separate discussion with Sharon Wroot.	**B Compton**
13.	**Any Other Business**	
	There were no items of Any other business from members.	
	FOR INFORMATION	
14.	**Risk Register and BAF**	
	Circulated for information.	
15.	**Financial Appeals Report**	
	Circulated for information.	
16.	**Quarterly Incident Report**	
	Deferred.	
17.	**Serious Incident Report**	
	Deferred.	
	Date and time of next meeting **Wednesday 18th December, 12-2pm, Bremerhaven Room, Grimsby Town Hall, Grimsby**	