NHS
North East Lincolnshire
Clinical Commissioning Group

# NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
# CARE CONTRACTING COMMITTEE

## ACTION NOTES OF THE MEETING HELD ON 14/10/2020 AT 9am

**MEMBERS PRESENT:**
Helen Kenyon, Chief Operating Officer (Chair)
Dr Ekta Elston, Medical Director
Christine Jackson, Head of Case Management Performance & Finance, focus
Laura Whitton, Chief Finance Officer
Anne Hames, Community Forum Representative
Mark Webb, CCG Chair
Bev Compton, Director of Adult Services
Jan Haxby, Director of Quality and Nursing

**ATTENDEES PRESENT:**
Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care
Eddie McCabe, Assistant Director, Contracting and Performance
Brett Brown, Contract Manager
Caroline Reed, PA to Executive Office/ Note taker
Julie Wilson, Assistant Director Programme Delivery & Primary Care (Item 5)
Nic McVeigh, Service Lead: Carers & Communities Care & Independence Team (Item 6)

**APOLOGIES:**
Dr Raghwani, GP Rep

### 1 APOLOGIES RECEIVED

### 2 DECLARATIONS OF INTEREST
*Dr Elston declared an interest in Item 5 and it was agreed that she would remain in the meeting for the discussion but be excluded from any vote.*

*Cllr Cracknell declared an interest in item 6 and it was agreed that she would leave the meeting whilst this item was discussed.*

### 3 APPROVAL OF PREVIOUS MINUTES
The minutes of the meeting held on 9th September 2020 were agreed as an accurate record.

### 4 ACTION TRACKER
The matters arising document was reviewed.

*Item 4.1 Rethink Crisis House, Lincsline and Mental Health SPA*
*L Holton to provide an update to the next meeting if there is significant progress to enable a meaningful discussion.*

L Holton fed back that he had been unable to progress this. The contracts team are supporting with this; however a contract extension will be needed to allow the required timeframe for a procurement process.

**Action: J Haxby to pick this up with L Holton outside of the meeting. An update to be brought back to the November meeting.**

9:13am L Whitton joined the meeting

- Updated ToR – *The updated ToR will be circulated to the October meeting*. Deferred to November.

- PTS Update

This was raised at the Leadership Team meeting on 13th October. It was agreed that further work was required, and a presentation on the wider transport agenda (health and community) will be given in late November/early December. Work will continue on the specification.

9:16 H Kenyon joined the meeting

Following a discussion, the Committee acknowledged that specialist patient transport (oxygen, MH, bariatric based etc) will require a separate contract and should not sit within a joint community offer with NELC due to its specialist nature. Conversations will continue with NHS colleagues across the Humber to ensure that new national changes around eligibility criteria and the potential for differing patient flows as a result of HASR will be reflected in the specification.

It was agreed that the presentation/piece of work around the wider transport agenda should look at: What is the broader patient transport requirement across the borough as part of an integrated system? There are two elements:

- How are we enabling people who do not require specialist funding to get to local appointments?
- How are we getting people to appointments when they require an increased level of support, eg, on stretchers, requiring oxygen etc.

## 5 Update on local Primary Care 24/7 Urgent Care Provision (including GPOOH)

E Elston declared an interest. It was agreed that she would remain in the meeting for the discussion but could not participate in voting/decision making.

A report was circulated for consideration. J Wilson provided a summary of the progress since the last meeting:

- The current GPOOH provider was notified of the contract extension to 31/03/2021 and the ability to extend for a further 3 months if necessary.
- A workshop was held in September with all practices to detail the overall 24/7 urgent care arrangements that are being discussed with PCNs, and to support individual practices in considering whether they want to take back responsibility for GPOOH (a deadline of 30th October was given).
- PCNs were going to consider the potential options for supporting the 'in-hours' response and bring back proposals; however, due to the challenges and commitments reported at the last meeting (implementing new PCN services, supporting the flu programme, managing a potential Covid surge etc), PCNs have requested additional time to work up the proposals (up to 12 months).
- It was also flagged during the workshop that the Extended Access arrangements (6:30-8pm and some weekends) was signalled as being part of PCN entitlement from April 2021 and

would be part of the national GP contract negotiations for next year. The outcome of this will not be known until March 2021; however, it has a potential impact on GPOOH service requirements. It would therefore seem appropriate to delay issuing an OOH spec to the market, as it may need a significant revision depending on the outcome of these negotiations.

- Since the September workshop, further guidance has been received from NHSE/I regarding the process for practices to 'opt-in'. Practices have a right to request opt-in, but this would be subject to approval by the CCG's Primary Care Commissioning Committee (PCCC). If Practices opted back in, they would take back the full responsibility for the provision of 24/7 GP care, unless they chose to sub-contract the out of hours element to another provider. If they chose to sub-contract the service, they would also need to seek approval from the PCCC. These details have not yet been shared with practices. The LMC are also seeking a legal view from the General Practitioners Committee/BMA as this is unprecedented. This will be put out as one set of advice to practices with the question: "Do you wish to opt back in?"
- The recommendation is that all practices would need to opt in or opt out to enable one service across NEL that is easy to navigate and seamless. It would avoid having pockets of urgent care and having to procure for some areas. This will be taken to PCCC for a decision.
- The Committee was asked to approve the variation to the existing GPOOH contract to enable a longer extension if required. This would be up to 12 months (31 March 2022) and a clause would be built into the contract enabling a six-month notice period at any time within the contract.

The Committee provided the following feedback:

- Could a single PCN deliver the service for the whole area? J Wilson advised that a view would need to be sought around the potential need to go out for procurement in this circumstance.
- Discussion around the move away from a traditional contracting and procurement way of working to more of a partnership way of working. Further work is required to look at what this might mean and how to better work as a system. It may be that procurement is not the right course of action and partnership working with the broader NHS is the appropriate direction of travel. Specialist advice may be required.
- Following the decision regarding opting in or out, there would need to be a secondary decision around how the service is to be delivered in the future. PCNs could potentially work in partnership with others to deliver the service. It would be helpful for practices to be aware of the potential options and opportunities around opting in.
- Timing continues to be an issue. There is still significant development work to do to support PCNs to reach where they want to be in the system and to build up appropriate levels of trust. There are other areas that PCNs could work on together to build relationships and trust; OOH may appear to be too high a risk at this time.
- Discussion around the former collaborative OOH service and whether there are lessons to be learnt? It was noted that practices took turns in providing the service or paid someone to provide the service, which resulted in significant gaps and the same practices/GPs providing the service. It was noted that NEL is still an under doctored area and that there is not an expanding workforce. The aim is for PCNs to provide services from 8am-8pm and at weekends, which may deter practices from wanting to opt back in to the OOH service.
- The model for the OOH service could change to one that is run at a place level by a collaborative of GPs and ANPs and others, potentially working with CPG, Navigo and other providers. The PCNs could have oversight and ownership and manage the service in accordance with what the demand is. GPOOH demand was historically patients who had run out of their medication or could not been seen within practice hours; the extended hours may minimise this type of demand and result in different demand, eg, MH crises etc.

- It was agreed that considerable work is required as a system to identify what is required from the GPOOH service going forward. Some of the ICS governance work around partnership and place might be helpful.

**The Committee agreed:**

- **To note the update regarding the discussions regarding 24/7 urgent care provision within primary care**
- **To approve the variation to the existing GPOOH contract to enable a longer extension if required with 31 March 2022 as the absolute end date.**
- **To recommend to the PCCC that in order for the GPOOH service to be managed by local practices, it would need to be an 'all in' decision from practices.**

The agenda was reordered with Item 6 taken towards the end of the meeting.

**7 Day Services Contract (Foresight)**

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

- Foresight is commissioned to deliver Day Opportunities and Befriending services (predominantly Learning Disability)
- All day provision, including some work done by CPG for the community, was closed during the early phases of the pandemic. This site has reopened but for a more limited offer. Part of the rationale for the reopening was that clients were struggling with isolation.
- The contract is longstanding and of relatively low contract value (65k).
- The contract is up for review; however, conversations are taking place with CPG in respect of their day offering as part of efficiency reviews. The proposal is to extend the contract and incorporate it as part of a wider review of day services, which will take approximate 18 months to ensure full and proper engagement with elected members and community.

The Committee provided the following feedback:

- It would be helpful, as part of the review, to understand which part of all of the services offered in day care are having an impact. B Compton advised that work has started to look at day opportunities. There is still a relatively traditional model in NEL (predominantly centre based); this may be appropriate for some needs but part of the review is to look at what else is available, eg, a number of different agencies could support the need. The objective is not to close day centres but to fully explore what is currently offered and how else the need could be supported. Other areas have looked at a more diverse offering. NEL could broaden out the support to other voluntary sector organisations rather than focus on a centre-based model.
- The review would need to consider the carers of those receiving support. Centre based set provision assists in providing them with respite. B Compton agreed that this would form part of the full and comprehensive review.
- The definition of day services will form part of the review; some of the service is about enablement/ reablement. Training will also be required in order to help practitioners understand what is available in the local community and how to make the appropriate links and form relationships.
- The review needs to look at how people are being supported to make the right connections into the community. There is the potential to pay people directly (similar to Direct Payments). It was noted that a discussion would be required with families/carers in order that direct payment did not become another burden to manage.
- Will a needs analysis be included of the different spectrum of need? B Compton confirmed that this will be part of the work.

**The Committee agreed to extend the current contract to July 2022 (to include a 6 month termination clause) until the broader service review is completed.**

**8 National Procurement IS Framework**

A report was circulated for consideration. E McCabe provided a summary:

- St Hugh's, Spire and other private providers were commissioned nationally to delivery capacity and support at the start of the pandemic. National arrangements then moved to supporting the backlog of activity as a result of the first wave of the pandemic. IS arrangements will be continued to support the gap.
- A National IS Framework has been introduced to promote consistency and speed in maintaining capacity. CCGs and Trusts are expected to use the framework to deliver the capacity.
- There are implications for the CCG as the legal right to choose at referral and at 18 weeks is unchanged. The CCG has been trying to prioritise those patients who have been waiting longest on the joint waiting list. The issue of choice is being addressed by stating that Trusts can use the framework collaboratively; should Trusts be sub-contracting this in order to control the flow of patients and how that might operate? A question has been submitted to query whether it would stop a private provider from having patients coming in and operating activity through choice. The view is that Trusts should maximise out demand so that they do not need to have additional spaces for people coming in via different routes.
- Discussions are ongoing across the ICS partnerships and with other CFOs around the complications and implications.
- Previous discussions regarding refreshing the NOUS and pain management AQP framework have been superseded by the new framework. E McCabe has spoken to the NOUS and pain management providers and flagged that they need to be on the new framework. The review of the specifications will continue.
- St Hugh's are currently on a national contract. They have been advised that they need to get onto the framework and the CCG could either call off the framework or NLaG and HUTH could contract directly with St Hugh's and Spire to manage the wait time (this conversation has not yet taken place).
- The framework does not include a number of services, eg, MH, community etc, however this could be a way of managing procurements going forward and there might be extensions to the framework in time.
- A number of questions have been submitted to the NHSE Team nationally, eg, how will things work if providers are not on the framework, will the CCG have to commission under non contract activity etc? Regular updates will be provided to the Committee.

The Committee provided the following feedback:

- Proposal that the CCG becomes adept at helping local organisations to get onto the framework quickly and effectively.
- Simon Stevens recently delivered a very clear message that there can not be the pause in elective activity during a second wave of Covid that occurred during the first wave. The pause in activity resulted in inequalities and deterioration in health and outcomes due to delays. All capacity in the system needs to be utilised even if activities in acute Trusts are reduced due to managing a potentially prolonged second period. Julian Kelly and others advised that funding was set aside for the independent sector and the sector needs to be utilised to maximum capacity to ensure that there is as much activity flowing through as possible. If activity is being stepped down in local acute Trusts from an elective perspective, the IS would be able to take up that activity. There is also a potential for penalties to be applied to providers when their activity goes below the required 90% of

continued activity. It is in the system's interest to use the independent sector and maximise their capacity. The key will be to ensure that the right flow is getting through.

- St Hugh's lists are predominantly run by utilising NLaG consultants. A conversation is required with St Hugh's to establish how to get additional capacity in over and above the consultants from the acute provider to ensure their ability to deliver elective activity is not impacted by NLG staff needing to work to support a second covid surge.

**The Committee noted the update.**

**9 Future of NHS Acute Contracting across the Humber for 2021 onwards**

A report which will be submitted to the Humber Oversight Group was circulated for consideration. E McCabe provided a summary:

- Discussions have taken place with Sarah Lovell (Acute Collaborative Commissioning Lead), H Kenyon, Chief Finance Officers and other colleagues across the Humber around how CCGs are going to be commissioning services, particularly around acute Trusts, where the accountability will sit and what the role of place will be. Key points include:
    - Contracts will move away from tariff. The aim is to reflect the true cost within the system (wider than just the acute Trust).
    - The Humber Partnership Board is likely to become the responsible body for overseeing the contracts with acute trusts. The Strategic commissioning board, the Humberside oversight group and the HASR Exec group will be responsible for the at scale delivery governance.
- Acute Trusts will need to review their own internal arrangements as Vanguard trusts have done. They will require a Committee in common or similar to delegate some of their decision making to. The aim is to have something in place within the next year.
- CCGs are still accountable and are unable to waive statutory functions, but they are able to delegate responsibility for enacting their functions on their behalf.
- Discussions regarding place are ongoing, ie, place does have a role with the Humber Partnership Board; however further conversations are needed to agree where the governance should sit as there needs to be local accountability with PCNs etc. The aim is for the two acute Trusts to operate more collaboratively to deliver a more sustainable services and a more financially sustainable approach.

The Committee provided the following feedback:

- NEL is at the forefront of discussions around what needs to happen in the system going forward. The big question is around the collaboratives which are being discussed as part of the ICS architecture. There will still need to be a flow of funding through to these providers and they will need to be held accountable for delivering in partnership. Commissioners will still be responsible for the high-level outcomes in place.
- Concerns regarding the potential risk of putting the two contracts together as they currently are and getting locked into that contract. A piece of work is required to discuss what the responsibility of the acute trust should be in terms of the specialist care element versus what should be taken out of the contract around out of hospital and the place based system elements, eg, outpatients etc. The timing needs to link in with other system realignments in order to avoid being locked into a contract which could reduce the flexibility to achieve change at a local level (working with PCNs and others).
- What is the timetable for the new framework? H Kenyon advised that the ambition is to operate in shadow form for some of the arrangements from April 2021.
- Agreement that some services would need to be out of hospital and not built around the HASR framework, eg, dermatology, which is not commissioned from the acute trust. Other areas for

discussion would include ophthalmology and neurology. HASR workshops are taking place; it was proposed that clarity should be provided on those areas which need to be delivered locally and not form part of HASR. It was agreed that further work is required around this.

- Request to ensure that the paper reflects the fact that patients need to be at the centre of all of this, ie, will the changes be right for patients and their families? H Kenyon acknowledged the need for the reminder that these organisations exist to serve the population. NEL wants to start from PCNs/ Place to ensure that services are accessible to its population.
- Has an Equality Impact Assessment been carried out for this process? This would look at quality and how any changes/proposals would impact on patients, eg, in terms of access etc. it was requested that workshop attendees or others involved in this work query this.

**The Committee noted the update.**

**6 Telecare**

A report was circulated for consideration. Nic McVeigh provided a summary:

- In March 2020, the CCC agreed a 6-month extension to this contract. The Committee was asked to agree a contract variation to extend existing provision until 31st March 2023 with yearly reviews conducted until the end of the extension period.
- The rationale for the extension includes:
    - The current provider is fully compliant with all KPIs and is successfully embedded within the local health and care system.
    - The contract provides value for money following a desktop review
    - This is not an appropriate time to be directing resource into or asking providers to engage in a procurement process (Covid 19 pandemic and winter pressures). The tender would need to commence in January 2021, if we were working to the existing timeline.
    - A tender would be unlikely to attract a lot of interest at this time. Providers are unlikely to be looking to expand their portfolio in the current climate or would not meet the key requirements for the service, eg, the provider would need to work locally and be embedded in the system, however, national providers tend to operate call centres from central locations.
- Carelink recently worked with NELC to contact individuals who were shielding during lockdown. This was provided at no cost.

The Committee provided the following feedback:

- Concerns that a tender process would disrupt the workforce in Carelink. They are linked into many other providers in the voluntary sector and can tap into services should the need arise for their client groups.
- The Committee agreed that there would be no benefit to using CCG resources for a procurement at this time and in the current climate, where it can be demonstrated that the provider is delivering value for money, added value at no extra cost and is delivering against the contract requirements. Resources need to be prioritised accordingly.
- Is there anything that the CCG can do to support/strengthen Carelink? Do they have resilience? Could they lean on the voluntary sector? N McVeigh fed back concerns regarding their funds as they are a charity with no surplus money. The contract is very low value. N McVeigh has encouraged them to self-promote to increase the number of self-funders. It was agreed that it would be helpful to support them to be viable in the market with or without the CCG.

11am B Compton left the meeting

- There is a risk of challenge if the decision is taken to extend the contract; however, clear, defendable rationale has been provided to support the proposal to extend, ie, the Covid 19 pandemic and desktop exercise (the current service is providing best value and good outcomes, market testing and research has identified that there are other providers in the market; however they are not local and would not provide the required service within the financial envelope).
- Would all current terms and conditions continue until 31st March 2023 or would there be an uplift? N McVeigh advised that it would be the same T&C with a view that, if the service goes out to tender, a review of the model be undertaken. There is a separate piece of work around charging/ taking a client contribution towards the cost of Telecare to ensure that there are more people through the commissioned route and keep the eligibility thresholds low.
- Proposal for N McVeigh to have a conversation with the Board of Carelink to encourage more strategic thinking around the development of Carelink.

**Action: N McVeigh to ask to dial into a Board meeting as a guest.**
**Action: N McVeigh to work with B Compton to and council collegues to establish if Covid funding could be made available for Carelink for the work undertaken around shielding.**

11:06 J Haxby left the meeting.

**The Committee agreed to extend the Carelink contract (including the carers alert card and supporting people elements) for 18 months**.

**10 Brexit – any emerging implications**
There was nothing to bring to the Committee's attention.

**11 Residential Care Homes assurance process 2020**
This item was deferred to the November meeting.

**12 Items for Escalation from/to:**
- Clinical Governance Committee – there were no items for escalation.
- Governing Body – there were no items for escalation.

**13 Items for Virtual Decision/Chair's Action**
There have been no virtual decisions/chair's action since the last meeting.

**14 Any Other Business**
There were no items of any other business.

**15 ITEMS FOR INFORMATION**
a) Residential and Home Care Update
The report was noted.

Date and Time of Next Meeting:
Wednesday 11th November 9-11am, MS Teams