ITEM 2

North East Lincolnshire
Clinical Commissioning Group

CARE CONTRACTING COMMITTEE MEETING
NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
HELD ON WEDNESDAY 13TH MARCH 2019
AT 9:00AM
IN THE CROSLAND SUITE, GRIMSBY TOWN HALL, GRIMSBY

PRESENT:
Helen Kenyon, Chief Operating Officer (Chair)
Mark Webb, CCG Chair
Brett Brown, Contract Manager
Jan Haxby, Director of Quality and Nursing
Anne Hames, CCG Community Forum Representative
Bev Compton, Director of Adult Services
Christine Jackson, Head of Case Management Performance & Finance, focus
Julie Wilson, (attendee only)
Caroline Reed, PA to Executive Office (Notes)

APOLOGIES:
Laura Whitton, Chief Finance Officer
Eddie McCabe, Assistant Director of Contracting & Performance
Dr Wilson, GP representative
Cllr Hyldon-King, Portfolio Holder Health and Wellbeing (attendee only)

Item		ACTION
1.	**Apologies** Apologies were noted as above.	
2.	**Declarations of Interest** There were no declarations of interest identified.	
3.	**Notes of the Previous Meeting – 13.02.2019** These were agreed as an accurate record.	
4.	**Matters Arising from Previous Notes – 13.02.2019** Item 7.1 - Update on Procurements - NELCCG requires an online procurement tool for some procurements. This issue will be raised formally at the Union Board. This has not been escalated to the Union Board as it has not met at this stage. B Brown confirmed that Embed have now confirmed that the tool under development is due to be completed by 1st April. A procurement commenced on 8th March without the required tool; it was agreed that this will be highlighted to the Union Board. Item 7.2 - ICP Development – Navigo, Care Plus Group (CGP) and Core Care Links (CCL) Extension - E McCabe and Service leads are leading on the SDIPs. The quality team to send quality elements to E McCabe for inclusion in the contracts (work that is required immediately or elements that require work during the year). This action is ongoing. A Clarke to make contact with the Quality Team following the publication of the NHS contract. Item 7.5 - Ophthalmology procurement update - The CCG procurement policy to be amended to state that variation from a national tariff should	**H Kenyon** **B Brown**

	only be allowed by explicit permission of the CCC with the clear rationale behind the change being supported. The policy to be updated to reflect the system of checks and controls. H Kenyon confirmed that this action is ongoing. The updated policy will be circulated to the Committee. E McCabe to confirm if discussions have taken place with New Medica.	**E McCabe**
	Item 7.6 - Policy Change on Health Tariff Changes in Procurements - It is proposed that all procurement documentation should clearly state the pricing of the contract at national tariffs for health contracts unless specifically agreed by the CCC from evidence that a different approach is appropriate and justified and that any proposal without this clearly stated will not be agreed. The Committee cover sheet be amended. E McCabe to provide a form of words for the cover sheet.	**E McCabe**
	Item 7.7 - Virgin Care Contract - Clarification was sought of whether the high level specialist clinical supervision provided by Virgin Care to local skin cancer clinicians is included in the contract. It was agreed that P Bamgbala needs to liaise with colleagues in order to pull together a mini specification to be included as a contract variation. It was agreed that assurance is required from P Bamgbala that the mini specification has been built into the contract as a variation. B Brown to also seek assurance from the NLCCG contracts team. This will be added to the April agenda as a specific Matter Arising.	**P Bamgbala** **B Brown** **Forward plan**
	Item 10.2 - Primary Care Commissioning – M Webb requested a report for the next meeting detailing: What the CCG has procured/commissioned in primary care. Assurance that the procurement has been carried out to a robust standard. J Wilson advised that Item 9 on the agenda includes a table of enhanced services and details around the core contract. Procurement for core contracts has not taken place since the Ashwood surgery which is due for renewal in 2022. The GP contract is a life contract; most practices tend to merge with another practice rather than give back the contract. If the Committee does not feel that sufficient assurance has been provided, this can be picked up at the next meeting. **The Committee noted the update.**	
4.1	**Update on DBS Checks** This item was deferred to the April meeting.	**Forward plan**
5.	**Residential and Home Care Update**	
5.1	**Residential and Home Care Update** A report was circulated for consideration. B Brown provided a summary: • The Grove - has now been removed from MIFs and contract monitoring is ongoing. • Supported Living – Aspects Care – the TUPE process is ongoing. • Glyn Thomas House – ongoing monitoring is taking place.	

- Kensington – contracts visits highlighted a lack of documentation and staffing levels. A joint CQC contract monitoring visit is due to take place in the coming weeks.
- Longhurst & Havelock Homes Limited have indicated that they are planning to sell Cranwell Court (52 residential beds and 17 enhanced dementia care beds) to a like-minded provider who would continue to provide the service. *Post meeting note: this information is now in the public domain.*

Domiciliary Care.

- A meeting was held with providers on 12th March to discuss discharge and capacity issues. A potential solution was identified for improving discharge, ie, carers to make one or two daily calls to the individual during their hospital stay in order to maintain mobility and potentially reduce length of stay. A new package would not need to be sourced as the existing package would be maintained (the principal delay links to arranging new packages). Further discussions would be required regarding governance arrangements etc. The proposal is supported by the discharge team. The aim is to trial the service in one or two wards initially.

The Committee provided the following feedback:

- Proposal to improve discharge:
  - The Committee supported the proposal but emphasised the need to formalise the arrangements, eg, governance, policies and procedures, liabilities, car parking etc.
  - Importance of ensuring that domiciliary care workers would only provide agreed services and should not be counted in the hospital staffing numbers.
  - The work underway regarding the ICP and the development of primary care networks could link into this, eg, policies, multi-disciplinary teams within federations/networks etc.
  - Would individuals who are admitted to hospital without a package be given a package prior to discharge? B Brown confirmed that this would be the intention even if it was only required for a short period.
  - This could help to encourage care workers to feel more like a part of the system.
  - Consideration would need to be given to ensure that carers would be consistent and identified.
  - Importance of demonstrating the added value that this service would provide, eg, improved discharge, reduced length of stay, wellbeing of the patient.
  - Proposal to nominate this for an award if it proved successful.

- Cranwell court – discussion regarding the possibility of the building being utilised for intermediate care facilities. It was agreed that discussions are required outside of this meeting. **H Kenyon**

The Committee noted the update.

5.2 **2 Carer Call Update**

B Brown provided a verbal update:

- The launch will take place in July with training sessions for OTs, carers etc to follow in August and November. The key message will be that not all two carer calls will change to single carer calls; the estimated figure is approximately 40%.
- A review of equipment will take place; it may be necessary to ring-fence equipment. The principal aim is to use the existing equipment better.

The Committee provided the following feedback:

- What is the feedback from carers regarding the change, eg, those who have historically travelled and worked in pairs? B Brown advised that NLCCG haven't provided any negative feedback from their carers following the change but will ensure that all parties have been considered and engaged with/listened to as part of the process. It was agreed that feedback will be included in the evaluations. **B Brown**

The Committee noted the update.

5.3 **Cost of Care Update**

(NB: this item was taken at the end of the agenda (11:15am)

A report was circulated for consideration. B Compton provided an update:

- Work has been ongoing with the residential care standing committee to develop the methodology and approach to residential care fee setting. A data collection tool was created and sent to residential care providers for completion with the clear message that a representative sample of data was required to make the exercise a success. 18 residential care homes responded; raising concerns that this is not reflective of homes in the locality.
- A high level analysis of the set of data will be carried out in order to establish what proportion of the rate is housing, heating etc. It was noted that one home is paying as little as £13 per resident per week for food.
- This might be due to coding; however it would helpful to have additional information. The analysis of the data set will help to inform the new model.
- Three options are being considered in order to take the fee setting work forward:
  - To base the "cost of care" and revised fee level on data received from an unrepresentative sample of returns.
  - To extend the deadline for completion of further returns in the hope that a representative sample is received.
  - To conclude this process and instigate an alternative method of establishing the cost of care, eg, by undertaking a full competitive tendering exercise.

The Committee provided the following feedback:

- Concerns that a full competitive tendering exercise would be a large undertaking and very disruptive to the system.
- The rebut to legal challenge could be the lack of sufficient data received.
- Is sufficient feedback collated from residents and their families regarding the care received? B Compton confirmed that this is done to a limited extent and data is collected from the portal and complaints but that more work is required on this.
- Proposal that the standing committee be asked to encourage smaller providers to complete the data template.

The Committee agreed:

- **To extend the deadline for completion of further returns in the hope that we get a representative sample.**

6. Contracting and Procurement

6.1 **Update on the Contracting Positon for the Year**

H Kenyon and J Haxby provided a verbal update:

- NLaG – there has been a significant overtrade in the current year (this is also the case for St Hugh's, Hull, Spire and Virgin). The over performance is predominantly due to an increase in non-elective care; which has not been offset by a reduction in capacity for elective care over the winter period. A year end position has not yet been agreed.

9:53am – B Compton joined the meeting.

- Navigo and Care Plus Group – performance has been good overall and there are no significant concerns raised from a contractual perspective.

- Quality
  - Yarborough Clee Care (YCC) – the Quality team is working with YCC around quality and clinical governance, eg support around the process for reporting Serious Incidents (SIs). YCC have not historically reported Grade 3 and 4 pressure sores.
  - St Hugh's – following a CQC visit during w/c 4th March highlighting significant concerns regarding radiology, St Hugh's agreed to voluntarily close radiology. St Hugh's reviewed their governance arrangements and addressed a number of the issues highlighted by the CQC. The CQC were satisfied that St Hugh's were safe to continue with the delivery of radiology; therefore the department has reopened. St Hugh's were tasked with improving their relationship with NLaG where they share staff. It was noted that it would be helpful to share the learning with other CCGs/providers. J Haxby has contacted Shaun Stacey in order to establish if the lost week of activity will impact on the ability to meet the 52 week wait target.

- Bradley woodlands – the CCG has been asked by NHSE to take on the role of quality oversight on behalf of all commissioners. A process is being developed to gather and share quality information. A positive meeting was held with the Manager and a Quality Risk profile (QRP) undertaken. The QRP scored 10 which is a medium risk. There are 8 incidents remaining out of the original 19; action plans are in place and the CCG is working closely with focus. It was agreed that Mark Wilson from focus and Clair Brookes will be invited to future meetings.

The Committee noted the update.

6.2 **Feedback on the Risk of Contracts and Key Issues - NLaG**

H Kenyon provided a verbal update:

- There will be a significant increase in the anticipated contract value for NLaG in 2019/20; which causes a pressure in the system. This is driven by activity and coding changes.
- NLaG have been doing a lot of work around accurately recording/coding which drives up cost. They have a 6 month period to demonstrate that they have completed the required work around coding and need to apply the cost in 2019/20. This adds approximately £2m onto the contract value. Improved efficiencies are being sought elsewhere via demand management.
- Productive conversations are ongoing with NLaG and relationships have improved; however it is noted that a number officers are in interim posts. Work is underway to try and recruit externally to current vacancies.
- The assumption was made that there will be no 52 week waiters; although the St Hugh's issue may now impact on that. In the 2019/20 contract the commissioner and provider will be fined for every 52 week waiter after April. It was agreed to set a maximum wait of 40 weeks for 2019/20 with the aim of reaching an aspirational figure of 26 weeks. Improvements in scheduling could result in the 40 week wait without significant additional activity.
- A marginal improvement in A&E activity is anticipated due to the Urgent Treatment Centre.
- A meeting took place on 8th March with NHSI and NHSE in attendance; it was agreed that arbitration would not be required.

Quality

- IT systems - there are concerns regarding NLaG's IT systems and the impact that this has on patients, eg, delayed treatment due to letters being lost in the system. Work is underway to identify and address the issues.
- Unexpected mortality – there has been a reduction in NEL (but not in NL); a lot of work is being done to look at this issue.
- Clinical harm – clinical harm reviews are ongoing. More work is required around people waiting longer than 6 months.

- Vacancy rates – are down to 8% with more doctors and nurses in the system. There are concerns regarding the retention of these staff.
- SI and incident oversight now sits under the Medical Director and complaints under the Chief Nurse. Improved learning is anticipated as a result.

The Committee provided the following feedback:

- A concern was raised re the transfer f personal information between providers, which resulted in individuals having to provide the same information to the various agencies involved at each point in the pathway, eg, from rapid response to ambulance and patients waiting days in hospital for tests. It was noted that these issues need to be addressed as part of the ongoing and systematic improvement programme.
- Concerns that there is little sign of improvement at NLaG despite considerable work at the front end of the hospital etc. An improvement around admissions and discharge would be expected. Why is the CCG continuing to accept the continuing overspend without trying to understand the impact of the work that has been carried out in recent years? Is NLaG demonstrating that they are making themselves as efficient and cost effective as possible? H Kenyon advised that whilst cost reductions may not have been realised, there has been work ongoing to understand the cost drivers and how to reduce spend going forward. The waiting list position has improved in NEL despite having increased in other areas. It was noted that further work is required around rapid response, support to care homes, hospital without walls, enablement etc, in order to improve patient movement in the system. Any capacity that is currently being freed up is being used to address backlogs. Some of the improvements planned for the coming year for example day case to outpatients will result in cost reductions for the CCG.
- It would be helpful to receive details of the ongoing improvement plan and how long it is going to take, in order that forecasts for future years can be made. **Forward plan**
- A formal report to be submitted to the Committee on a routine basis.

The Committee noted the update.

6.3 **EMAS Update**

H Kenyon provided a verbal update:

- There is currently a £21m gap between commissioners and EMAS for the 2019/20 contract. A call is due to take place at 2pm today in order to attempt to avoid arbitration. Additional monies were put into the contract in 2018/19 in order to improve performance; however the required improvements have not been realised.
- NEL has been working more closely with NLCCG to oversee quality. Sue Cousland, EMAS is working with both commissioners and is looking at systems, staffing, rotas etc.

The Committee noted the update.

6.4 **TASL Update**

A report was circulated for consideration. J Cunningham and S Hudson provided an update:

- Since the start of the contract in NEL, TASL has struggled to deliver against the KPI targets within the contract.
- NLCCG gave notice in 2018 and has a new provider in place from 6th March 2019 and Hull CCGs served 12 months' notice on 4th March. Other CCG's covering Lincolnshire, Nottinghamshire and Leicestershire are reviewing their positions in light of continued performance and CQC issues. This may present a risk to the financial viability of the provider.
- There is little evidence of a sustained improvement in performance and a recent CQC inspection returned a rating of Inadequate. NELCCG's quality team also undertook an inspection; there were no real concerns on the Grimsby site, however issues regarding mandatory staff training were identified.
- There is a risk to the CCG's reputation if they continue to accept TASL performance.
- TASL have consistently failed to provide reliable performance information, eg, incorrect format or inaccurate information. Meetings have been arranged to address these issues; however these have been cancelled by TASL.
- NELCCG is currently spot commissioning additional services from two other providers to pick up urgent activity. Some of this activity relates to Lincolnshire patients using NLaG services. This is at significant cost to the CCG.
- There are 3 options regarding managing the contract going forward:
  - Option 1 - Termination of contract with 12 months' notice. This would require a procurement exercise and would present a financial risk. Other local procurements have received a limited number of affordable bids.
  - Option 2 - Seek agreement to release contracts for Same Day and Renal lot by agreement from TASL, still giving 12 months' notice but working with current provider. TASL would be expected to work to a robust performance action plan on the remaining planned PTS lot. This could be underpinned by a contract performance notice. The risk would be a lack of improvement from TASL on the planned activity and the potential for the provider to become unstable as other contracts are served notice. If the contract continued, the CCG could begin work to scope alternatives including working with NELC whilst the performance notice was in place.
- Option 3 – Do nothing. The CCG could continue to work with TASL to provide quality support, understand data and performance improvement and support development of robust policies and procedures. This option also carries the risk of provider failure.

The Committee provided the following feedback:

- Is there an option to commission jointly with other CCGs? This could be an option, but not with NL who have just completed their procurement & would be the most logical partner given our patient flows.
- Option 2 – concerns that TASL would not want to continue locally or nationally with such a reduced level of activity. J Cunningham advised that there is no indication that they would remove themselves from local or UK operations.
- If there is a risk of provider failure, the CCG should work will smaller providers to work up their contract.
- A key priority for the Union over the coming year is transport. It will be important to put adequate time and resource into this in order to identify solutions. It was acknowledged that considerable work has been undertaken in the past regarding transport and that it is very complex and logistically challenging. The Committee agreed that working with NELC is key, eg, review the frequency of eligibility checks, establish what transport is utilised for children with high end needs etc
- Is there any feedback regarding NLCCG's new provider? It was noted that early indications are good; however the provider have notified commissioners that they will not take on another contract from TASL.
- The Committee agreed that Option 2 was the preferred option but raised concerns regarding the CCG's reputation. It was agreed that the CCG will need to be clear that there is not an alternative affordable provider in the local area to provide the planned activity and that the CCG will work closely with TASL to improve performance and quality and will also begin work to scope alternatives including working with NELC.
- A report to be submitted to the next meeting detailing the formal improvement notice and articulating why the CCG has chosen Option 2 in case of a challenge from NHSE.

Forward plan

The Committee agreed to support Option 2.

6.5 **NOUS Contract Extension**

A report was circulated for consideration.

The Committee agreed:

- **To extend the NOUS contract for the three remaining providers NLAG, 360 care and Mediscan.**

As the CCG is extending to all incumbents and the market is already demonstrably covered evidence by withdrawal of two other providers since 2016 the CCG is acting within its procurement rules and is giving equity of treatment.

6.6 **Tier 3 Weight Management Service**

This item was deferred.

7. Extended Access Update

This item was deferred.

8. **Primary Care Strategy and Capacity**
This item was deferred.

9. **Primary Care Enhanced Services – Commissioning Approach**
This item was deferred.

10. **Items for Escalation from/to:**

- **DAC**
- **Clinical Governance Committee**

This item was deferred.

11. **Virtual agreements/ Chair's action**

- **ASC fee uplifts**

This item was deferred.

12. **Any Other Business**
There were no items of AOB.

Date and Time of Next Meeting:

Additional meeting – Wednesday 20th March, 9-11am, Banqueting Room, Grimsby Town Hall

Wednesday 10th April, 9-11am, Lounge Bar, Grimsby Town Hall