NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
DELIVERY ASSURANCE COMMITTEE
WEDNESDAY 29TH AUGUST 2018
MUNICIPAL OFFICES, GRIMSBY

PRESENT: Helen Kenyon, Chair, Deputy Chief Executive, NELCCG
Laura Whitton, Interim Chief Finance Officer, NELCCG
Sue Ward, Assurance and Delivery Manager, NHSE (representing S Jones)
David Walker, Community Member, NELCCG
Dr R Matthews, GP Member
Jan Haxby, Director of Quality and Nursing (representing L Golby)

APOLOGIES: Lydia Golby, Nursing Lead for Quality
Eddie McCabe, Assistant Director Contracting & Performance, NELCCG
Martin Rabbetts, Performance Manager, NELCCG
Geoff Barnes, Deputy Director of Public Health, NELC (representing S Pintus)
Lisa Hilder, Assistant Director, Strategic Planning, NELCCG
Shaun Jones, Head of Delivery, NHS England
Bev Compton, Director of Adult Services, NELCCG

IN ATTENDANCE: Simon West, Finance Manager, NELCCG
Rebecca Makayi, Head of Finance, NELCCG
Andy Ombler, Service Lead (Item 5)
Levi Clements-Pearce, Service Manager (Item 5)
Caroline Reed, PA to Executive Office, NELCCG - Note Taker

	Item	**Action**
1.	**Apologies** Apologies were as noted above.	
2.	**Declaration of Interest** No declarations of interest were made relating to the agenda. Members were reminded that they were required to complete the conflict of interest training by the October meeting. If the training has not been completed, members will be excluded from any decision making/voting at meetings, and their membership suspended until the training has been completed. A list of those who have not completed the training to be requested from the Governance Team.	**C Reed**
3.	**Notes From Previous Meeting – 27.06.2018** The notes from the previous meeting were approved as an accurate record.	
4.	**Matters Arising Sheet – 27.06.2018**	
	The matters arising sheet was noted. Item 6 - Disabilities and Mental Health Update – Public Health team mental wellbeing needs assessment – a report will be available in September. G Barnes/Public Health to feed back anything that the CCG needs to be aware of/take action on. C Reed to follow up with G Barnes. Core and the potential move to Core 24 – S Ward advised that the clinical strategy team confirmed that in order to achieve Core 24 both sites would need to be compliant. H Kenyon asked whether one site could be identified as the designated site. S Ward proposed that case studies be submitted in order for further consideration to be given to this issue. Item 8 – Integrated Assurance report, Proportion of GP referrals made by e-referrals – H Kenyon fed back to S Jones and the Planned Care Board that GP	**C Reed**

	practices are using other providers as a result of eRS. It was recognised that action cannot be taken until waiting lists are at a more comparable level to other Trusts. It was also noted that an issue relating to eRS raised at the Planned Care board is being picked up by Julie Wilson and will be fed back to the next Planned Care board meeting. *12:14pm - Dr Mathews joined the meeting*. Item 6 – Disabilities and Mental Health Update, health checks for people with LD. Dr Mathews confirmed that the issue of low numbers was fed back at the federation meeting; 12 out of 13 practices confirmed that they carry out health checks and the template is being updated (facilitated by G Rogers) but that there is no standard around frequency etc. S Ward reported that some practices have fed back that they are completing the checks; however the payment did not correspond with the numbers. Additional work is being carried out to address this. M Rabbetts was of the view that this was not solely a data quality issue. Gaynor Rogers to be asked to look at this issue across all federations.	**M Rabbetts**
4.1	**Corporate Business Plan - Review domiciliary care delivery model to transform service delivery from focus on time and task to team based delivery across local geographies focussed on users' wellbeing – Update on timescale**	
	This item was deferred to the next meeting.	**Forward plan**
5.	**Emergency Preparedness, Resilience and Response (EPRR)**	

	A report was circulated for consideration. A Ombler/ L Clements-Pearce provided an update:
	• The CCG has made significant progress against the EPRR Action Plan from last year's assurance process (substantial compliance was achieved). Areas identified for improvement included attendance at all LHRP meetings at Director level and a greater focus on continuous training and development of staff, particularly incident commanders (on-call staff).
	• LHRP meetings - there is CCG attendance at meetings; however 75% director level attendance is a difficult standard to meet for the CCG and other partners.
	• Training and Development - significant work has been done including:
	  • A training needs analysis document was drafted and circulated to the local Emergency Preparedness and Response Group (EPARG) to ensure that any training needs across the patch were met as a health community. This process will be finalised by the end of September 2018.
	  • The CCG will look to facilitate training and table-top exercises through EPARG that meets the needs of the group.
	  • An "On-call Handbook" providing instructions on how to effectively deal with an emergency at Category 2 responder level has been drafted. Once finalised, the Handbook will form part of a physical "crash box" to ensure that it can be accessed in the event of an IT failure. Internal training on the handbook will be provided to on-call Directors.
	  • Two NELCCG Directors and two Emergency Officers participated in the Strategic Leadership in a Crisis Course in December 2017.
	  • The CCG has teamed up with NLaG to facilitate loggist training.12 staff have volunteered for the training. Trained loggists (included as a core standard) will be responsible for logging decisions during an incident or emergency. L Hilder has been asked to extend the number of staff required to work 24 hours in the event of an incident/emergency as currently only the 3 on call Directors are required to work 24 hours. The list will be extended to the wider Senior Management Team. It was noted that the CCG would be unlikely to have access to 24 hour loggists; therefore the CCG has marked itself as partially compliant. The Committee questioned the rationale for 24 hour loggists as a Category 2 responder; S Ward to look into this and feed back.
		S Ward

- CCG staff have attended or will attend local and external exercises before September 2018 including Exercise Accentus, Local Infectious Disease outbreak exercise and NELC exercise to test the management and back up emergency co-ordination centre in the Municipal Offices.

- Planning - EPARG identified the lack of local plans in place around certain incidents identified as high risk on the Humber risk register, including Pandemic Flu, Flooding and Severe Weather. G Barnes is drafting the pandemic flu plan and will present at EPARG next year. Work is underway to identify how the CCG can work in a more joined up way with NELC going forward regarding flood planning. NELC has agreed that the CCG can use the control room at the Fishing heritage centre. The CCG does not have a severe weather plan; however is liaising with partners on this. It was noted that there will be further joint working and increased cooperation going forward, eg, vulnerable people plan etc.
- Business Continuity and Risk Assessment - The CCG has focused on business continuity planning this year; this will be reviewed in light of the CCG office move. Business continuity arrangements with primary care are being strengthened. Discussions have taken place around support between practices in the event of incidents/emergencies, eg, relocation etc and work is ongoing to get primary care to consider staffing, place etc.
  EPARG will review local risks annually through a local risk register presentation from the Humber Emergency Planning Service at the start of the financial year. The CCG intends to bring the review date for the business continuity plan in line with the annual review to ensure that it reflects real local risks.
- Communications - last year's assurance process noted that the CCG was lacking in its ability to contact all staff out of hours quickly; which resulted in the creation of the "NELCCG Broadcast" WhatsApp group. The majority of staff are members of the group (or have supplied personal contact numbers). A test was carried out in May 2018 which proved successful. It was also used successfully during the period of adverse weather.
- EPARG Cycle – the CCG has produced a new cycle of work to be completed by EPARG.

Work to be done following the 2018/19 assurance process:

- The Core Standards have changed this year with the addition of some new standards with increased focus on Business Continuity and requirements for CCGs to have their own Incident Control Centre (ICC) arrangements.
- NHSE informed participants in a teleconference in August that they expected many providers/organisations to report lower compliance than the previous year because the new standards have "moved the goalposts" and given providers and organisations further improvements to make.
- The CCG is currently non-complaint in relation to 7 core standards out of 43 (4 of these are new). This equates to partial compliance. The non-compliance relates to the following standards:
  - LRHP attendance
  - Business Continuity Audit – the CCG has carried out audits on a regular basis; however this has not necessarily been annually. It was noted that it is likely that the CCG will need to get assurance from providers that they have robust business continuity plans in place.
  - CCG to have its own ICC – arrangements aren't fully in place; however this could change.
  - Pandemic influenza – plan is being draft.
  - Loggists – 24/7 cover cannot be guaranteed.
  - Trained media spokesperson to be available at all times – the Senior Team has attended generic media training but not specific training relating to incidents. M Hannam has sourced some training.

The Committee provided the following feedback:

- The recent positive examples when business continuity was tested were noted, eg, during the period of adverse weather and the lack of access to the building when meetings were conducted virtually.
- Work is underway to move some of the standards forward. Could this result

	in a change to the level of compliance by October? It was noted that compliance could change to substantial if two further standards were met. The ICC element will be finalised by October and it is possible that the business continuity standard could be completed. • What are the consequences for being partially compliant? A Ombler advised that there have been no consequences historically due to the action plan being in place. • Are the Emergency Officers satisfied that the CCG has robust and rigorous plans in place? A Ombler confirmed that there are robust and rigorous plans in place and that these have been strengthened by the EPARG group. • The report needs to be submitted to the Partnership Board on 3 September; it was agreed that the report will continue to show partial compliance and demonstrate the plan to achieve substantial compliance by October. • Concerns regarding the limited reference to IT failures; the business continuity plan redirects to the Embed major incident plan. It was agreed that amendments be made to reflect the changes to relationships following the CCG move to an NELC building. • Proposal to liaise with other CCGs to identify any solutions to the gaps. L Clements-Pearce to liaise with NHSE and other CCGs regarding advice/a template relating to the business continuity audit. • A Ombler and L Clements-Pearce were thanked for their hard work. **The Committee agreed to note and accept the contents of this report and self-assessment return prior to sign off at Partnership Board on 13th September 2018.**	**L Clements-Pearce** **L Clements-Pearce**
6.	**Finance Report**	
	A report was circulated for consideration. S West provided a summary: • There has been a lot of movement in relation to budgets since the last meeting. • Nlag – considerable work has been carried out to gain a view of: i) the activity levels required to achieve a stable waiting list, (ii) a 50% reduction in 52 week wait, (iii) an assessment of the additional activity required to address the backlog linked to patient safety concerns. • This has resulted in a revised contract value of £101.4m being agreed, which is £2m higher than the CCG's plan assumption. The increase has been funded by CCG reserves. Additional work is ongoing with NLCCG and Nlag to manage the activity levels; this links to the capacity and demand work and is feeding into the A&E Delivery Board and Planned Care Board. The £101.4m contract value could increase or decrease. There is still a lot of risk in the system to manage; however there is commitment across the system to work together in order to minimise the risk. • Hull & East Yorkshire Hospitals (HEY) – there has been an overtrade predominantly due to an increase in non-elective activity. This is partly due to capacity issues within Nlag which has resulted in emergency referrals to HEY. This issue is anticipated to impact for the remainder of the year. • VirginCare Dermatology – activity is higher than planned due to Virgin trying to clear the backlog and waiting list. Virgin is carrying out modelling work in order to try and provide a forecast on the annual impact. This should be available for the next meeting. • Reserves – the Planned Investment Reserve budget is £2.9m as at Month 4. This reflects the net movement of the £2m NLAG Contract Risk Reserve. • Better Payment Practice – continues to meet the target (currently 95%). Discussions are ongoing regarding ways to improve the timeliness of invoices paid via the NELC shared service. S Ward queried whether the overtrade in non-elective activity was linked to Nlag or EMAS? S West to look into this and feed back. **The Committee noted the update.**	
7.	**QiPP Update**	

	A report was circulated for consideration. R Makayi and L Whitton provided an update:
	• A more focused separate report has been produced. A QIPP Dashboard will be used for each of the schemes to provide the Committee with an overview of:
	  • Progress against milestones as per the CCG Corporate Action Plan. It was noted that the corporate action plan will need to be completely accurate; this will be picked up with the wider executive team.
	  • Service Highlights
	  • Finance savings achieved (where applicable) against the planned trajectory
	  • Performance against the activity trajectory
	• QIPP Dashboards have only been developed for the NHS schemes. The plan is to roll this out to cover ASC over the next few weeks.
	• The aim is for one set of data to flow to the different forums.
	• The CCG is working with providers and primary care to facilitate the schemes becoming successful in order to create consistency of understanding in the wider system.
	• The health schemes are £81k behind plan (approximately 7%). This is due to a combination of the phasing not being quite accurate (eg, gastro) and the risk of overall non-delivery.
	• For schemes which present a risk, eg, community pharmacy, the Finance Team have countered for that risk in the risk register and are liaising with the scheme leads. The level of risk and mitigation will be discussed at the September OLT meeting.
	• Humber Coast & Vale CCGs received support under the national QIPP4 programme. 3 areas of focus have been agreed by all 4 Humber CCGs:
	  • QIPP Alignment & Best Practice;
	  • CHC strategic improvement (all 4 CCGs),
	  • North Lincs QIPP delivery improvement (NLCCG only) and
	  • CHC strategic improvement (all 4 CCGs). Elements 1 and 2 have been supported by Deloittes and element 3 by MIAA (Mersey Internal Audit Agency). The Deloittes work has been concluded and a handover session taken place; the CHC work is still underway.
	
	• QIPP Alignment & Best Practice – 2 areas of good practice were selected: Advice and guidance and IFR check and challenge process. Potential savings have been identified for years 1 and 2. The IFR work should assist in identifying inappropriate IFR procedures/ charges and improving capacity issues at Nlag.
	  • Advice and guidance – there are practical examples as it has already been rolled out on the North Bank. One barrier related to engagement with clinicians.
	  • There are no dashboards for these areas at this stage. A report to agree next steps, milestones etc will be submitted to the next Planned care board meeting. CR to advise J Templeman for the next agenda.
	• Some schemes are progressing against milestones and have detailed action plans; however the corporate plan is not being updated. Scheme leads will be advised of the necessity of updating the corporate action plan
	
	The Committee provided the following feedback:
	• The actual and forecast savings are showing a large gap in some instances and need to be better aligned. R Makayi agreed that schemes need to move faster and further for a more realistic forecast. The information will improve going forward.
	• Positive feedback regarding the dashboards; however previous feedback highlighted the fact that QiPP feels very financial and that further information and clarity around quality, innovation and productivity would be helpful. The overall outcomes will also be built in as part of the monitoring templates.
	• The mitigation element is required to demonstrate what is going to bring the schemes back on track. This should be described in the milestone notes.
		C Reed

	• Scheme leads to be invited to attend DAC to provide a deep dive on their area as required. **The Committee noted the update and agreed that it was useful to have a separate QiPP report.**	
8.	**Integrated Assurance Report**	
	An update report was circulated for consideration. H Kenyon provided a summary of key areas: • A&E 4hr wait – performance for August was down at 87.7% and the YTD 87.7% which is behind the STF 90% trajectory for August. Activity has been high for NEL and other CCGs (Lincs, Doncaster, ERY). • Activity o Non-elective – 0.6% below plan at Month 3. There has been a big rise in activity associated with ambulatory care. There is also a big overspend with NLAG which requires investigation. o Outpatient firsts - 2.8% (above plan but down slightly from month 2). This is predominantly due to ophthalmology (NLAG improving waiting times and New Medica having a greater level of referrals than anticipated). o Outpatient follow ups - above plan; this is mainly due to Virgin activity and picking up transfer of NLAG patients but also activity duplicates (issue with EMIS); work is underway to address this. • A&E – down to 2% above plan; this is slightly below the national trend. • RTT – performance continued to improve in July by 1% and is now at 77.1%. The waiting list overall reduced by 300 patients o Ophthalmology - meeting the national standard of 92% for NELCCG and for NLAG for NELCCG patients o Cardiology - improved by 1.5% and waiting list reduced by approx 10% o Gastroenterology - performance up 4.5% and waiting list down 10% o Neurology improved by 8% to 67% with 15% drop in waiting list o Performance issues remain re Urology, Rheumatology, General Surgery and ENT. • LD Health checks – significant issue with practices' data not getting submitted to CQRS; data was only showing for 2 practices. S Hudson is looking into this. • IAPT - July figures (the latest rolling quarter) is 0.1% behind the target for access but recovery rates were above the 50% target at 51.7%. The Committee provided the following feedback: • Extended Access – the CCG had plans in place to commence extended access prior to the October deadline; these were delayed as a result of TPP unit delays. Are there any plans to do any mitigation and still go live as opposed to waiting for TPP? H Kenyon confirmed that NEL will be starting extended access ahead of October. S Ward asked whether there is any risk to delivering the target (100% of population). H Kenyon confirmed that the CCG is on track to delivery to 100% by 1st October. • Is RTT linking through to the winter plan. The planned care board is focusing on this area. • A capacity and demand meeting is taking place with Nlag on 30th August in order to focus on the work the Trust has worked through for the remaining specialities. **The Committee noted the update.**	
9.	**Corporate Business Plan**	
	A report was circulated for consideration. H Kenyon provided a summary: • As at 20th August the Corporate Action Plan was 17% complete, which is off track by 11%. There are currently 13 actions that have missed their agreed milestones. The Committee provided the following feedback: • Leads need to own and update their actions and ensure that milestones are	

	appropriate and the progress bar is updated. • A discussion might be required to establish if leads are reporting via a number of different meetings/mechanisms. It would be helpful to have one central reporting mechanism with the option for somebody else to update the plan. **The Committee noted the update.**	
	13:49 – H Kenyon left the meeting.	
10.	**Escalation to the Partnership Board**	
	It was agreed that the following needs to be escalated to the board: • EPRR – a separate report will be submitted and a reference made in the main board report. • QIPP – to be incorporated in the finance report. • Performance - issues around Urology, Rheumatology, General Surgery , ENT • IAPT extended access – details of the plan to meet the 1st October deadline.	
11.	**Items for Information**	
	• Financial Appeals Update - deferred • Risk Register and BAF • Annual Complaints Report • Quarterly Incident Report • Triangulation of Intelligence • Serious Incident Report	
12.	**Any Other Business**	
	There were no items of Any Other Business.	
	Date and time of next meeting Wednesday 31st October, 12-2pm, Venue The Lounge Bar, Grimsby Town Hall	