ITEM 2

North East Lincolnshire
Clinical Commissioning Group

CARE CONTRACTING COMMITTEE MEETING
NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
HELD ON WEDNESDAY 10TH JULY 2019
AT 9AM
IN THE BREMERHAVEN ROOM, GRIMSBY TOWN HALL, GRIMSBY

PRESENT:
Helen Kenyon, Chief Operating Officer (Chair)
Mark Webb, CCG Chair
Laura Whitton, Chief Finance Officer
Bev Compton, Director of Adult Services
Eddie McCabe, Assistant Director of Contracting & Performance
Brett Brown, Contract Manager
Christine Jackson, Head of Case Management Performance & Finance, focus
Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care (In attendance only)
Caroline Reed, PA to Executive Office (Notes)

APOLOGIES:
Jan Haxby, Director of Quality and Nursing
Dr Wilson, GP Representative

IN ATTENDANCE:
Julie Wilson, Assistant Director Programme Delivery & Primary Care
Bruce Bradshaw, Strategic Lead for MCA, Older People & CHC (Item 5)

Item **ACTION**

1. Apologies
Apologies were noted as above.

It was confirmed that Anne Hames has resigned from her role as Community Forum Representative for this Committee. A new representative will be recruited. The Committee thanked Anne for her active participation and helpful contribution during her membership of the Committee.

2. Declarations of Interest
There were no declarations of interest identified.

2.1 Conflicts of Interest Training
Members were reminded of the requirement to complete the mandatory online training.

3. Notes of Previous Meeting – 12.06.2019
The notes from the last meeting were agreed as an accurate record.

4. Matters Arising from Previous Notes – 12.06.2019
The updated matters arising document was noted. All actions were completed.

FOR DECISION

5. Care At Home

An update report was circulated for consideration. B Bradshaw provided an update:

- The specification has been updated following feedback received at the last meeting. It will be circulated to relevant partners for comment.
- The specification states that providers must work with CCG systems/projects in order to improve quality rather than detailing explicit systems. This should enable flexibility with the agreed model.
- Work is ongoing to agree outcome focused KPIs.
- The procurement options for consideration are: 1/ existing 3 locality/provider Model, 2/ Variable Provider Model.
- Discussions are continuing regarding the Controc system. Two potential solutions have now been identified and are being modelled by focus with anonymised data. The aim is to identify one methodology. A 3 month extension is requested in order to ensure that the system is tested and fit for purpose prior to procurement. This would also avoid an adverse impact to the service relating to winter pressures.

The Committee provided the following feedback:

- Some of the information included in the specification is out of date. C Jackson to provide updated information/feedback to B Bradshaw outside of the meeting. **C Jackson**
- Are there any implications for the procurement process relating to inexplicit information provided within the specification, ie, will the CCG be unable to provide clarification to queries? B Brown confirmed that the CCG can indicate its direction of travel and strategy plan without providing explicit information or confirming the specific tool or methodology.
- The need to leave room for flexibility within the specification was acknowledged; however the Committee queried when some of the "hooks" would become actuals in order to assist the selection process eg, IT systems, competencies etc. B Brown advised that some elements will not become defined prior to the specification being published as they are more emergent, eg, IT systems. It was proposed that information relating to the IT system should be located within the core contract rather than the specification. A service development improvement plan (SDIP) should be created to support the contract and specification.
- The Committee discussed the invoicing system and whether the specification should stipulate that the provider is required to use Controc or whether they could use another system provided that the correct information was provided. Could the CCG purchase and provide the system? B Bradshaw advised that further information will be available following the meetings between focus and Controc. It was agreed that this information will be required by 8th November. It was proposed that, if a suitable system/piece of software is agreed, the specification should specify this, irrespective of whether it could disrupt the system/deter certain bidders.
- The paper refers to moving on from the basics of domiciliary care; will this be detailed in the specification? It was noted that there is

reference to the intention to develop a domiciliary care plus model in future.

- Importance of care to be provided by a consistent core team with the appropriate skill sets and competencies. Commitment is required from providers that the care and staff/teams will be consistent and have the appropriate skills and training. Emphasis needs to be on the individual and their support needs. B Bradshaw confirmed that the specification states that the service will need to "deliver an "enhanced" function to meet the needs of service users with complex and or comorbid conditions by having access to staff trained and competent in those services".
- The Committee discussed whether a single provider or multiple providers are being sought to provide the service. It was noted that reference is made within the report/specification to a single provider. B Bradshaw to review this. The Committee acknowledged that there are pros, cons and risks in regard to both models. The current model provides advantages in terms of cost and capacity; however results in multiple management costs. Concerns were raised regarding a single provider monopoly and a risk of vulnerability if the relationship breaks down between commissioner and provider. It was noted that the provider/s would need to meet the peaks of troughs of the service. **B Bradshaw**
- Further integration is needed with Primary Care Networks (PCN) who will have responsibility for population management. It was noted that the 5 PCN geographical areas overlap. It was requested that Dr Sinha be given the opportunity to comment on the specification. It has been agreed that there will be PCN representation on the multi-disciplinary team meetings. Work is required to improve the ownership and feeling of value of domiciliary care and its carers amongst other professionals, eg, district nurses, GPs, social workers. How is the system going to make their voice better heard? Work is required between the CCG, domiciliary care and other providers to ensure appropriate relationships between the individual and everybody else involved in their care. PCNs could assist with this.
- The Committee discussed the current domiciliary care geographical areas. Each geographical area has approximately the equivalent number of hours per week (the area covered by LCQS has slightly more activity; however this could be linked to extra care housing). The overall view is that the geographical areas are appropriate and work well for providers and individuals. It was noted that disruption caused by a new provider could be minimised due to the tupe of staff as individuals would continue to receive support from the same carers/teams. The Committee agreed that the procurement should be based on the current 3 geographical areas.
- Could a provider bid on more than one geographical area? The Committee agreed that providers could bid on more than one area; but would not be able to provide the service in more than one area.
- Clarification was sought regarding the financial envelope and what is being built in regarding inflationary uplift year on year. B Compton advised that it will be similar to the cost of care exercise. R Brunton to be asked to work up some projections based on the living wage. It was requested that clarity needs to be provided that calculations are based

on the living wage as oppose to the nationally mandated minimum wage. **B Compton**

- It was agreed that Care at Home is one of the most critical components of the health and social care service and that delivery of the service must be right.

The Committee agreed:

- **A single item agenda meeting to be scheduled in August in order to review the final specification and SDIP.** **C Reed**
- **To approve the existing 3 locality/provider Model.**
- **To approve the 3 month extension request.**
- **To approve a 5 year plus 2 contract.**

6. Cost of Care – Residential Care

An update report was circulated for consideration. B Compton provided a summary:

- Previous updates informed the Committee that the financial data collection exercise achieved a 39% response rate against an aspirational rate of 50%. Professor Bolton advised the CCG to continue the dialogue with providers and to interpret and review the available sample data.
- Further conversations have taken place with a small group of residential care providers acting as a standing committee. The standing committee agreed that the fee rate should be based on an assumption of an efficient market and that the calculation would be based on a 90% occupancy rate.
- Concerns remain that engagement remains low amongst providers and that conversations are not taking place with a representative voice in the market.
- Homes requiring improvement were operating at higher costs. This could be due to the additional capacity and investment needed to meet the CQC's improvement plan. It was agreed that the CCG should not be paying for inefficiency in the market.
- It has been agreed that the model will be based on the main elements of cost plus capital repayments with the profit element considered at a later date. It was agreed to remove values that were plus or minus 10 per cent from the average for the data set. This exercise is likely to raise the current price for the simple average cost per resident per week.
- Wider engagement and full consultation will be required with providers prior to agreement of the final cost in order to minimise the risk of challenge.

The Committee provided the following feedback:

- Will the cost of care exercise assist with managing out poor performing homes? B Compton confirmed that costs will be based on a 90% occupancy rate and that work is taking place with providers not meeting the required standard. Providers will retain the current fee level until they meet the appropriate standard. The CCG will need to be proactive in decommissioning services not meeting the required

standards. It was noted that property prices in NEL are attractive, which impacts on the market.

- Part of the negotiations will be the expectation that providers adhere to the legal guidelines regarding top ups. This will impact on the market.
- Work has commenced around reablement models which could provide an opportunity for the market to work differently.
- Proposal to review the data to understand if going with an average cost is the appropriate decision, i.e. is it the same homes with consistently high costs? B Compton advised that the data is anonymised but that from the anonymised data it can still be seen that it is not the same providers that have the highest costs in each area.
- Jeanette Logan (working for e-Factor as a business advisor to residential care homes) to be invited to a Care and Independence team meeting and to be informed of the CCG's minimum expectations in terms of service delivery to then help support provider development and delivery.

The Committee agreed:

- **To endorse the CCG to propose a model to providers and to subsequently carry out a further engagement exercise and do a full consultation.**

7. Clinical and Corporate Network Provision Update

This item was deferred due to a delay in the procurement process.

FOR DISCUSSION

8. NLaG Update

A report was circulated for consideration. L Whitton provided a summary:

- The report details the NLaG Cost Improvement Plan (CIP) and how the plan links to the contracting arrangements and the process and timescale expected to see the Trust return to a sustainable position.
- Weekly Northern Lincolnshire planning meetings are taking place to review the information in detail. L Whitton and H Kenyon attend the meetings.
- There is an overall system savings requirement of £36m for 2019/20 (NLCCG, NELCCG, NLaG). Schemes have been split into 2 categories: organisational and system. Organisational schemes (2/3) are those within the control of the organisation and not dependent on the actions of the system, eg, CHC, agency staff. System schemes (1/3) are those that are reliant on system transformational change, eg, high cost drugs etc).
- All schemes with the exception of high cost drugs are transformational and directly linked into the SDIP. Focus will be on delivery of the transformation schemes in year, however the "system benefit" will not be realised in full until 2020/21 due to the time taken to translate the reduction in referrals into an activity reduction and the ability for NLaG to take cost out "in year".
- Non recurrent funding via the release of contingency funding /earmarked reserves will need to be used in 2019/20 to mitigate

against this. There will still be a gap and discussions are taking place to identify how else to take cost out of the system.

The Committee provided the following feedback:

- When is the Trust likely to return to a sustainable position? L Whitton confirmed that the expectation is that the "system" will have returned to a recurrently balanced position by the end of the 5 year plan.
- Query regarding "clinical Income (depth of coding)". L Whitton advised that there were issues within the hospital in the way that patients were being coded and resulted in a lower price for activity due to inaccurate data recording.
- Clarification was provided that the System Schemes table demonstrates cost pressures and issues in the system, with the exception of the high cost drugs line (work is underway to determine whether there is an opportunity to identify £2.3m of savings). Each of the schemes requires a plan. It was noted that for non-elective demand management, some activity will be stopped and NLaG will identify what cost it can pull out of their system, eg, can they close an escalation ward?
- Is the non-recurrent contingency the total amount of earmarked reserves available? L Whitton confirmed that it is a combination of earmarked reserves and monies that have to be set aside as contingency funding, which do not have any pre commitment against them. A report will be submitted to the Governing Body to propose that, if the budget can be managed in other areas, the first call on earmarked reserves should go back into the system.

The Committee noted the update and requested that regular updates (quarterly) be submitted to this committee in order to see a reduction of the £12m. **Forward plan**

9. EMAS Update

A report was circulated for consideration. E McCabe provided an update:

- The contract has been signed. The final contract value was £188,262,930 (NEL CCG Share £6,311,760). This was within the CCG's financial planning.
- The additional investment to enable delivery of the ambulance response targets was £20.1m across all CCGs. It is anticipated that EMAS will spend this on recruitment etc. Quarterly meetings will take place between the EMAS Director of Finance and 3 of the CCG DoFs to monitor the spend.
- The Lincolnshire trajectory will be behind the other two divisional areas (achievement of CAT 1, 3 and 4 ARP for March 2020 and Cat 2 for April 2020).

The Committee noted the update.

10. Transport Update

E McCabe provided a verbal update:

- Conversations have taken place with NELC and Engie regarding overall transport, including services currently provided by TASL (renal, same day, planned). NELC is going out to procurement for the Phone

a Ride service; consideration to be given to the CCG supporting this, although there is a potential challenge around eligibility.
- An update will go to the Union Leadership Committee and a report to be submitted to the Union Board in the autumn.
- An update will be submitted to the September meeting on TASL and transport generally.

Forward plan

The Committee noted the update.

FOR INFORMATION

11. Contracting and Procurement Update
There were no further updates. A report will be circulated to the next meeting.

12. Residential and Home Care Update
A report was circulated for information.

13. Local Primary Care Schemes Contracting Arrangements
A report was circulated for information. J Wilson highlighted that a decision has been taken to postpone a mini procurement for micro suction services. This is due to a review of ENT models; there is a potential for micro suction to become part of a wider ENT model. This will go to PCCC for a decision.

14. Items for Escalation from/to:
- **DAC**
- **Clinical Governance Committee**

There were no items for escalation; however it was agreed that the following needs to monitored:
EMAS Category performance trajectory.

15. Items for Virtual Decision/Chair's Action
There were no virtual decisions/chair's action taken since the last meeting.

H Kenyon advised that the Committee will be asked to provide a virtual decision in the coming weeks regarding GP extended access (contractual elements).

16. Primary Care Commissioning Committee Meeting Minutes – 26/3/2019
Circulated for information.

17. AOB
There were no items of any other business.

Date and Time of Next Meeting:

Additional meeting (single item agenda)
Tuesday 20th August, 11am-12pm, Committee Room 4, Grimsby Town Hall

Wednesday 11th September, 9-11am, Banqueting Room, Grimsby Town Hall