ITEM 2

North East Lincolnshire
Clinical Commissioning Group

CARE CONTRACTING COMMITTEE MEETING
NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
HELD ON WEDNESDAY 8TH MAY 2019
AT 12PM
IN THE COUNCIL CHAMBER, GRIMSBY TOWN HALL, GRIMSBY

PRESENT: Helen Kenyon, Chief Operating Officer (Chair)
Mark Webb, CCG Chair
Jan Haxby, Director of Quality and Nursing
Laura Whitton, Chief Finance Officer
Eddie McCabe, Assistant Director of Contracting & Performance
Anne Hames, CCG Community Forum Representative
Brett Brown, Contract Manager
Caroline Reed, PA to Executive Office (Notes)

APOLOGIES: Dr Wilson, GP Representative
Christine Jackson, Head of Case Management Performance & Finance, focus
Bev Compton, Director of Adult Services

IN ATTENDANCE: Julie Wilson, Assistant Director Programme Delivery & Primary Care
John Mitchell, Associate Director of IT (Item 6)
Jill Cunningham, Service Manager (Item 11)

Item		ACTION
1.	**Apologies**	
	Apologies were noted as above.	
2.	**Declarations of Interest**	
	There were no declarations of interest identified.	
3.	**Notes of Previous Meeting – 10.04.2019**	
	The notes of the previous meeting were agreed as an accurate record.	
4.	**Matters Arising from Previous Notes - 10.04.2019**	
	The Committee discussed the outstanding actions: 13th March meeting Item 5.2 - 2 Carer Call Update – B Brown confirmed that carers will be consulted on the changes and their feedback sought. The provider in NL has received positive feedback from carers. The launch date will be in July and training to be booked in October/November. 20th March meeting Item 4 - Extended Access Update - Federations to be asked to provide assurance that they will continue to deliver the service in the interim period. J Wilson confirmed that the service is continuing and practices have until the end of May 2019 to confirm sign up to the extended interim service. *9:10am E McCabe joined the meeting.*	

	10th April meeting Item 4.3 - Update on DBS Checks – B Brown advised that recent feedback indicates that the situation has improved with some home care providers getting the DBS checks back within days. Item 4.4 - Assurance regarding Virgin Care Contract – a formal update on the revised service specification/amendment to contract regarding the training requirements to be submitted to the next meeting. Item 4.5 - Update on Online Procurement Tool – B Brown confirmed that the tool has been completed and will be used for the ophthalmology procurement. Testing has been carried out. Item 11.1 – DAC - It was agreed that DAC would be asked: How the CCG is assessing its performance against CHC requirements. To focus on the issues with the ambulance contracts. L Whitton confirmed that this will be picked up at the next DAC meeting.	**Forward plan** **L Whitton**
	FOR DECISION	
5.	**Navigo Complex Care Unit Update**	
	This item was deferred to the June meeting.	**Forward plan**
6.	**GP IT procurement**	
	A report was circulated for consideration. J Wilson and J Mitchell provided a summary: • Following CCC approval in December 2018 to proceed with a procurement of GPIT services, the Committee was asked to approve the process and timeline and to approve in principle the service specification, which will be discussed at the Clinical Leads meeting on 16th May. • The service specification has been developed with the involvement of practice representatives and the LMC. There are outstanding queries, eg, PC supporting services (dentists etc) which NHSE requested be included in the specification. The potential impact of this is being worked through. NHSE has indicated that the CCG may be able to recharge for this. • The current provider contract expires on 31 March 2020. **The Committee agreed:** • **To approve the procurement process and timeline** • **To approve in principle the Primary Care IT Support Service Specification, subject to views from the CCG Clinical Leads on 16th May 2019. The specification would only need to come back to the Committee if Clinical leads request material changes (this is not anticipated due to the engagement with primary care and the LMC).**	
	New Clinical and Corporate Network provision	
	A report was circulated for consideration. J Mitchell provided a summary:	

	• The current network infrastructure (the N3 Network) needs to be replaced as a matter of urgency due to issues regarding speed and cost. • NHSE has now delegated responsibility for provision of the new networks to CCGs and will provide a contribution to each CCG towards the cost. • Since July 2018 the Humber CCGs have attempted to procure the new network via NHS Digital's preferred Y&H PSN framework; however this framework proved to be unsuccessful in providing a valid quote and NHS Digital are now supporting the CCGs to move to the alternative Crown Commercial Services framework (14 approved providers) in order to facilitate a rapid procurement/deployment. • Due to tight timescales, procurement will commence on 9th May with the authorisation and confirmation of the contract award by August 2019 and completion of deployment by 30th November 2019. Failure to meet the deadlines would jeopardise funding. The Committee will be asked to approve the preferred provider and price prior to awarding the contract. • NEL will be the nominated lead for the procurement. The Committee provided the following feedback: • Where was the service specification signed off? J Mitchell advised that this was historically commissioned by NHSE. • What is the financial risk if the funding does not cover the cost of the new system? J Mitchell confirmed that pricing information has not been available but that conversations indicate that this should not be a significant issue for NEL. • Is NELCCG named on the framework? J Mitchell confirmed that NEL is named on the framework. • An update to be submitted to the Committee in July. **The Committee agreed to approve the procurement**.	**Forward plan**
7.	**Alliance Agreement**	
	A report was circulated for consideration. L Whitton provided an update on the Alliance agreement position, including the risk and reward model, the service specifications and the assurance process to ensure that the Alliance is fit for purpose for integrated urgent care (IUC) provision: • There is a risk linked to the development of the PCNs. The 3 GP federations were previously signed up to the Alliance, however the development of PCNs has resulted in only one committing at this stage (it will retain its federation footprint as a PCN). It was noted that practices were advised by the LMC not to commit to the Alliance until the PCNs have been agreed and worked through. This will need to be closely monitored. The new timescales for finalisation of the Alliance (by 30th June 2019) means that a successful Alliance can still be delivered. • The Alliance agreement equates to a total budget across all partners of c£27m (this will need to be refreshed to 2019/20 prices). The element of each partner's contribution to the Alliance will be within their existing contract with the CCG, eg, a provider with a £20m	

	contract with the CCG will have an addendum to their contract detailing that £2m relates to the Alliance. • Existing payment mechanisms (PBR, Block) will continue to be used for Alliance members but in addition there will be a "new reward" target (separate to CQUINS) which will be designed to encourage the Alliance members to work together and achieve common outcomes. It is proposed that there will be no more than 5 or 6 outcomes. These are being developed with all Alliance members. Formal sign off will be sought at the next Alliance Board meeting. • £500k non-recurrent funding has been set aside by the CCG to support transformational change, with the expectation that Alliance partners would contribute to the costs of any transformational change along with the CCG. A business case would need to be agreed by the Alliance Board prior to any funding being released. This "non-recurrent" funding would be repayable on achievement of the "reward" outcomes. It was proposed that partners be advised that there is money available (without detailing the amount) and that the business case needs to have an intervention, ie, partners will need to put in a share, for example 30/40% is fairly typical in industry. • Reward funding will be recurrent. It should be noted that there is no recurrent funding set aside to cover the "reward", this funding would be generated via the release of savings / cost reductions linked to the "reward" outcomes. • The "reward" money would need to be used to continue to sustain services. The Alliance would be responsible for deciding how to divide up any surplus from the "reward" money after the cost of continuing any services put in place had been covered. • The ICP submitted their quarterly assurance document at the end of March 2019; it specifically picked up on the key points that were fed back by the CCG following the first submission at the end of December and provides additional assurance regarding those areas. Partners will be asked to update the entire document and to ensure that any changes are captured. There were no significant issues highlighted as a result of the document. • A meeting is taking place on 10th May to finalise the IUC specification. There will be more opportunity to do further work on the other 2 specifications. Once finalised, the specifications will be included in all contracts. The Committee provided the following feedback: • Further conversations will be required if some PCNs chose not to be part of the Alliance. A report to be submitted to the next meeting. • Is there an expectation regarding the amount of activity linked to the Alliance agreement? L Whitton confirmed there will be clear activity based outcomes linked to the contract, eg, reducing length of stay admissions. • Who is responsible if one member of the Alliance fails to deliver? It was confirmed that this would be a joint responsibility across the Alliance. If a provider was struggling to deliver, the Alliance could agree as a collective to deliver in a different way, eg, via another partner. Funding would need to flow differently and a contract variation	**Forward plan**

	could be enacted. If all partners were not able to agree, there would need to be a notice period. If another partner was not able to pick up a service, the Alliance could source another provider or pass back to the CCG for procurement. If a provider continuously failed, they would be held to account via contract performance monitoring. • Outcomes and expectations need to be very clearly outlined in specifications. • It was proposed that a record be kept on how the "reward" money is being spent. It is important to keep track of sustainability. • Is the "reward" money specifically related to transformational change around IUC? L Whitton confirmed that focus in year one will be on IUC. Partners would need to demonstrate that what they are proposing to use the money for would contribute to an improvement in IUC in its broadest sense, eg, end of life care to help the overall management of the system. After the first year, if successful the model could be used to support the development of other areas. • Who is responsible for monitoring the Alliance? It was confirmed that the CCG is a member and will be monitoring the Alliance. **The Committee agreed:** • **To note the position with regard to the Alliance Agreement and the assurance received** • **To support the proposed approach with regard to the risk and reward model, subject to the comments made during the discussion being addressed**.	
8.	**Extra Care Housing Update**	
	A report was circulated for consideration. H Kenyon provided a summary: • The CCG has previously been in a joint venture agreement with Ashley House to develop 300 extra care housing placements, over a 3 year period. Due to delays not attributable to Ashley House, the 300 units have not yet been fully delivered so this paper is asking the CCC to approve the continuation of the joint venture agreement with Morgan Ashley until the 300 extra care housing placements have been created. The Committee provided the following feedback: • Concerns regarding the reference to a "verbal agreement". • The original agreement was with Ashley House. Legal advice to be sought to establish whether a formal agreement can be entered into with Morgan Ashley and whether any risks have been appropriately addressed. **The Committee noted the report.**	**L Whitton**
9.	**EQIA Process for NELCCG**	
	A report was circulated for consideration. J Haxby provided a summary: • The Humber Joint Commissioning Committee (4 Humber CCG's) are working together to support a single approach to assessing the impact of commissioning decisions or service change, where more than one CCG is involved or affected.	

	• The 4 CCGs have jointly developed an Integrated Impact Assessment (IAA) tool and policy, which assesses the impact of a proposed commissioning decision. The tool is designed to be applied proportionately, depending upon the size and scale of the proposed commissioning decision. • The tool and policy are out for consultation and will be agreed at the next JCC meeting on 10th May. • The NEL CCG Senior Leadership team have reviewed the tool and the policy and have proposed that the tool be adopted for NELCCG/ potentially Union stand-alone commissioning. **The Committee agreed:** • **To approve the use of the tool and policy in joint commissioning decisions,** • **To support the decision for NEL CCG to adopt the tool for single CCG (potentially Union) commissioner decisions as well, pending a local policy reflecting the local process.**	
	FOR DISCUSSION	
10.	**Contracts Update**	
	A report was circulated for consideration. E McCabe and L Whitton provided a summary: • EMAS – discussions are going; however there is still no decision on the contract with no expected end date. The regulator is involved and it is likely that CCGs will have to pay the increase despite not receiving a guarantee of delivery. *13:58 – J Haxby left the meeting* • NLaG – an agreed contract is in place; however as NLaG has not secured sufficient income against all of its contracts to cover its costs the Board took a decision not to sign off against its control total as this would have left them with a gap of £13m after income central support funding and cost improvement programmes had been delivered. As a result, they would not have given access to the to central funding that would have been made available to them further worsening their financial position. Following a system (NLG, NELCCG & NLCCG) meeting with the regulator, NHSIE, an additional £10m has been offered to the system to close the financial gap on the understanding that the local system will identify £2m, the raining £1m is resolved due to reduced interest payments. System wide conversations have taken place to agree ways to plug the £2m gap, work better as a system and do things more efficiently. Areas identified include prescribing (high cost drugs) and wound care. Initial transformational plans have been built into the contract. A formal response will be submitted back to the system today (8/5/19). There is agreement across the system that robust monitoring of schemes, governance and timescales are required. Processes will be put in place to address any slippage and mitigate the impact. • Navigo – an agreement has now been reached.	

	The Committee provided the following feedback: • Concerns regarding the additional £2m funding and the impact on savings already identified. It was noted that this funding is provided across the whole system (NLaG and the 3 CCGs). All parties will work collectively to agree how it will be transacted through the system. Delivery will be monitored through the CCGs and NLGS now established performance and assurance processes. QIPP savings will still need to be delivered. L Whitton to share the presentation that was given to NHSI to provide assurance to the committee re the funding and processes in place to manage the system. • It would be helpful to have a better system wide understanding of internal saving schemes, eg, NLaG's cost improvement programme (CIP). NLaG to be asked to share a copy of their CIP. **The Committee noted the update.**	**L Whitton** **L Whitton**
11.	**TASL Update**	
	A report was circulated for consideration. Jill Cunningham provided an update: • The Committee agreed in March to support 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. This was relayed to TASL who indicated that they intended to retain all 3 elements of their contract. A letter was sent outlining the CCG's concerns (non-delivery of performance target etc) and a meeting was scheduled to discuss this formally. The meeting was cancelled due to a CQC visit and is scheduled for w/c 13th May. Notice has not been served at this stage. • A significant area of concern is the same day service out of DPOW for Lincolnshire patients. H Kenyon will meet with the new Joint Lincolnshire CEO to discuss a number of issues regarding these cross border issues. • An evaluation will be carried out on the renal element of the service in order to look at best cost effective options. • The CCG is in close contact with other commissioners and NHSE in the East Midlands who still want to work with TASL to ensure services are maintained. • Discussions to take place with NELC regarding transport to discuss other potential options. An update to be brought to a future meeting. The Committee provided the following feedback: • Feedback from the Quality team indicates that things have deteriorated in terms of compliance, eg, mandatory training. • Proposal for the contract to include a responsibility for the provider to understand patient discharge/hospital flow, eg, coordinator to identify patients who are due to be discharged and will require transport. • The CCG needs to be proactive in market making if 12 months' notice is served, ie, supporting other providers to scale up and work as part of a consortium. It was noted that the direction of travel is to move away from a one provider model and look at an AQP/consortium	**Forward plan July**

	approach. It was proposed that some funding could be utilised to recruit a coordinator to facilitate the flow. • Discussions with NELC to include voluntary car schemes and services that are less NHS/clinically focused. It was noted that a large percentage of journeys do not require ambulance provision. • Proposal to explore the potential to utilise a personal health budget for renal patient transport **The Committee agreed:** • **To formally serve notice to TASL if they are not prepared to discontinue the Same Day and Renal lots.** • **Updated letter to be provided to TASL with the revised date.**	
12.	**Primary Care Network**	
	J Wilson provided a verbal update: • GPs are currently having discussions in order to agree who they would want to work with within a PCN. Guidance has been provided in a number of documents including the GP contract 5 year deal and contract network DES. • The deadline for registering PCNs is 15th May with an anticipated go live date of 1st July. • Confirmation has been received from Freshney Pelham that they are retaining the same federation footprint. • PCNs' population size must be between 30-50000 and must cover all areas. The guidance proposes a single geographical area for a PCN; however different teams will be working across the same areas in NEL due to patients not necessarily being registered at their nearest practice. • There has not been a lot of engagement with the CCG from practices and a reminder email was sent on 7th May. • There are concerns regarding Panacea if it forms 3 PCNs which would all be close to the 30000 minimum population. If one practice were to leave, this would cause significant issues. A conversation will be required at PCCC. The Committee provided the following feedback: • What would happen if a PCN population fell below 30000? J Wilson confirmed that further guidance is required but that patient services would need to be delivered by another PCN. • If one primary care centre is covered by two different PCNs, concerns were raised regarding potential inequalities for patients. J Wilson confirmed that every PCN is required to address the inequalities in their population but noted that there is the potential for a difference in patient experience in this scenario. **The Committee noted the update.**	
	FOR INFORMATION	
13.	**Residential and Home Care Update**	
	A report was circulated for information. B Brown provided an update:	

	• Carisbrook care home has indicated that it is closing due to financial difficulties. Profiling has commenced on the 9 residents with Learning Disabilities. 3 options were identified by MIFS: 1/ a potential buyer could purchase the care home, however it is unsure that they would keep the service running. 2/ relocate all residents together. A potential unit has been identified for this (this is the preferred option). 3/ relocate residents individually. • The Committee were asked to approve the MIFS group to make this decision following profiling and best interest decisions. The Committee provided the following feedback: • The new provider to be advised that the CCG would want to Tupe as many of the staff as possible. **The Committee agreed to support the request for the MIFS group to make a decision based on the best interest of the residents.**	**B Brown**
14.	**Quarterly Update from Sub Committee - MIFS**	
	A report was circulated for information.	
15.	**Annual Schedule of All Contracts**	
	A report was circulated for information.	
16.	**Quarterly Low Value Procurement Update**	
	A report was circulated for information.	
17.	**Tier 3 Weight Management Service Update**	
	An update report was circulated for information. The Committee provided the following feedback: • Further information would be helpful regarding cost savings across the wider system, eg, reduced GP time, reduction in prescribed drugs etc. • What is the impact of the Tier 3 service in terms of cost and patient outcomes? Is it working as a preventative for Tier 4 surgery? Why are patients dropping out of the service? • National benchmarking information to be sought. It was noted that Hull are very interested in working with the new provider to understand pathways etc. • Further conversations to take place with Tier 2 provision, ie, Public health, social prescribing etc) **The Committee noted the update and requested a further update in the Autumn.**	**Forward plan October**
18.	**Items for Escalation from/to:** • **DAC** • **Clinical Governance Committee**	
	There were no items for escalation.	
19.	**Items for Virtual Decision/Chair's Action** • IFR & Prior Approval policies – approved	

	• Ophthalmology – approved	
20.	**Any Other Business**	
	There were no items raised.	
	Date and Time of Next Meeting: **Wednesday 12th June** **9-11am** **Lounge Bar, Grimsby Town Hall**	