

**Agenda Item 13**

Report to: (Governing Body/Committee): Governing Body

Date of Meeting: 13th June 2019

Subject: Commissioning, Contracting and Integrated Assurance Report

Presented by: Helen Kenyon – Deputy Chief Executive

**STATUS OF THE REPORT *(auto check relevant box****)*

For Information [x]

For Discussion [ ]

For Approval / Ratification [ ]

Report Exempt from Public Disclosure [ ]  No [ ]  Yes

|  |  |
| --- | --- |
| **PURPOSE OF REPORT:** | This report sets out key service, finance and performance issues for major contracts to highlight work going on to address key risks and developments. This report includes the Delivery Assurance report as an embedded document which has significant ore detail across the theme areas rather than by specific provider. Any further information from the summary can be found within this DAC report and members of DAC will be able to provide information as to the detailed discussions they have had on these issues. The Care Contracting Committee also has oversight at a provider level on the agreement of contracts and the overall performance and risks.This is the first report in this format and feedback on information provided is appreciated to continually improve the information in a most appropriate form to the members of the Governing body. The report is potentially longer than normal as it is picking up a number of issues agreed within contracts at the start of the year. |
| **Recommendations:** | The Governing Body note and accept the issue within the report and the associated risks and developments identified. |
| **Committee Process and Assurance:** | The Delivery Assurance Committee has oversight on the elements included within the report and overall performance on finance and delivery. Other committees will feed information into that DAC report, and would include the Contract Transformation Board with NLAG and individual contract discussions with providers. The Care Contracting Committee has oversight of individual contracts and the processes to agree them, which feeds into the information within this report. |
| ***Implications:*** |  |
| **Risk Assurance Framework Implications:** | The report highlights significant risks, which will be addressed through the DAC in detail and puts them in the context of individual providers rather than at pathway level. |
| **Legal Implications:** | There are no legal implications  |
| **Data Protection Impact Assessment implications (DPIA):** | Are you implementing a new system, data sharing arrangement, project, service redesign or changing the way you work? | **No** |
| If yes to the above – have the DPIA screening questions been completed? | **No** |
| Does this project involve the processing of personally identifiable or other high risk data? | **No** |
| If yes to the above has a DPIA been completed and approved? | **No** |
| **Equality Impact Assessment implications:** | An Equality Impact Analysis/Assessment is not required for this report [x] An Equality Impact Analysis/Assessment has been completed and approved by the EIA Panel. As a result of performing the analysis/assessment there are no actions arising [ ]  from the analysis/assessmentAn Equality Impact Analysis/Assessment has been completed and there are actions arising [ ]  from the analysis/assessment and these are included in section \_\_\_\_ of the enclosed report |
| **Finance Implications:** | The report summarises at significant provider level key financial risks, but more detail is contained within the Specific Finance report from the CFO. |
| **Quality Implications:** | This report details a positive impact on quality. [ ] The proposal put forwards, if agreed, would have a positive impact in terms of enabling providers to meet safe staffing targets. Retention and recruitment is forecast to be improved, which would have a positive impact on the safe delivery of local services.This report details a neutral impact on quality. [x] The report will not make any impact on experience, safety or effectiveness. This report details a negative impact on quality. [ ] The report details the need for budgets to be significantly reduced. It is clear that the report summarises that quality will be negatively impacted by this as decisions to remove services/provide a lower level of provision to solely meet the ‘must do’s’ of provision in terms of meeting people’s needs has to be made. It is forecast that service user experience will be negatively impacted by this position. |
| **Procurement Decisions/Implications *(Care Contracting Committee):*** | No Implications |
| **Engagement Implications:** | No Implications |
|  |  |
| **Conflicts of Interest**  | *Have all conflicts and potential conflicts of interest been appropriately declared and entered in registers which are publicly available?****)***[x]  Yes [ ]  No |
| **Links to CCG’s Strategic Objectives** | [x]  Sustainable services [ ]  Empowering people[ ]  Supporting communities [x]  Delivering a fit for purpose organisation |
| **NHS Constitution:** | <https://www.gov.uk/government/publications/the-nhs-constitution-for-england> |
| **Appendices / attachments** | See report below |

Governing Body Report to April 2019

**Northern Lincolnshire & Goole Foundation Trust**

* **Service Developments / improvements**

As part of the contract agreement with NLAG for 2019-20 the Northern Lincolnshire CCG’s and NLAG have taken a system and joint approach to resolving some of the fundamental issues which have affected the ability of the Trust to address issues of capacity, clinical backlogs and associated harm and affordability within the system.

The Trust and CCG have agreed priority areas, which were chosen based on the most at risk services for staff capacity, where there was risk of clinical harm or areas had the biggest gain available in the shortest time

 The programmes agreed are as follows;

1. Outpatients:

The Trust is to instigate a radical change to the process for Out Patient appointments across seven defined specialties, (ENT, Cardiology, Ophthalmology, Urology, Respiratory and Gastroenterology and Colorectal) in 19-20, with the aim of a significant reduction in “not necessary” appointments. The Trust and CCG’s will operate a joint programme to include consultation, planning, implementation with all stakeholders. These were selected based on services identified at risk due to capacity such as ENT and Colorectal, or backlog issues such as Cardiology, Respiratory or urology, those which are part of the national “Right care programme” and Ophthalmology which is a combination of all these factors plus risk of clinical harm due to delays in treatment from the backlog. The aim is to reduce the level of follow up appointments that are not clinically necessary, freeing up capacity for patients who need to be seen for ongoing treatment or for first outpatient appointments. A joint CCG and NLAG Outpatient transformation group that will give us improvement trajectories by the end of quarter 1 is working on a timescale and trajectory.

1. Day case to Outpatient Procedures:

The Trust and CCG’s have identified that across a list of defined treatments carried out as day case, some of these must be reclassified to Outpatient procedures. Other Day case procedures are in other hospitals carried out as standard within an outpatient setting. The Trust needs to make changes to their clinical pathways and processes to move as many services to the most appropriate setting. The CCGs and Trust will agree a 19-20 schedule that will reclassify and redefine a set of procedures. This will reduce the use of theatre time to increase efficiency, address backlog issues, and reduce the tariff charges to the CCG.

1. High Cost Drugs Review:

The Trust and CCG’s have agreed a programme to review High cost drugs to ensure that local practice is in line with national changes. The Trust will follow national purchasing rules and look at a move to biosimilar (generic type drugs rather than branded) to save costs to the Trust and to the CCG’s.

**Finance**

The signed contract value for NEL CCG remains at £113m; this excludes any cost benefit impact of the service developments planned to take place in 2019/20 or any non-elective demand management schemes. As reported previously the CCG has assumed a £1.9m cost benefit from the service developments. NLAGs total planned operating income for19/20 is £391.9m.

**Performance**

The CCG detailed performance is set out in the Report to Delivery Assurance but headline figures for the Trust in **April** **2019** are as follows.

* A&E 4 Hour Wait (80.0% vs 85.2% target)
	+ Issues are growth in demand, use of early supportive discharge to assess, outlying medical patients & ensuring consistent discharge flow
* Cancer 2 week (96.6% vs 93% target) and 62 day (74.8% vs 73.3% target)
* Referral to Treatment (76.7% vs 76% target)
* 52 Week waiters (6 vs 0 target)
	+ due to capacity constraints within Oral Surgery, Colorectal, ENT, Ophthalmology, Gastroenterology and Chronic Pain
* Diagnostics 6 week wait (86% vs 91% target)
	+ Ongoing use of mobile radiology equipment with limitations on modality. NLAG to Complete capacity and demand models for CT and MRI

Performance targets for next year as per NLAG’s plan are;

|  |  |
| --- | --- |
| A&E | 89.80% |
| RTT | 81.20% |
| 52 Week waits | Nil |
| Cancer 2 week waits | 95.60% |
| Cancer 31 Day Treatment | 99.40% |
| Cancer 62 day GP referral | 80.80% |

Note the CCG plan will be different as It includes other providers and just the DPOW Site.

* **Quality**

Mixed Sex Accommodation – The Trust has reviewed its local application of the policy and there has been a significant reduction in breaches to 0 in April.

CQC review – the last review was September 2018, which showed improvement in the general ratings but significant issues still around the backlog and clinical harm from those areas.

The Trust have been working hard to improve the waiting time position and commissioners have assurances that new patient tracker systems are in place and overseen by both senior clinical and managerial staff in the Trust. There is more robust internal governance to maintain progress on the backlog and the waiting times in all specialties including escalation to Chief Executive officer level. This has helped the Trust to achieve its nil 52 week wait position by end of March 2019, and to report a slightly improved position in the overall waiting list at the end of the last financial year – despite the national guidance being to sustain the same waiting list position as end March 2018, and whilst most other trusts nationally reported a deteriorated position.

NLaG have also recently achieved the JAG accreditation back in endoscopy for the SGH site, which is a real achievement and will assist with overall RTT performance.

There are one or two specialties where excessive waiting is still a significant concern, in particular in ophthalmology and we are working with the Trust to address this and to reduce any clinical risks for patients trust-wide.

We have seen a significant increase in pressure ulcer reporting which we believe is down to the Trust reviewing their assessment and management of pressure ulcers and are now grading them more accurately. We are setting up new multi-agency workstreams across a number of providers to approach pressure ulcers together.

**East Midlands Ambulance Service (EMAS)**

**Service Developments and Improvements**

The focus by EMAS and commissioners is about the delivery of the Ambulance Response targets (ARP). This is the time a blue light ambulance takes to get to a patient, dependant on the evaluated level of urgency. So the most urgent life threatening is category 1 with a national target mean time of 7 minutes. As of March 2019 the mean response time for Lincolnshire and Northern Lincolnshire was 8 minutes 44 seconds. The CCG’s and Ambulance Trust have seen some improvement for the investment in 2018-19 but there is still some way to go in certain county areas despite the plan for significant further investment. This is covered in the performance section.

The 23 CCG’s as party to the contract had agreed £18m investment over two years for delivery of the ARP Targets.

The Regulators have given EMAS explicit requirements to deliver the target otherwise regulatory action will be taken against them. The issue of delivery has been part of the concern, delaying the signing of the contract for 2019-20. EMAS will be required to deliver national targets by October 2019.

**Finance**

The contract value for 18-19 had an under trade due to reduced level of See & Convey of £64k and an under trade on the ARP performance value of £240k due to non-delivery of performance targets. Therefore, outturn was £5.6m for 2018-19 against a contract value of £5.9m

The contract value (across all 23 CCGs) for 19-20 has increased due in part to the full year effect of funding to deliver ARP, (£9m to £18m). The value across the contract has been agreed as £188.5m, for NEL CCG this would approximately equate to between £6.3 and £6.4m. The increase is about £300k over the funding initially set aside for the contract. The excess will covered within Qipp requirements.

The contract will be signed by 14th June 2019, as Lead commissioner and EMAS have signed Head of Terms of contract with the support of NHSE/I on Friday 24th May.

**Performance**

*Explanation of the measure.*

The overall performance for ARP in 2018-19 was as set out below. TRJ is the agreed local trajectory of improvement, i.e Cat 1 national target is a mean of 7 minutes, the local trajectory of improvement towards the national target was 7 minutes 41 seconds.

The 90th percentile figure is the other statistical measure, i.e 90% of the activity should be within a set time. In this case, the local trajectory was 15:21 for cat 1, so 90% of the activity should be less than that; EMAS achieved 16:40 missing the target.



No Target was met for Lincolnshire by the end of the year as was planned. The NHSI/E as part of contract for 19-20 would require achievement by October 2019. Other EMAS county areas are delivering to national target in April 2019. One of the reason cited for the difficulty in achieving the ARP target is the significant wait times for handovers in Boston and Lincoln, which impact on ambulance availability. A meeting will take place in July between Trusts and CCGs to evaluate this impact on the delivery of ARP and how this will be improved as this is part of a CQC performance issue with United Lincolnshire Hospitals Trust.

For more details, follow the link below;

<https://www.england.nhs.uk/publication/new-ambulance-standards-easy-read-document/>

**Quality**

No quality issue with the exception of ARP standards

**Navigo**

Service developments and Improvements

The investment in Mental Health services as part of parity of esteem and the NHS 5 year plan means investment in services was increased for 19-20 and service development areas within the contract include;

* Joint management of Out of Area Budget Adults and older people
	+ Ensuring placements are managed pro-actively and a smooth repatriation for all service users as appropriate. Finances are managed within budget and service users rights are maintained
* ADHD & Shared care drug costs
	+ Clear understanding of the financial flows and who (ie. Navigo or primary care) are responsible for prescribing which drugs.
	+ Any cost pressures are fully understood and solutions sorted.
* Complex rehab pathway
	+ Clear understanding and smoother experience of the pathway for both service users, carers, and staff
* Complex dementia pathway
	+ Service specification for complex dementia pathway to be updated and service in place under ICP and South Humber footprint pathway
* Develop local workforce plan to consider improvement in staff skills and knowledge
	+ Explore potential for new/alternative roles, link with workforce development
	+ Better informed staff operating at higher skill level increases safety and experience of service users/carers

**Finance**

A contract value of £27.7m for 19-20 has been agreed which reflects the additional investments required from the NHS plan. This includes additional funding for;

Crises & acute care dual diagnosis towards MH Liaison/core 24

Physical Health Check Interventions

Early intervention in psychosis

Expansion of psychological Therapies

Which are all commitments under the Mental Health 5 Year forward view.

**Performance**

End of year 2018-19 data

IAPT Access rate – 5.12% (green)

IAPT Recovery rate – 46.9% (amber)

IAPT 6 week and 18 week target – 88.5% & 99.2% (green)

**2019-20 Mental Health Planning targets**

|  |  |
| --- | --- |
| **Planning Line** | **2019/20 NELCCG Target** |
| IAPT roll-out | 5.5% Q4 |
| Estimated Diagnosis Rate for people with dementia | 66.70% |
| IAPT Recovery Rate | 50% |
| IAPT Waiting Times - 6 Weeks | 75% |
| Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks | 95% |
| Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week | 95% |
| IAPT Waiting Times - 18 Weeks | 95% |
| Psychosis treated with a NICE approved care package within two weeks of referral | 56% |
| Improve access rate to Children and Young People's Mental Health Services (CYPMH) | 34% |
| People with severe mental illness receiving a full annual physical health check and follow up interventions | 60% |

**Quality** Care Plus Group

**Service developments and Improvements**

One of the key focus will be work done with the Alliance Agreement on out of hospital care and the development of the Urgent care Centre. This will require additional funding which will only be released as part of the programme of development. This would include,

* INTERMEDIATE CARE AT HOME
* CARDIOLOGY SCHEME

This funding would be for the system benefit to promote care out of hospital

The CPG contract will have significant services integrated into the Alliance arrangements. The Alliance agreement sits within members of the Alliances main contract, setting out the services and finances associated with elements within the Alliance service specification for urgent care. For Care Plus Group rapid response team will form part of that Urgent care response and support the ability to avoid patients attending A&E or being admitted from Care Homes when additional support and advice to patients will allow them to continue to be supported in their home setting. Alongside the SPA and telephone support these elements alongside NLAG are key drivers of improving the urgent care response in the area and avoid the increased level of attendances and admissions in the hospital.

Other development required in the contract

* CPG will be asked to plan how they will achieve alignment to Primary care Networks
* Full service scope of the contract with cost per line
* Review of performance improvement measures, including therapies equivalent to NLAG
* Full List and Full cost – move from individual service items to revised specifications to cover broader range with outcomes focus and built into revised specs eg community urgent care spec e.g.
	+ Community Urgent care
	+ Discharge and Re-ablement onward care
	+ Long term Conditions support LD PD Fraility OP Falls Cardio
	+ End of Life
	+ Transport
	+ Support Services – Carers
* How we measure the impact of all these changes on Pressure damage and the system required saving – Nursing capacity, Teller, ALS beds and equipment issue
* Dressings review to reduce and impact on FP10’s
* Implementation of the IV at home scheme

**Finance**

A contract value of £19.5m for 19-20 has been offered which. This is an increase from last year’s contract, which was £18.5m. Contract documents are awaiting signature.

**Performance**

End of year 2018-19 data

ASCOF 2B (Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services) – 2018/19 Performance 86.2% against target of 89.5% (Amber).

ASCOF 1G (Proportion of adults with learning disabilities who live in their own home or with their family) – 2018/19 Performance 90.81% against target of 79.7% (Green).

ASCOF 1E (Proportion of adults with learning disabilities in paid employment) - 2018/19 Performance 11.27% against target of 5.0% (Green).

**Delivery Assurance Embedded report**

