

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 10/02/2021 AT 9am**

**MEMBERS PRESENT:**

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

**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  
Rachel Brunton, Finance Manager, CCG for Item 11.1

# APOLOGIES RECEIVED

There were no apologies received.

# DECLARATIONS OF INTEREST

The following declarations of interest were made from Committee members:

Item 6 – Annual Assurance report – Social Prescribing and Thrive

M Webb and A Hames declared an interest in their roles as Centre4 Board members.

Item 8 - Contract extensions procurements

CPG - G Raghwani declared an interest in his role as Medical Adviser of CPG.

NOUS - E Elston declared an interest as her practice has links to a company providing NOUS services.

Item 12.2 – Quarterly Low Value procurement update

E Elston declared an indirect interest in relation to Roxton Occupational Health Ltd.

# APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 13th January 2021 were agreed as an accurate record.

# ACTION TRACKER

The action tracker was reviewed. All actions were completed and therefore closed.

The update regarding the ICP and contracting was postponed to a future meeting as there was not sufficient information available at this stage for a meaningful update/discussion.

9:08am Ekta Elston joined the meeting.

# Annual Review of CCC Terms of Reference (ToR)

A report was circulated for consideration. H Kenyon provided a summary:

* The terms of reference were reviewed and amended in October 2020 to take account of the changes made to the Governing body Committees, and were put onto the revised template. The following minor amendments were proposed:
  + Quoracy to be amended from 50% to 5 members as the committee consists of 9 members.
  + Sub Committee section to be amended to reflect the change of name of the Risk and Quality Panel to the Individual Commissioning Approval and Advice Panel (ICAAP)

**The Committee agreed:**

* **To approve the Terms of Reference**

# 6 Annual Assurance Report to the Governing Body on Activities

M Webb and A Hames declared an interest in their roles as Centre4 Board members. It was decided that they could remain in the meeting for the discussion.

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

* CCC is required to provide an annual effectiveness report to the Governing Body providing details of its activities over the past 12 months. An Assurance Committee Effectiveness Checklist is also used to assess the Committee’s effectiveness.
* Covid-19 impacted on the day-to-day work of CCC; however, the Committee was made aware of the changes and of any risks and potential impact due to the changes. Issues have been robustly debated and challenged.
* Key decisions included: Support at Home, Patient Transport Services, Rethink, Advocacy, Ophthalmology, Telecare Monitoring, GP Out of Hours, AQP Contracts for NOUS and Pain management.
* Future changes to contracting and commissioning have been announced. The CCG procurement policy and strategy will need to be reviewed once there is a clear direction of travel.

Committee members provided the following feedback:

* The information provided in the checklist around attendance is sufficient with the focus being on meetings being quorate.
* The narrative around the number of meetings in the checklist to be strengthened to clarify that alternative governance arrangements were in place via the Risk Committee.
* Discussion around where the responsibility for oversight of the IFR process should sit and whether the IFR panel should become a sub group of this Committee. It was noted that the updated Humber policies are submitted to this Committee for approval.

**Action: J Haxby/E McCabe to check whether the IFR panel ToR specifies where the panel should report to**

**The Committee agreed that it was happy in principle to propose to the Governing Body a change to the CCC ToR with the IFR as a sub group. A bi-annual update report and the annual report would be submitted to the Committee.**

**The Committee noted the report.**

# 7 Operational Plan Contractual Requirements / Implications Update

E McCabe provided a verbal update:

* All contracts will roll forward for the first quarter of the year with their current arrangements. Commissioners have been instructed to stand planning down at this stage; however, work is still required around service developments and transformation, eg, how is the CCG complying against the Mental health investment standard and what changes/improvements are required? Planning is required on the diagnostic hubs.

**The Committee noted the update.**

# 8 Contract extensions / procurements

J Raghwani declared an interest in his role as Medical Adviser of CPG. It was agreed that Dr Raghwani could remain in the meeting for the discussion but could not participate in the discussion.

E Elston and J Raghwani declared a potential interest in relation to NOUS and left the meeting for the discussion.

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

Care Plus Group

* The contract is due to end on 31st March 2021 following an extension in 2020 during the Covid-19 pandemic. The intention was for the CCG to use the one-year extension to work with CPG on a number of issues; this work has not fully taken place due to the pandemic and the issues still need to be addressed.
* The key areas for the year were the development of PCNs and the alignment of districting Nursing Teams to start to create integrated community teams, the development of Cambridge Park as an intermediate care facility and the development of the Community Urgent Response Team.
* The proposal is to award CPG a 3 year plus one year contract, which would bring them in line with Navigo and would ensure consistency and sustainability of arrangements in light of the development of the ICP/ ICS. The contract would include details of key areas of development and clear intentions and outcomes.
* A Commissioning Intentions letter would set out the strategic developments required over the life of the contract and clarify where developments are expected to support the wider system. The contract would also include notice periods for services; should change be required.

A discussion then took place in relation to the proposal and the following was noted:

* Has the CCG received the appropriate assurances in terms of performance and service delivery against the contract requirements and are there any relationship issues and how will we ensure that if we issue a 3-year contract, we will be able to address any performance issues that arise? It was noted that CPG is delivering against its contractual obligations, but there have been concerns about the pace of delivery against some of the transformational work being undertaken, in particular in relation to getting Cambridge park operational at full capacity.

Routine performance information has not been monitored during the past year due to the pandemic but will be sought going forward to ascertain which, if any, areas of the contract are underperforming and whether remedial action is required.

* It was queried who will hold the Provider to account in the new NHS arrangements? It was noted that it is not yet clear who the contract will novate to if the CCG ceases to exist, but that would be the same for all contracts and should not be a barrier to ensuring continued service provision for NEL residents.
* It was noted that some of the funding and services in CPG’s contract relate to Adult Social Care and the council may not wish to be part of any future arrangement established by the NHS and would they be locked in under a 3-year contract.
* It was noted that there would be a potential significant risk to continued service delivery for the NEL population if a one-year contract were issued given the forthcoming changes in the broader NHS system. A 3-year contract has been proposed to provide some certainty in the system and to support CPG in becoming stronger as part of the ICP. It would also give providers the opportunity to work in a more integrated way. The contract would still be subject to review and include the ability to make changes annually or include a break clause for all or specific elements, including ASC. It was felt that this would provide additional assurance re the issuing of a longer-term contract.
* Markers can be built into the contract, to provide clarity on what the CCG’s expectations are and what the provider is expected to achieve at specific points in time. Markers were built into the current service improvement plans; however, the pandemic resulted in meetings being cancelled and the monitoring/reviews did not occur.
* Service specifications will be required to be produced for all areas detailing clear expectations of service delivery and outcomes.
* It was noted that there had been some concerns regarding CPG leadership and transparency, but that conversations have taken place with CPG around strengthening their leadership, which they reacted positively to, and have accepted CCG support to strengthen.
* It was also acknowledged that CPG have worked hard and done good work during the past year during the pandemic, stepping up their support to the system in relation to Infection Prevention and Control (IPC), the establishment of the testing CHUB, and in their contribution to the Covid vaccination programme.
* A few of the PCNs have expressed an interest in directly providing district nursing. If the CPG contract is extended, would this present a problem around PCNs not being consulted? It was noted that the aim is for CPG to work with PCNs around the provision of district nursing as part of the development of integrated community teams. It was requested that the Senior Nurses at the CCG and CPG to be involved in conversations around community nursing as nursing is a profession in itself and should be able and supported to work autonomously. This will be picked up with J Wilson and S Dawson who are leading these conversations.
* It was suggested that the CCG and CPG could hold a board-to-board meeting with Execs and Non-Execs present if it were thought that that would be beneficial.

10:04am M Webb left the meeting.

The Committee agreed:

* To support the proposal to award CPG a contact until 31st March 2024 with a one-year extension option to align with Navigo. The contract will have an expectation of a strong strategic component to ensure sustained improvement and will include a one-year break clause.
* That an update be brought to a future meeting regarding how CPG is performing against its contract requirements.
* That a Commissioning Intentions letter to be drafted within the next six weeks to be attached to the contract. This will highlight the requirements and expectations around four or five priority areas for the coming year, eg, Cambridge park, PCNs, ASC (day services), intermediate care, community teams. There will also be an explicit statement around the ICP and other system changes and the need to work differently as a result of these developments It will also set out markers for expected outcomes by six months, a year etc.
* **Action: E McCabe to liaise with colleagues and to pick up at OLT to capture information for the Commissioning Intentions letter.**

**GP Out of Hours (GP OOH)**

* The Core Care Lincs contract for providing the GPOOH service was extended to 31st March 2022 and the intention was to either have agreed the new arrangements or to go out to procurement in the Autumn of 2021.
* PCNs have not been able to progress discussions regarding the service due to the Covid-19 pandemic and there is still significant work to do around the Community Urgent Care Team, ambulance conveyance, better GP/SPA integration etc.
* It is unlikely that the CCG will start a procurement process in the Autumn.
* An update around the direction of travel will be brought to the Committee in late Spring.

**The Committee noted the update.**

**Non-Obstetric Ultrasound (NOUS)**

The Committee were made aware of a potential issue relating to a provider of NOUS locally, who may not want a contract for the service in 2021/22. An urgent conversation is being set up with the provider to understand the issues and mitigations. The Committee raised concerns regarding a potential backlog and emphasised the need for oversight on patient safety.

**The Committee noted the update.**

# 9 Items for Escalation from/to:

# Governing Body – there were no items of escalation from or to the Governing Body.

# Clinical Governance Committee – the February meeting was cancelled and an update on quality surveillance was submitted to the Risk Committee. Concerns were raised at the November meeting around the backlog of cancer patients and the impact on patient safety. This will be raised at the February Safety Review group. It was agreed that the provider Risk Profiles will be shared with CCC for their information. It was noted that the CPG profile could be helpful for the information gathering exercise discussed in Item 8.

**Action**: **J Haxby to forward the CPG profile to E McCabe**

# 10 Items for Virtual Decision/Chair’s Action

# There were no updates for the Committee.

# 11 Any Other Business

**11.1 Fee setting**

A detailed report will follow, and a virtual decision will be sought from the Committee.

R Brunton shared the fee table (attached).



* The ambition was to carry out a fair cost of care exercise for other parts of the market (in addition to the residential care market); however, this has not yet been completed.
* The proposed fee rate increases for residential care, supported living, support at home, enhanced dementia, direct payments and CHC were shared. The increases have reference points to the national living wage, the RPI and the CPI.
* The proposals would result in an estimated increase of £1.1m, which is partially offset by an increase in income (£132k). This information been submitted to Cabinet.
* Meetings were held with providers to discuss any concerns around fees. The residential care sector highlighted the impact of the Covid-19 pandemic on their insurance costs. A temporary adjustment to the fee rate was made pending further information from providers. It was noted that concerns may be raised if the government were to stop providing free PPE.
* The Direct Payment fee will be reviewed once the prepaid card system is in place. It was proposed that further analysis should be done to understand the Direct Payment cost, eg, how it compares to an hourly rate for residential care which could be alternative provision. An update to be brought back to a future meeting.
* Fees for community providers, eg, CPG, Navigo are usually set following planning guidance. They will be aligned with social care for the time being and adjusted as necessary.
* A key change to previous years is the residential rate for CHC. It is proposed to offer a range of rates for different needs (base, enhanced and complex rate). This may reduce the need to negotiate potential 1:1 costs and enable people to be placed in area. It would still allow for bespoke packages of care.

11.04am J Raghwani left the meeting.

The Committee provided the following feedback:

* Request to check the numbers in relation to Supported living.

**Action: R Brunton to review and feed back.**

Post meeting note: R Brunton reviewed the difference in cost between Supported Living and support at home and confirmed that this is due to the 21/22 estimated annual CCG spend on Supported Living exceeding support at home by £1.6m.

* Are there sufficient monies in the budget to cover the increase? R Brunton confirmed that there was money in the budget for the increase in costs.
* Further information was requested on the CHC element, eg, is the proposed approach used elsewhere, what would be included in each of the rates, what might the add-ons be etc?

**Action: R Brunton to work with J Elliot and J Haxby and include more information in the formal report to be circulated for virtual decision.**

* It was noted that a lot of work has been done with care providers and a lot of support provided during the Covid-19 pandemic. A report is due to be submitted to the March meeting around the residential care market place and sustainability. A request was made that the report include details around what things should be built into business as usual in order to preserve the good work undertaken.

Post meeting note: the virtual report was circulated to the Committee on 16th February. The fee table within the report was updated: missing information was completed and the change in fee values from 20/21 to 21/22 represented as a percentage change were adjusted to reflect the final fee rate figures.

**The Committee noted the update.**

# 12 ITEMS FOR INFORMATION

* Residential and Home Care Update
* Below Threshold Value Contracts Quarterly Update

**The reports were noted.**

Date and Time of Next Meeting:

Wednesday 10th March 9-11am, MS Teams