

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 13/10/2021 AT 9AM**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)
Mark Webb, Lay Member (Governing Body)
Anne Hames, Community Lead
Laura Whitton, Chief Finance Officer
Jan Haxby, Director of Quality and Nursing
Christine Jackson, Head of Case Management Performance & Finance, focus
Dr Jeeten Raghwani, GP Rep
Bev Compton, Director of Adult Services

**ATTENDEES PRESENT:**

Brett Brown, Contract Manager
Caroline Reed, PA to Executive Office/ Note taker)
Gaynor Rogers, Commissioning Officer, Service Planning and Redesign (Item 7.1)
Julie Wilson, Assistant Director Programme Delivery & Primary Care (Item 7.1)
Emma Overton, Policy and Practice Development Lead Care and Independence (Item 7.2)
Julie Elliott, Specialist Nurse Continuing Healthcare (Item 7.2)
Rachel Staniforth, Medicines Optimisation Pharmacist, NECS (Item 7.3)

# APOLOGIES

Dr Ekta Elston, Medical Director

Eddie McCabe, Assistant Director Contracting and Performance

Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care

# APOLOGIES RECEIVED

Apologies were received as noted above.

# DECLARATIONS OF INTEREST

There were no declarations of interest made from Committee members. It was noted that on-going declarations of interest stood for every Care Contracting Committee meeting and were publicised on the CCG’s website.

# APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 11th August were agreed as an accurate record.

The Committee agreed that no redactions were required prior to formal publication.

# ACTION TRACKER

The action tracker was reviewed.

#  Items approved virtually since the previous meeting

• ICF Contract Award – approved

• Day Opportunities Review – approved

**6. ITEMS FOR ASSURANCE**

**6.1. H2 Planning**

L Whitton provided a verbal update:

* H2 planning is underway following allocations and guidance received on 30/9/21. H2 is a continuation of the arrangements set out in H1 from an NHS perspective.
* The main changes from a funding perspective are: the agreement of the Agenda for Change pay award and the allocation adjustments to reflect that, and an increased efficiency requirement which mirrors the government’s approach that things are starting to return to normality. Providers should be focusing more on reinvigorating their savings plans that may have been put on hold or been lighter touch during the pandemic. The CCG is in the process of communicating out to all non-NHS providers what the uplifts/adjustments will be.
* Contracts are in place for the independent sector to support the waiting list reduction, building on arrangements agreed in H1. There is additional funding to support the increased activity associated, but it is measured across the whole of the NHS.
* The deadline for finalising the H2 plan is 16th November; after which time planning for 2022/23 will commence.

The Committee provided the following feedback:

* Is there a pressure in the allocations to get back to normal quicker than our budget will allow? L Whitton confirmed that there is an expectation centrally that there should be a move back towards normality; however, there is recognition that it will take time to get back to pre-Covid positions in terms of accrued pressures, eg, waiting lists etc. From a finance perspective, there is confidence that current allocations will be sufficient; however, the main pressure will be going into next year with an anticipated gap between the allocations and the underlying spend. It was proposed that planning should commence as soon as possible to prepare for this eventuality and that providers should be made aware that challenging decisions will be required.
* Future activity planning needs to commence to establish where we would like our activity to land and be managed and to establish the ambition for the system, eg, when services are effective, they reduce demand in other parts of the system.
* A current issue is how to prioritise the current workforce as the headcount is unlikely to increase. Difficult discussions will be needed around the priorities for action. An update to be brought to the December meeting to outline the approach to future planning, ie, once the H2 plan is completed rather than waiting for guidance and how the process is going to run for this year in health and social care.

**Action: Forward plan to be updated.**

* Concerns regarding the potential impact of minimum wage increases. A recent exercise comparing wages in the care sector with the retail sector identified a large gap. It was proposed that conversations take place outside of the committee around the value to the local community to be able to access high quality, skilled jobs. It would be helpful to develop a strong case for appropriate pay and training and career development within the care sector that would be difficult for others to challenge. Conversations to include:
	+ How to get more value out of the community.
	+ Comparison between NHS and care sector wages to start to highlight the disparity.
	+ Quality outcomes and their impact.
	+ Complexity of individuals receiving care (better planning).
	+ Career pathways.

It was agreed that this would need to be fed through to the ICP linking in with Navigo, CPG, the voluntary sector and PCNs with a view to agree how to start to look at things differently and how to create a true community MDT to start to bring about change.

* Conversations have started with the ICP around how to create a sustainable workforce for the future; including questions relating to career progression. There is the opportunity to jointly create some innovative and exciting ways to encourage people in to the care sector.
* Recognition needs to be given to the huge role that the care sector plays in the system and the negative impact to the NHS when there is not the right amount of resource/ support /infrastructure.
* Increased collective thinking to be given to the way resources are used flexibly around the extended times in general practice with focus on people as well as money.

**Action: H Kenyon, B Compton, L Whitton to start discussions, potentially via SMT.**

**7. ITEMS FOR DISCUSSION/DECISION**

**7.1** **Tier 3 Weight Management Update**

A report was circulated for consideration. G Rogers and J Wilson provided a summary:

* ABL has agreed the revised service specification and it is now in place. They are confident that they can deal with the increase discussed at previous meetings.
* There was a significant increase in referrals in Q3 (61%); the majority from GPs. This may be due to the profile being raised of the Tier 2 service and the digital offer.
* There remains some confusion in primary care around referral. Public Health have been asked to firm up the referral pathway for the Tier 2 service; this will be in place by 22nd October and shared with general practice. A full pathway will then be developed and shared.
* Public Health are starting work to map out food outlets and access to fresh, affordable, and nutritious food across the borough, highlighting gaps and areas with high concentrations of fast-food outlets. It will also involve mapping nutritional health measures such as obesity, childhood obesity and tooth decay and this will be compared to the mapping of food outlets.
* Public Health will provide an update on the work underway to the preventable long term conditions working group; members include Community food co-ordinator Mary Vickers and Carol Prendergrast from Green Futures. The group may support the work from January as there is a real focus on food and nutrition as a prevention for long term conditions.
* Health checks are taking place; which are also useful in terms of data re BMI etc.
* Confirmation of an additional £70k of funding secured for the Humber (£20k for NEL) is awaited from NHSE/I. ABL have confirmed that they will be able to see a further 22 patients in NEL between November and March. Additional admin staff have been recruited to support this.
* All GP practices in NEL have signed up to participate in the enhanced weight management service.
* Thrive Social Prescribing have been working closely with ABL and make up about 10% of all referrals to the service. ABL supported them with better equipment to make better quality referrals (re weight, BMI etc).
* The results from ABL for the end of Q3 are encouraging. One concern was 57% of people achieving 5% weight loss against the target of 60%. ABL explained that this was due to complexities, learnt behaviour, comorbidities etc. They have been asked to provide studies/evidence to support this rationale.

The Committee provided the following feedback:

* There is a real opportunity to grow the message via pubic and patient engagement forums.
* Will there be a strategy to address the number of fast food outlets from a public health perspective in terms of prevention? It was agreed that engagement and support is required from planning, education, community, elected members etc. It was proposed that the Health and Wellbeing group at place would be an appropriate group to address this issue.
* Clarification regarding the additional £20K funding. It was confirmed that the funding will go directly to the individual CCGs. B Brown will do a contract variation for NEL once confirmation is received from NHSE/I.
* Is there a direct interface for patients to be referred to Hull for bariatric surgery? It was confirmed that ABL work closely with the Tier 4 service and flag those patients in Tier 3 who still require bariatric surgery. All patients are required to go through Tier 3 unless there is an urgent case, which may require the process to be accelerated.
* What is the process for patients requesting Saxenda? ABL is currently directing people through PALS to gauge the numbers. A communication will be sent out to primary care once approved by Dr Ekta and Dr Sinha.
* Is there data available to show the longer term impact and the sustainability of what people are achieving locally? Work is underway with the Business Intelligence Team to look at data collation, primarily around prescribing. Data captured by primary care from annual health checks would also be helpful. It was agreed that further work is required to establish how to gather the long term evidence.
* Consideration needs to be given to the procedures for agreeing treatment following significant weight loss, eg, surgery for removal of excess skin (currently via IFR in NEL). Patients and primary care need to be aware of the whole pathway.

**Action: G Rogers to link in with Elaine Johnson to ensure that all services are included on the directory of services.**

**7.2 Micro-commissioning Policy “Eth and Prag” Update**

A report was circulated for consideration. E Overton and J Elliott provided a summary:

* The Committee were reminded that amendments can be made to the “Eth and Prag” policy as a result of policy/ombudsman decisions or by relevant decision-makers, eg, chair of ICAAP, CCG COO or DASS following a complaint etc.
* Following a recent ombudsman decision, which resulted in criticism of a Local Authority’s lack of guidance around individuals placing themselves in a non-contracted home, the policy has been amended to reflect NEL’s approach.
* At the August meeting, the Committee discussed at length how to approach/manage a situation when an individual wanted to remain at home, but professionals did not consider this to be safe. E Overton met with decision makers to discuss this further and agree more operational guidance to the agreed approach. The policy was amended to reflect these discussions and to provide assurance that the process is robust and that decisions would only be made via ICAAP/CHC Decision forums. J Elliott confirmed that professionals work with individuals to consider what care can be provided for the assessed need; individuals have the option to pay for any gaps in funding if they choose to remain at home and are advised of the risks. Withdrawal of funding would present a greater risk. Safeguarding and other relevant teams would be notified of the risk if a person chose to remain at home despite the advice of professionals.
* The policy has been helpful in Ombudsman cases, eg, the ombudsman agreed with the steps taken by the CCG due to the extent of comprehensive assessments and care planning to support an individual.

The Committee provided the following feedback:

* It was agreed that the amendments to the policy do not trigger the formal duty to consult; however, it was agreed that it is important to engage with Accord, service users and general practice.

**Action: E Overton to attend Community forum to discuss effective engagement with the wider Accord membership and the community.**

**Action: E Overton to liaise with J Wilson to establish the most appropriate forum to attend to increase GP awareness.**

**The Committee agreed to approve the amended policy.**

**7.3 Humber Area Prescribing Committee Merger Proposal Plan**

A report was circulated for consideration**.** R Staniforth provided a summary:

* The Committee was asked to approve the proposed plan and draft Terms of Reference for the merger of the two Area Prescribing Committees to form the Humber Area Prescribing Committee (APC).
* There are currently variations in the formularies which potentially cause issues. The merger would enable the process to be streamlined by aligning formularies and shared care guidelines.
* The proposal plan has been received by the Combined Humber SLT. Feedback on the considerations is detailed in the paper.
* The new model will have 2 sub committees to feed into the APC which will feed into the relevant committee going forward (to change post April 2022).
* Humber SLT proposed to delay the decision around funding as the scheme of reservation and delegation for the ICS is still in development. Decisions will continue to go to individual CCGs for approval where there is a financial or commissioning impact in the interim period.
* Humber SLT to consider APC recommendations that would incur significant financial cost or have an impact on commissioning. The APC minutes will be shared for information.
* Primary and secondary care interface groups to feed into the Medicines Guideline and Use group and vice versa.

The Committee provided the following feedback:

* Would there be one GP representative per PCN or per Place? It was confirmed that the Clinical Directors would identify one GP rep per place.
* Consistency across formularies etc will be helpful to reduce risk etc as there are increasing numbers of staff working across a number of areas, eg, Nlag staff working on the North Bank.
* It was confirmed that CPG are involved.
* There is an issue with the differences in monitoring in Hull and Grimsby in relation to oral methotrexate in the community (the Hull model results in an increased workload in general practice). It was confirmed that this issue has been raised and Hull are aware.

**The Committee agreed to approve the proposed plan and new Area Prescribing Committee model.**

**7.4 Supported Living Plus Update**

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

* At the August meeting, concerns were raised regarding whether the proposed hourly rate of £18.50 was sufficient to attract a provider and to meet the enhanced level of training, management, and complexity of the supported living plus model.
* Engagement sessions have been undertaken with providers and benchmarking work has been done with finance colleagues, which has resulted in a proposed hourly rate of £20.17.
* The Committee were asked to consider 3 options and approve the preferred option, option 1, in order to attract a suitably specialist provider to meet the specification:
	+ Option 1. £20.17 per hour with the view this would be uplifted in line with other social care providers for 2022/23 once more is understood around the increases in National Minimum Wage and inflation.

The Committee provided the following feedback:

* Clarify was sought regarding the annual cost avoidance. It was confirmed that the new service will enable the needs of the cohort who would otherwise be out of borough to be met. The cost avoidance figure is based on what it would cost to place people out of borough.

**The Committee agreed to approve Option 1.**

**7.5 External support to developing a demand management approach**

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

* As part of the council’s budget negotiations for 2019/20, there was additional investment into the ASC budget to meet some of the inflationary pressures. There was a requirement to commission some work that had been done in children’s services to look at demand management approaches in creating a more business intelligent led approach to developing practice for ASC. B Compton has been working with IMPOWER who have worked extensively with adult services across the region and with NEL children’s services to develop a more pre-emptive and proactive approach to managing demand.
* Work has taken place to identify the best opportunities for the demand management work; with the reablement pathway (one of the ICP priorities) identified as a key area. The aim of the work is to try and create the data and evidence base to set out some prospective trajectories about where we want to manage people in the system and to give confidence that we are managing people in the right way. IMPOWER will build the data and insights infrastructure with us and also look at our patterns of working, behaviours, capacity and where best to invest to get the right size of support to provide the outcome of better value from care.
* It was agreed, following conversations with contracting colleagues, that a contractual route was more robust than a consultancy model. A contracting route will enable the CCG to hold the provider to account.
* The proposal is to use the CCG’s procurement approach and directly award a contract of approx. £150k to IMPOWER to carry out the demand management work.

The Committee provided the following feedback:

* Will this work look across a health and social care lens? It was confirmed that it will look at health and social care and that the system is keen to proceed with this work. B Compton has engaged with E Elston and Jane Miller as the strategic leads; their main ask is that the work results in influencing practice. Preliminary work has been done to pull together a number of data sets. The key aim will be how to manage demand more systematically and how to understand the values that are possible to achieve in terms of investment and outcomes.
* Discussion regarding awarding a contract as opposed to going out to procurement. It was confirmed that IMPOWER have already completed the preliminary work and knows the CCG/NELC/Union and the system well, which would enable them to start the work promptly. They have already worked with NEL children’s services which would enable more aligned working with children’s services and enable the preparing for adulthood work to be more seamless.
* How long would IMPOWER be contracted to do the work? It was confirmed that there would be a 12 week (approx.) programme from mid-November.
* Will £150k be sufficient for this piece of work. It was confirmed that a focused and targeted piece of work is required, therefore, negotiation would be needed.
* This would be a standing order waiver and would require reporting back to the IG and Audit Committee if approved.
* The Committee requested further details around the rationale for the piece of work and the agreed outcomes. It was agreed that a briefing would be shared at the next meeting outlining the scope of work, the performance metrics in terms of system improvement, confirmation of how this fits in with the population health management approach and the required outcomes.

**Action: an update to be submitted to the next meeting.**

**7.6 ICAAP Update**

A report was circulated for consideration. C Jackson provided a summary on behalf of Debbie Harding (ICAAP chair since July 2021):

* A review has taken place of the types of requests that are submitted to ICAAP.
* The Chair has proposed that the authorised amount that Advanced Practitioners (APs) can approve be increased from the current value of £220 to £300. Panel members agree with the proposal and it was confirmed that expenditure would be closely monitored.
* This change will enable more autonomy and greater job satisfaction for APs. The additional level of responsibility will enable APs to develop more autonomous decision making skills and reduce the impact on team resources from a reduction in the amount of staff needing to attend ICAAP.
* There has been an increase in demand for additional support. The additional support is predominantly relatively low cost additions to support packages, but the current authorisation level does not allow for these to be approved within the social work teams.
* The Covid-19 pandemic and national lockdowns resulted in increased demand and an increase in the level of care packages. Referrals are also at a pre-pandemic level in terms of volume; however the complexity has increased.

The Committee provided the following feedback:

* The report focuses on values of units of time and less on how individual user outcomes are being met. It was proposed that continued financial assurance is sought around creating the flexibility and assurance is also provided around the outcomes that are being sought and met.
* The Committee requested some additional details:
	+ The number of packages which could be authorised as a result of the change.
	+ How many people have deteriorated during the pandemic to a point where they are unable to regain their previous levels of mobility? This would help to determine whether some work is needed with specific groups to support them in getting back to pre-pandemic levels.
* It would also be useful to understand some of the challenges and what this informs us about the needs of our population in order to ensure that this is taken into account when planning.

**Action: C Jackson and B Compton to feed back the Committee’s requests to D Harding/focus**

11:02am Dr Raghwani and B Compton left the meeting.

**7.7 Developing Proposals around the ICP Update**

L Whitton confirmed that work is ongoing. An update to be brought to the next meeting.

**7.8 Items for Escalation from/to: Governing Body/ Risk Committee/ Quality Governance Committee**

* Cambridge Park CQC report to be picked up at the Risk Committee and Governing Body meetings.

**8. ITEMS FOR INFORMATION**

**(including Minutes from relevant sub committees)**

**8.1 Residential and Home Care Update**

**8.2 PCCC Minutes – 8/6/2021**

The Committee noted the reports received for information.

**9. ANY OTHER BUSINESS**

**Date and time of next meeting: Wednesday10th November, 9-11am, MS Teams**