NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
CARE CONTRACTING COMMITTEE
ACTION NOTES OF THE MEETING HELD ON 11/05/2022 AT 9AM

MEMBERS PRESENT:
Helen Kenyon, Chief Operating Officer (Chair)
Christine Jackson, Head of Case Management Performance & Finance, focus
Laura Whitton, Chief Finance Officer
Mark Webb, Lay Member (Governing Body)
Bev Compton, Director of Adult Services

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)

APOLOGIES
Dr Ekta Elston, Medical Director
Dr Jeeten Raghwani, GP Rep
Jan Haxby, Director of Quality and Nursing

1 APOLOGIES RECEIVED
Apologies were received as noted above.

2 DECLARATIONS OF INTEREST
There were no declarations of interest made from Committee members.

3 APPROVAL OF PREVIOUS MINUTES
The minutes of the meeting held on 13th April were agreed as an accurate record.

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

4 ACTION TRACKER
The action tracker was reviewed.

Matters Arising (9th February meeting) Item 7.7 GP Out of Hours Update
Proposal to look at what capacity is within primary care for nurse practitioners to see patients, prescribe, diagnose etc. J Wilson advised that ANPs are already widely used both in core general practice and CCL; she will follow up with E Elston to check whether there are any other opportunities and provide an update to the Committee.

There was no update available from J Wilson. E McCabe confirmed that a contract variation has been completed to extend the CCL contract to 30th September 2023.

Item 7.1 Utilisation of Covid Related Funding. It would be useful to understand how many additional staff were recruited as part of the recruitment drives. R Brunton to share information on how many staff were recruited and how many were lost.

B Compton confirmed that it is difficult to monitor the impact of the recruitment drives due to a constantly changing position; however, providers have fed back that low numbers of additional staff were recruited directly as a result of the drives. The worst position for NEL was domiciliary care staff down by 20%. Providers have recently fed back that the situation is starting to improve; however, there will be a long journey of recovery ahead. A lot of work has been undertaken to address the workforce issue, eg, refreshed advertisements in job centres, utilisation of funding to buy advertising materials (banners, vehicle adverts, videos), a workforce survey and a planned provider event.

It was acknowledged that workforce is a wider system issue and is mirrored across the ICS. An ICS workforce strategy is being produced looking at the short, medium and long term with ambitions of reaching into communities around education and career pathways etc.
The HCP has identified workforce as a priority area for this year. It will be important to ensure that the workforce plan is stitching into ASC from a focus and service perspective.

Item 7.1. A conversation to take place outside of the meeting to discuss the potential extension of the funding for the additional nurse in the IPC team currently funded by NELCCG and Public Health.
L Whitton confirmed that the funding was approved as the role was viewed as critical.

5 Items approved virtually since the previous meeting

There have been no items approved virtually since the previous meeting.

6. ITEMS FOR ASSURANCE

There were no items for assurance.

7. Items for discussion/decision

7.1 True Cost of Covid for Health and Social Care

L Whitton shared a presentation to demonstrate where the money was allocated:

- Hospital discharge (£2.6m in 2021, £3.7m in 2022).
- Workforce costs across CPG, Navigo and the CCG; this included additional shifts for staff, getting staff ready to be able to work.
- Primary care (£517k in 2021, £449k in 2022)

The main funding received was the Covid expansion fund, which was passed to primary care to enable them to work in a different way and put specific measures in place, eg, PPE.
Other funding was also passed to providers around after care and support, enhanced PTS, segregation of patient pathway.

Substantial additional funding went directly to NHS providers. A lot of the funding has now reduced significantly, and work is taking place as part of planning to understand which costs need to continue as part of the new ways of working regardless of funding and what things can stop. The significant pressure seen at the start of planning linked to IPC and social distancing rules etc has reduced due to a move back towards pre-pandemic arrangements.

There are continued costs that link to the transformational way of working, eg, more remote working; however, this has replaced the need to invest in future years to get new ways of working embedded into the system.

The Committee provided the following feedback:

- It needs to be clear that those things which improved the system as part of the changes made during the pandemic (transformational change) will not be stopped, eg, revised processes and systems for discharge. It was confirmed that the additional funding for discharge has ceased; however, a proposal of £1m of funding has been made to the ICS/B. This would focus on 3 areas: maintaining the additional Hales team, Red Cross additional funding and 20 spot bed purchases. Conversations are also taking place with CPG and NLaG on how best to utilise the capacity at Cambridge Park for example whether CP could be used to support stroke discharges and the CCG is looking at how to fund the facility in a different way. A three month pilot funded by the Better Care Fund around discharge to assess is currently being trialled. This will be assessed in June/July to understand what will be required on an ongoing basis.

B Compton provided a summary:

- The mandated fair cost of care exercise (all age domiciliary and over 65 residential) has commenced with domiciliary care. This will provide further evidence of any residual cost impacts from the pandemic; the most significant is likely to be workforce.
- There are issues with the processes around discharge in NEL; however, it is functioning and there is good partnership and willingness to try new ways of working. Other areas across the patch have experienced more issues and difficulties with discharge, eg, debate around who funds what.
- NEL has gone through the process to look at the funding received and to collectively agree which are the important elements that need to continue regardless of whether they sit in health or social care. It will be important not to lose things that helped as a system during the pandemic and will continue to help going forward.
- The focus should be on the individual and their experience in and journey through the care system. Their choice and preference can sometimes be lost. Individuals need to receive the right care at the right time and for the right amount of time.
- Clarity was sought regarding the cost of vaccinations; the presentation referred to £20k. It was confirmed that this figure relates to some specific funding linked to addressing inequalities in how the vaccines were administered and does not represent the total cost of the vaccine programme. Funding for the vaccination programme was provided by the centre directly to providers and did not come via the CCG.

The Committee noted the update.

7.2 Contracts Update

E McCabe B Brown provided a verbal update:

- Contracts are in the process of being developed and signed and national variations are being done for all health contracts that are not new.
- A financial value has been agreed for Leeds and Sheffield which is within the NEL plan. Sheffield has added their share of elective recovery funding to the contract for the ICB; other areas have not done this. This has been escalated to the CFOs for clarity on the correct approach. It was confirmed that a significant amount of the funding is linked to the achievement of elective recovery. If the system does not achieve the 104% target, the £50m funding identified in the ICB will be reduced. It will be important locally to work with NLaG to help them to achieve their target.

- The principal for local independent sector provider (ISP) contracts is for approximately 70% of activity to come from transferring patients from the acute hospitals (NLaG, HUTH, ULHT). A risk has been flagged that, if the activity is not picked up by the hospitals, patient choice via the electronic referral system could impact on the 70%. This will need to be kept under review as people may be treated "out of sequence".
- All documentation is ready for the NLaG contract. The priority for NLaG and HUTH has been agreed as vulnerable services (phase 1 of HASR). Finance and activity information will be added to the contract once available. L Whitton confirmed that the final ICB plan was submitted at the end of April which included NLaG's activity and assumed contract values from all of the CCGs; however, a further submission is required in June as the plan shows a financial deficit. Further work will be required to look at recovery and the achievement of the 104% across the system.
- An ICB wide approach will be required for NLaG, HUTH, Harrogate, York etc. It was proposed that the contract group formally write to CFOs and/or come up with a proposed approach.
- There are significant concerns regarding EMAS performance. Derbyshire (lead contractor) has accepted the financial envelopes from the CCGs across the EMAS area which left EMAS with an initial deficit of £17m. EMAS took on additional efficiency and other elements of improvements which reduced the gap to £10.2m deficit. A risk share arrangement has been proposed. If, within a given month, the financial deficit became bigger than the planned deficit; a financial risk share would be triggered. It was agreed that further work is required regarding the risk share agreements.

The Committee discussed the waiting lists and ISP/NLaG activity at length. Clarification was received:

- The key message is to ensure that patients with the greatest clinical need are treated as the highest priority for being seen and treated.
- The situation at St Hugh's hospital (SHH) will be monitored at fortnightly meetings with SHH, the acute providers and commissioners in attendance. Any issues will be reported out to the system.
- Priority of access at SHH is for the acute patients; SHH will not be able to have vacant sessions. If acute patients do not appear within a reasonable planning time (2-3 weeks), SHH is required to open up their ERS list. SHH has indicated that filling the slots with their own patients has become more prevalent since December. This has been escalated and NLaG has confirmed that it continues to transfer its long waiters to SHH.
- SHH is selective in the services/treatments it provides. Conversations have taken place regarding the potential for getting different surgeons in for different specialities which have long waiting lists.
- Hull have significant long waiter problems and there is a push for them to utilise SHH; however, patients have been unwilling to travel to SHH. Some patients are willing to travel to the acute hospitals; therefore, NLaG has offered to take Hull's long waiters and transfer some of their own patients to SHH which would reduce the long waiters overall as a system.

It was agreed that a paper is required for the next meeting to:

- Highlight all of the contracts and outline this year's financial value versus last year's financial value and where appropriate the pre-covid values to demonstrate the variations and to identify changes resulting from covid and transformational change.
- Highlight the main risks for each contract at Place.

It was noted that the June meeting is the final CCC meeting prior to the close down of the CCG. A conversation will be required regarding what should be in place in the new architecture to ensure contracting oversight, assurance and decision making.

The Committee noted the update.

7.3 This item was redacted.

7.4 Planning for 2022/23 Update

L Whitton provided a verbal summary:

- The Final ICB plan has been submitted to the centre. There is still a significant financial deficit of just over £50m. Discussions will take place across the ICB to try to achieve financial balance.
- There has been some challenge regarding some of the trajectories, which are lower than other ICBs. These will be reviewed and refreshed.
- The plan will be resubmitted; an update will be brought to the next meeting.
- Discussions are taking place with the ICB on how to smooth any pressures across CCGs in order that there is no disadvantage from the start of the transition.

The Committee noted the update.

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

No items were identified as requiring escalation.

8. ITEMS FOR INFORMATION
(including Minutes from relevant sub committees)

8.1 Residential and Home Care Update
8.2 MIFS Bi-annual Update
8.3 ICAAP Bi-annual Update
8.4 Below Threshold Value Contracts Quarterly Update

The Committee noted the reports received for information.

9. ANY OTHER BUSINESS

Date and time of next meeting: Wednesday 8th June, 9-11am