NHS
North Lincolnshire
Clinical Commissioning Group

Date: 09.06.16 Meeting: Governing Body **Item No. 7.3** **Public ✓ Private**	**REPORT TITLE:** **CCG Corporate Performance Executive Summary 2015/2016 Year End Summary** **DECISIONS TO BE MADE:** To receive and note the report and be assured that areas of underperformance are being addressed at a local level to meet agreed targets and commitments.

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Continue to improve the quality of services	X	**Improve patient experience**	X
Reduced unwarranted variations in services	X	**Reduce the inequalities gap in North Lincolnshire**	
Deliver the best outcomes for every patient	X	**Statutory/Regulatory**	X

Executive Summary (Question, Options, Recommendations):

The reports purpose is to provide the CCG with assurance against its corporate performance responsibilities as set out in the CCG Assurance Framework and against its commissioning plan.

It informs the CCG Engine Room on an exception basis of its corporate performance position (In support of the Business Intelligence Zone which can be accessed live by those authorised to do so) on the following link where more detailed recovery actions against these standards can be found and supporting reports and analysis http://biz.nyhcsu.org.uk/nlccg/.

Equality Impact	**~~Y~~/N**	
Sustainability	**~~Y~~/N**	
Risk	**Y/~~N~~**	The report supports the Quality/Performance section of the CCG Assurance Map, in particular Performance reporting – Financial and Quality. It provides management level assurance to the Engine Room and Governing Body to enable them to provide second line assurance to the CCG Council of Members. The content of the report also provides assurance in support of the NHS England Balanced Scorecard. In addition the report provides assurance against the CCG Board Assurance Framework (BAF) Risk FP1. Position monitored by CCG Engine Room and Governing Body. Reviews of monitoring reports. Added to BIZ. Audit Group monitors adequacy of controls.
Legal	**Y/~~N~~**	CCG's are accountable for the delivery of their statutory and local priorities.

Finance	**Y/~~N~~**	Additional Quality funding is dependent on the delivery of the Quality Premium Measures; a summary of the position against this is contained in this report.

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***DATE***		***N/A***	***Y***	***N***	***DATE***
Patient:					Clinical:				
Public:					Other:				

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North Lincolnshire CCG Corporate Performance Executive Summary 2015/2016 Year End Summary

Author	Business Intelligence Team
Date	1st June 2016
Meeting Date	9th June 2016

Performance Executive Summary: Position at 1st June 2017

The purpose of this report is to provide the North Lincolnshire CCG Engine Room and Governing Body with an updated summary position on an exception basis on the national performance indicators as set out in the NHS Outcomes Framework and Everyone Counts guidance and which form part of the CCG Assurance Framework.

This is supported by the Business Intelligence Zone (BIZ) which will be reviewed as part of the CCG Engine Room meeting, and can be visited by **CCG members** at any time on the following link: http://biz.nyhcsu.org.uk/nlccg/ - Please use this link and save to your favourites, any comments would also be appreciated. You can also sign up to receive a newsfeed e-mail alert. If you require any assistance with the site please contact either Emma Mundey in the BI Department or your CCG Relationship Manager.

In all cases of deviation from target an **Exception Report** is raised whereby the lead in this area must provide underlying cause information as well as recovery actions if applicable. These reports are available on the BIZ and in 2016/17 the key information will be more extensively incorporated within this report.

1. CCG Assurance

Are patient rights under the NHS Constitution being promoted?

Overall Constitution Indicator Performance

In 2015/16 the CCG has been developing the way it counts/reports the constitution indicators (CIs). This has resulted in the number of CIs changing between reports. In 2016/17 a detailed explanation of any changes will be incorporated within this report.

5	3	18

The following indicators all remain strong and are achieving the required level of performance or more:

- RTT 52 Week Waits
- 12 Hour Trolley Waits
- 2 Week Cancer Referral to First Seen
- 2 Week Cancer Referral to First Seen – Breast Symptoms
- 31 Day Cancer Diagnosis to Treatment
- 31 Day Cancer Subsequent Treatment Waits (Drug Regimens and Radiotherapy)
- 62 Day Cancer Referral to Treatment - Consultant Upgrade Status
- Mixed Sex Accommodation Breaches
- Cancelled Operations (including 2nd Cancellations)
- IAPT Entering Treatment and Recovery Rates
- Mental Health Care Programme Approach (CPA) Follow Up

Areas by Exception:

Area	RAG	⇩⇧ *From Previous Month*	Comments	Lead
18 Week Referral to Treatment Times: Admitted (Target 90%) Non-Admitted (Target 95%) Incomplete (Target 92%)	R		All 3 RTT 18 Week indicators have again failed to meet the required levels in March 2016 and the closing 2015/2016 position has also not met the target. The main driver behind this is the position locally at Northern Lincolnshire & Goole Hospitals (NL&GFT). Significant pressure specialties continue to be Orthopaedics, Ophthalmology and ENT. The Trust have confirmed that a range of proactive	CB

			improvement measures have been instigated across the Trust to regularly manage and monitor the 18 week performance position, including capacity and demand plans by clinical groups for all specialities. A Validation Team has been created to improve quality of data to support improved performance monitoring. A weekly performance report highlighting the 18 week position is submitted to the Executive Team and Associated Chief Operation Officers' meetings. At the NL&G Quality Contract (QCR) Meeting, on the 21st April, members formally requested further assurance of the Trusts approach to managing RTT. Members of the QCR agreed to escalate this request to the NL&G Executive Contract Board (ECB). Commissioners were informed, by the Trust at the NL&G QCR meeting, that the RTT Remedial Action Plan is due to be submitted to NL&G Executive Team on Tuesday 26th April for review and approval, it was agreed that this Action Plan would be circulated to members of the NL&G ECB and members of the NL&G QCR once it has been approved by the Trust. As part of the contract negotiations for 2016/2017 the Trust has calculated the cost of the position returning to plan. This is currently being reviewed by the CCG.	
A&E 4 Hour Waiting Times (Target 95%)	R		A&E Performance in March 2016 at 90.1% did not meet the required level but did improve from the previous month. The local Scunthorpe position has been stronger than Grimsby but both sites failed to meet the target. The Trust has a full detailed action plan in place to address performance in this area, a copy of which is available on request and as part of the exception report. A summary provided by the Trust identifying the main challenges during the period include: • Inpatient bed availability • Physical space - Urgent Care Centre at Scunthorpe • Large volumes of medical outliers and pressure on existing Physicians • Increased complexity of patient presentations Faced with these difficulties the Trust has put into place several initiatives. These include enhanced medical support at the weekend with an additional Consultant Physician and Junior Doctor to support weekend discharging at both Diana Princess of Wales site in Grimsby and the Scunthorpe site. The Urgent Care Centre workforce weekend was also strengthened during the winter period with an additional middle grade or junior grade on Saturdays and Sundays at both sites. It is expected that the Trust will return to 95% by the end of June 2016. Actions shown in the action plan and	CB

			associated milestones will support the improvement expected. Actions to Support Recovery are as follows: **Inpatient discharges –** focus on earlier discharge during the day and continued work on weekend discharges to even out the flow of patients through the 7 day week. **Development of Acute Care Physician model** – recruitment to additional acute care physicians with further development of ambulatory care in the Trust. **Physical space at SGH** - the ECC will be redesigned to create separate minors and majors entrances and patient flows within the department . **ECC workforce** – both medical and nursing workforces have been reviewed and are being optimised to better match workforce against patient flow. **Nursing recruitment and retention** – the Trust will continue to pursue recruitment of nurses through a variety of UK and overseas channels. It will also increase its focus on retention of nurses by carefully managing nurses recruited from overseas and where/how they are placed within the organisation to improve integration.	
Patients receiving first definitive treatment for cancer within 62 Days of referral from NHS Cancer Screening Services (Target 90%)	R		The March 2016 position failed to meet the target, at 66.7%. The number of patients on this pathway however is very small and the percentage only represents 2 patients out of a total of 6. Both patients were initially seen at Hull & East Yorkshire, one of which was subsequently treated at NLAG, the other remaining in Hull. This data became available on the 6th May 2016 so is in initial stages of investigation with the providers involved, but supporting information will follow in due course and will be contained in an exception report on the BIZ. There is work underway locally in response to performance in these areas and all cancer pathways. NLAG have reported that they have introduced a Trust wide Action Plan and a weekly Chief Operating Officer led Task & Finish Group to support implementation with oversight at Executive level. The Action Plan includes all aspects of pathway management, breach review and reporting to support improved performance. In addition a new detailed report monitoring performance, Trust wide and by tumour site, has been introduced and deployed on a weekly basis. A weekly Chief Executive challenge meeting is also in place to support delivery of recovery actions. RCA for all patients breaching treatment targets is undertaken. Areas that the Trust are reviewing are: • Improving time to 1st outpatient appointment	CB

			• Managing the increased number of 2ww referrals • Timely access to diagnostics (MR/CT & prostate biopsies) • Proactive management of patient pathways to improve efficient flow • Availability of patients The Trust are currently undertaking some analysis of referral trends as there has been a significant increase in referrals on a 2ww basis and a subsequent drop in treatment conversion rates. Attached are the cancer action plans that the Trust has recently circulated to QCR and ECB.	
Category A Ambulance Response Times 8 Minute RED 1 (Target 75%)	R		Performance at East Midlands Ambulance Trust (EMAS) against the Category A 8 minute indicator for RED1 calls did not reach the required level in March 2016 (64.1%) *The position for all ambulance Cat A response times are assessed at Trust level. The RED1 North Lincolnshire position at March 2016 is 69.1%.*	CB
Category A Ambulance Response Times 8 Minute RED 2 (Target 75%)	R		EMAS overall performance remains well below the required level at 47.0% in March 2016. *North Lincolnshire performance in March 2016 is also below the target at 64.2% but to a lesser extent.*	CB
Category A Ambulance Response Times 19 Minute (Target 95%)	R		EMAS overall performance is 79.4% in March 2016. *North Lincolnshire performance in March 2016 is stronger but also below the target at 86.6%.* Performance for all three standards continues to fall below the National Standards, with A19 now being **unachievable for the year.** The revised Remedial Action Plan (RAP) has been received and shared with Chief Officers and County leads. Once agreed, it will be monitored both through the Partnership Board and through the monthly county level contract meetings if appropriate. EMAS have informed the coordinating commissioning team that the current national performance standards will not be achieved in Quarter 1 2016/17 so the RAP will be continued into the next contractual year. The 2015/16 contract began as a Block but the majority of CCGs agreed to block the position based on the forecast outturn at Month 8. Most commissioners also agreed to make an additional non recurrent payment to EMAS to support them with the additional costs they incur due to Handover delays at Acute Hospitals. Inclusive of the points summarised, the 2015/16 year resulted in a total underspend of £3m against the initial annual expected contract value. The CQC have issued an improvement notice to EMAS which highlights staffing levels and handovers as areas for concern. This notice will be shared on 10th May.	CB

Are health outcomes improving for local people (CCG Assurance Indicators Only)?

Areas of Exception:

Area	RAG	⇩⇧	Comments	Lead
Reducing potential years of life lost from causes considered amenable to healthcare (all ages)	R		The indicator is calculated using the Office for National Statistics Mortality data and the mid-year population data as a directly standardised rate (DSR) per 100,000 registered patients. The target of 2083 has not been met as at September 2015 the rate has deteriorated to 2250.5 (DSR). Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare" The actions from the CCGs strategic plan and commissioning intentions will all contribute to the improvement in this indicator. Specifically as outlined in the Strategic Plan 2014/15 – 2018/19 the following 3 interventions are aligned to securing additional year of life: • Long Term Condition (LTC) Self Care • Whole System Approach to LTC Care • Early Cancer Diagnosis A joint piece of work is underway by the CCG and Public Health team to look at a full breakdown of the indicator to allow the CCG to get assurance as to what we are currently doing that will improve areas and other areas to look at. The outcome of this work will be discussed by the CCG executive team and outcome of which brought back to a future CCG Governing Body.	AC
Treating and caring for people in a safe environment & protecting them from avoidable harm – C Difficile	G		The CCG has remained inside its tolerance level for 2015/2016, with 31 cases against a tolerance level of 31 cases. Details of each RCA can be found as part of the exception report on the BIZ along with the weekly HCAI report.	CW
Treating and caring for people in a safe environment & protecting them from avoidable harm – MRSA	A		During 2015/2016 there was only 1 MRSA case reported. This was in November 2015 at Scunthorpe General Hospital. It was identified as a community acquired infection. The patient had been transferred from a GP practice to A&E. The patient had long standing problems and was known to have previous history of MSSA and MRSA. Decolonisation attempts had been unsuccessful. Patient attended both the GP practice nurse and community Podiatry service weekly for dressings from April 2015 The lead nurse for infection control has provided the full details of the RCA (Route Cause Analysis) of this case which can be found in the exception report on the BIZ.	CW

2a. CCG Quality Premium - 2015/2016

The premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. This will be based on the following measures that cover a combination of national and local priorities.

A CCG will not receive a quality premium if it is not considered to have operated in a manner that is consistent with Managing Public Money or ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position incurs a qualified audit report in respect of 2015/16.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/2016

Measure	Short Name	% of Premium	Current Target	Current Performance (period)	Indicator Status / Direction of travel	Comments
Reducing potential years of life lost *(Source: HSCIC Indicator Portal: CCG OIS 1.1)*	Potential Life Year Lost	10%	2126.1	2250.5 (2014)		Next update due September 2016.
Urgent & Emergency Care - Achieving a reduction in avoidable emergency admissions *(Source: Levels of Ambition Atlas: Composite of all avoidable emergency admissions (ISR))*	Avoidable Emergency Admissions	30%	2505	2863.9 (2013/14)		
Mental Health - Reduction in the number of people with severe mental illness who are smokers *(Source: Data Extract by GPES)*	The number of people with SMI who are Smokers	8%				Comparison of % between 31/3/15 and 31/3/16. No current access /availability of data extracted by GPES to ascertain baseline, set target or get a current position.
Mental Health - Reduction in the number of patients with A&E 4 hour breaches who have attended with a mental health need together with a defined improvement in coding of pateints attending A&E	A&E 4 Hour Breaches who have attended with a Mental Health need	10%	95%			Reporting in Development.
Mental Health - Increase in the proportion of adults with secondary mental health conditions who are in paid employment *(Source: HSCIC Indicator Portal: CCG OIS 3.17)*	Adults with SMI Conditions who are in Paid Employment	6%	12.3	9.9 (2014/15)		Mar 2016: Oct14-Sep15 position suppressed due to small numbers. Next update due September 2016.
Mental Health - Improvement in the health-related quality of life for people with a long-term mental health condition *(Source: GP Patient Survey, CCG OIS 2.1 & 2.16)*	Health-Related Quality of Life for People with a Long-Term Mental Health Condition	6%	0.195	2014/15 data suppressed due to small numbers		This is a comparison between 14/15 and 15/16. 2014/15 data available September 2015. 2015/16 data available September 2016.
Improving antibiotic prescribing - reduction in the number of antibiotics prescribed in primary care *(Source: e-Pact)*	Antibiotics Prescribed in Primary Care	10%	1.213	1.130 (2015-16)		Achieved
Improving antibiotic prescribing - reduction in the proportion of broad spectrum antibiotics prescribed in primary care *(Source: e-Pact)*	Broad Spectrum Antibiotics Prescribed in Primary Care		13%	10.2% (2015-16)		Achieved
Improving antibiotic prescribing - secondary care providers validating their total antibiotic prescription data *(Source: ?)*	Secondary Care Providers Validating their total Antibiotic Prescription Data		NLAG - Yes	Yes (2015-16)		Achieved
Local Measure 1 - Emergency readmission within 30 days of discharge from hospital *(Source: Local SUS Data: crude rate)*	Emergency Readmission <30 days of Discharge from Hospital	10%	14.5	Q4 15/16 = 17.9 (Final 14/15 = 17.7)		Next update (Final 2015/16) due July 2016.
Local Measure 2 - Hip fracture - timely surgery *(Source: NHFD Commissioner Report / HSCIC Indicator Portal: CCG OIS 3.12)*	Hip Fracture - Timely Surgery	10%	75.5%	December 2015 = 58.5%		Next update due December 2016.

Due to data availability it is too soon to forecast a value of the quality premium, however based on current performance the only element that would attract a financial payment is the 10% medicines management indicators. Based on the population of 171,000 this would be circa £86K (out of a total circa £860K).

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

The following table summarised this position and the potential percentage reduction of available premium:

Quality Premium – NHS Constitution rights and pledges gateway (Target)	%	Achievement Level	Status	MET?
Referral to treatment times 18 weeks incomplete (92%)	30%	92.9%	G	YES
A&E 4 Hour Waits (95%)	30%	93.09%	R	NO
Cancer 2 week waits from urgent GP referral (93%)	20%	97.9%	G	YES
Category A Red 1 ambulance calls (75%)	20%	69.1%	R	NO

The above indicates that due to the performance in these 4 areas at March 2016, the CCG is only expected to achieve any 50% of the premium for 2015/2016 *(subject to confirmation by NHSE).*

Based on the calculations of the current performance above (circa £86K) this would be reduced to £43K due to the constitutional penalties.

2b. CCG Quality Premium - 2016/2017

For 2016/2017 the gateways in relation to Quality and Finance remain the same, as do the Constitutional penalties (with a slight adjustment to % weighting). These will be reflected in the 2016/2017 report.

The following details the specific quality premium measures and targets set by the CCG for 2016/2017.

2016/2017 Quality Premium

National Measures	Ambition	Weighting
Cancer - Diagnosis at Stage 1 or 2	Achieve 60% diagnosed at Stage 1 or 2 or improve by 4% points.	20%
GP Patient Survey	Achieve 85% having a 'good experience' or improve by 3% points.	20%
E-Referrals	Achieve 80% by March 2017 or March 2017 performance to exceed March 2016 performance by 20% points.	20%
Improved antibiotic prescribing in primary care	Part A) Reduction of 4% (or greater) reduction on 2013/14 performance or equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU Part B) number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to either =<10% or to reduce by 20% lower than 2014/15 value	10%

Local Measures - Linked to NHS Right Care	Ambition	Weighting
Reduction in Non-Elective COPD Admissions	5% Reduction	10%
Reduction in Elective Gastroscopy	15% Reduction	10%
Improve recorded prevalence of AF on GP registers against expected prevalence	5% Increase	10%

3. Highlight Report

This section of the report is meant to act as a soft intelligence section, and also to highlight any potential new or significant performance issues or risks. It may suggest action to be undertaken or simply be used to make the CCG aware of a status.

No	Description	Flag Type	Assigned	Status
1.	**2016/2017 Available positions** As the many of the April 2017 positions have very recently become available a summary is provided below of the areas of concern by Exception, specifically those which form part of the Constitution. • **Referral to Treatment Times** The provisional April position shows that we have again failed to meet the required levels in all three indicators. Performance against the Incomplete waits is 90% against a target of 92%. The position continues to struggle at NLAG and HEY, specifically in Orthopaedics, Ophthalmology and Cardiology. • **6 Week Diagnostic Waits** NLAG have failed to deliver the 6 Week Diagnostic Standard in April 2016. This has been cause by a high number of breaches in both CT and Gastroscopy. Current narrative supplied points to the cause being related to the Junior Doctor strike. Further information has been requested from the Trust including their appropriate planning prior to the strike • **A&E 4 Hours Waiting Times** The April position was below the required 95% level at 89.9% trust wide. The Scunthorpe position was stronger at 91.2% but still below target. May 2016 is looking much stronger, particularly at Scunthorpe which as at the 22nd of the month is achieving the 95%. Performance is expected to return to plan Trust wide by the end of June 2016. • **Infection Control** The position against Infection Control standards look strong in 2016/17 to date, with no MRSA cases reported and only 2 cases of C Difficile reported against a trajectory of 5.	News	BI	Open

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