

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 14/04/2021 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
Dr Jeeten Raghwani, GP Rep
Jan Haxby, Director of Quality and Nursing
Mark Webb, Lay Member (Governing Body)
Dr Ekta Elston, Medical Director
Anne Hames, Community Lead
Laura Whitton, Chief Finance Officer

**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
Gaynor Rogers, Commissioning Officer Service Planning and Redesign (Item 5)

# APOLOGIES RECEIVED

There were no apologies received.

# DECLARATIONS OF INTEREST

Item 5 – Tier 3 Weight Management Contract (Thrive Social Prescribing) – M Webb and A Hames declared an interest in their roles as Centre4 Board members.

# APPROVAL OF PREVIOUS MINUTES

10th February 2021- it was agreed at the previous meeting that one section of the minutes needed to be amended. The revised minutes were approved.

10th March 2021 – the minutes were agreed as an accurate record.

# ACTION TRACKER

The action tracker was reviewed.

Item 4 – Action Tracker. IFR oversight. CCC ToR to be updated to reflect the change.

**Action: The Terms of Reference will be updated and shared at the next meeting.**

Item 7 - Procurement Consultation Document Update. E McCabe to reflect the comments received during the meeting in the ICS return and submit the document on 12th March.

This was completed.

**Action: E McCabe to share the final letter with the Committee.**

Post meeting note: this was circulated to the Committee on 19th April.

# Tier 3 Weight Management Contract

M Webb and A Hames declared an interest in their roles as Centre4 Board members. They remained in the meeting for the discussion.

G Rogers declared an interest in her role as a Councillor in Sidney Sussex ward. She did not participate in the decision making process.

A report was circulated for consideration. G Rogers, E McCabe and E Elston provided a summary:

* ABL Health were commissioned from 1/7/2019 to provide the Tier 3 Weight Management Service across NEL. The contract was extended in 2020 to July 2021.
* ABL are currently commissioned to support 60 clients per year. During 2021, they supported more than 120 clients. ABL did not cover their overall costs, and this is not a sustainable service for them.
* Discussions are taking place with ABL regarding the options for the service going forward. They are interested in working more with PCNs and Thrive social prescribing as a wider health management service to meet local need.
* 70.3% of adults in NEL are overweight or obese. Many of these individuals have long term conditions, eg, diabetes. ABL working with PCNs, Navigo and Thrive would provide individuals with an individual holistic multi-discipline assessment to get to the route of their obesity. They would then tailor a programme to meet the individual’s needs. The service would fill the existing gap in weight management services. Feedback from current clients of the service has been positive.
* Substantial long term savings could be made in the treatment of overweight and obese patients (reduced costs in prescribing, orthopaedics, mental health referrals etc).
* The option of a service across HCV was considered; however, Hull and East Riding are happy with their current services and are not looking to commission a service across a wider footprint.
* The recommendation is to award ABL with a contract for three years at a value of 180 patients per year at an increased cost of £63,600 above current expenditure: £139,500 above current budget. A procurement process would not be required due to the work already done.

The Committee provided the following feedback:

* What is the integration between the Tier 3 and Tier 4 services? E McCabe advised that ABL works with the bariatric team in Hull and are stitched into the local service.
* The Tier 3 service was brought in to try and prevent the immediate move of patients to the Tier 4 service and the aim was to fund the service through the savings made. The proposal is now to expand the service; however, there is no indication that there will be monetary savings. This is a cause for concern due to the size of the increased costs. It was noted that there are reductions in activity and cost elsewhere but due to the Covid-19 pandemic and changes to the NHS financial structure, they will not be realised in the same way.
* Is the service mandatory? It was confirmed that an individual who is obese is not able to have bariatric surgery unless they have been successful through Tier 3.
* If people drop out of the service and then go back does that incur an additional cost? E McCabe confirmed that there would not be a re-referral. The dropout rate is small (approximately 3%). Individuals are expected to make a strong commitment to the programme prior to commencing on it.
* Is there data available regarding whether people managed to sustain their weight loss? It was noted that 72% of patients lost weight; however, data around whether the weight loss was sustained is not yet available.
* What are the tangible benefits of expanding the service? Patients who are currently given a diet and exercise sheet from their GP would receive the holistic assessment from ABL and be signposted to an individually tailored programme. More people losing weight would lead to health benefits and long-term cost savings.

9:35am J Haxby joined the meeting.

* Assurance is needed that monetary and health savings will be made. It was agreed that work is required with PCNs as part of the structured programme to establish how a patient’s journey will be monitored and how to build an evidence base around outcomes and savings. When an individual is referred onto the programme, a review of medications and current and potential costs to the system could be undertaken. The individual’s journey could be tracked to identify the savings. This would probably need to be for a cohort of patients initially due to a lack of infrastructure. ABL receive details of patients’ HbA1c levels when they are referred. Would it be possible to ask ABL for specific objective markers, eg, a drop in Hba1c from the start and after one year (directly linked to diabetes status), and cholesterol levels at the beginning and end (directly related to cost and cardiovascular risk). It was confirmed that ABL are keen to work with PCNs and the ICP to start to track patients. This will be developed as part of the service specification.

9:44 – E Elston left the meeting.

* The Committee supported a proposal to extend the current contract for one year. This would enable the patient tracking and data collection elements to be built into the specification.
* Discussion around the possibility of children accessing the service, which is currently adults only. Conversations would be required to discuss a structured pathway for children to identify the criteria to access the service. Paediatricians would need to be consulted around how younger children would best be supported. ABL offer a family service in other areas; it was agreed that this would be worth exploring.
* The extended service would mean a significant financial increase; however, the Committee agreed that the service was a priority area as it would prevent additional costs and ill health in the longer term. It also fits into the Union objectives and the planning guidance priorities and links to the obesity strategy due to be published later this year. It is unclear whether there would be some separate funding from the centre to support the obesity strategy and plan. Funding (approximately £162k) was made available for Tier 2 services provided by Public Health.
* Public Health colleagues are in conversation with ABL. It was agreed that a more holistic and joined up approach is required to look at the obesity plan across the Council and CCG. It was proposed that this be taken to the Union Board.
* Targeted work will be required, potentially on a ward basis, to start to address the inequalities as part of the structured programme on inequalities. Further data on adult obesity will be required to identify where to target the funding. Data is available around which GP practices have engaged with ABL; this can be followed up.
* Proposal to develop a CCG strategy for obesity to set out intentions and focus. It was agreed that a stock take is required to look at all work taking place around obesity and to identify any gaps. This could be pulled together into a strategy.

**The Committee agreed:**

* To approve the extension of the contract for one year.
* To approve the extension of the cohort (not solely the pre-bariatric areas).

**Action: E McCabe and L Whitton to discuss the number of cases outside of the meeting.**

* To work with ABL to start to pull together a more detailed outcomes set and evidence around the difference the service has made to an individual’s health as well as their weight. This will be built in as part of an extended pilot linking in more with Thrive and PCNs and will be a more structured programme with a broader footprint.
* To develop an overall plan for obesity, which will inform any longer term contracting and will link into a strategic direction and intent.
* A discussion to take place with Public Health regarding working with the CCG as part of a joint structured programme around weight management.

**Action: Gaynor Rogers and Eddie McCabe to agree a structured approach to incorporate all of the above actions**

# Q1 & 2 Planning Guidance

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

Contracting

* Contracts are required for non-NHS providers. These are in progress.
* There are no contracts required for NHS providers this year. NLaG and Hull will be receiving block values for 6 months.
* CQUINs are not running; however, providers will be paid the value.
* CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. The first plan is required by 6th May 2021.

Finance

* The finance regime from the second 6 months of last year is carrying on in to the first 6 months of this year.
* There is more discretion around local arrangements around the contract value of local Trusts. The CCG is working to what was paid last year plus inflation in line with guidance. Discussions are taking place with the local CIC providers to ensure that they are not disadvantaged. There may be some financial consequences and pressures due to current allocation and funding.
* A significant potential pressure is around Agenda for Change. National discussions are ongoing, and a final uplift has not yet been agreed. The increase has not been included in the figures and values and will be a subsequent adjustment once the uplift has been agreed. This has a potential risk to the CICs as any additional funding may not flow down to them. This will be monitored.
* There is no growth funding within allocations to the CCG. Work is ongoing on an ICS basis.

The Committee provided the following feedback:

* Query regarding the requirement for a contingency of up to 0.5%. L Whitton confirmed that this is not mandatory but is expected. This can be helpful as it provides a level of flexibility if the contingency can be created.
* Was the CCG expected to produce a balanced budget? L Whitton confirmed that this was expected. Within the Humber ICS, each organisation is building up individual plans and looking at this against allocations. If there are any individual organisations in a deficit position, consideration will be given to allocating central funding. If there were still a deficit, savings plans would be looked at as a system to bring the organisation back into balance.
* Are plans in place to bring in ICP arrangements later on in the year? L Whitton confirmed that the development of the ICS and ICP are being managed in parallel. There is a local finance group with the ICP which is linking across at ICS level.

**The Committee noted the report.**

# Contract Position/ Sign Off Update

E McCabe provided a verbal update:

* All non-NHS contracts are drafted and should be sent out within the next few days.
* St Hugh’s – a 6-month contract based on the increasing capacity framework has been sent out for signing. The activity was based on a Q1 submission from Nlag, ULHT and HUFH around the activity they are diverting to support the backlog. The plan does not have any direct patient choice under ERS in the activity. Conversations have taken place regarding increasing activity from NLaG (only 20% of the activity was from NL, compared with 50% from Hull and 30% from Lincolnshire). The cost of the contract is significantly lower than previously, and more understanding is required regarding where patients are going.
* St Andrew’s – the contract will be the standard contract.
* CPG – the draft commissioning intentions letter is waiting for final comments. There is a month one finance plan, but there are a number of issues in terms of planning, eg, Agenda for Change uplift. A service development improvement plan will be developed within the first few months to set out a schedule of works for the year. This will capture the work around Cambridge Park, ASC etc.
* Navigo – a contract variation will be issued (currently a 5-year contract). The finance schedule is being worked through.
* New Medica – a contract variation will be issued (Lincolnshire CCG have asked to become an associate).
* Spire – are opened up to ERS at the current time and do not want to work on the backlog capacity. Work is ongoing with Hull CCG as some support is required locally for some activity.
* Yarborough Clee and other smaller contracts – awaiting finance schedules.
* L Whitton is drafting a finance summary (approach, timings etc) to ensure consistency across providers.

**The Committee noted the update.**

# Any contract extensions / procurements required following on from the contracts register review

Procurements:

* Advocacy – currently out to procurement
* Direct Payments – will go out to procurement in approximately September.
* Supported living plus – currently in the planning stage.
* Contracts ending in 2021/22 are under review and engagement is taking place with Service leads.

# Items for Escalation from/to: Governing Body/ Risk Committee and Clinical Governance Committee

It was agreed that following the discussion around obesity, the following should be escalated as part of the Union arrangements:

* Development of an obesity strategy / plan for NEL
* Work required to ensure that the council and CCG don’t have separate pieces of work being undertaken in parallel on Union activity to ensure that “we are joining the dots”.

# 10 Items for Virtual Decision/Chair’s Action

* RAIDR – this was approved; however, there were a number of questions raised; which will need to be picked up moving forward. It was proposed that a demonstration of RAIDR be provided to Community Forum.

**Action: H Kenyon and A Hames to discuss outside of the meeting.**

# 11. Any Other Business

# 11.1 The Phoenix Partnership (TPP)

The TPP SystmOne community element licenses are due to expire at the end of July. E McCabe and John Mitchell have met with TPP. A new framework is due to come out and some significant changes around the system and the support funding are anticipated. John Mitchell is proposing to invoke the extension period of 2 years within the current contract. A report will be circulated for a virtual decision or will be submitted to the May meeting.

**11.2 - CQC Inspection**

An update was requested on the CQC inspection referred to in the Residential and home care update (Item 12). B Brown confirmed that CQC has not yet published its findings; however, it is likely to be “requires improvement”. The Contracts team is working with CQC and Safeguarding to ensure that there is one action plan in place.

**11.2 - Quality Oversight with NLaG**

J Haxby and Clare Linley (NLCCG) have raised concerns regarding a change to the arrangements with NLaG regarding quality oversight. During the Covid-19 pandemic, NLaG, supported by NHSE, pulled out of the regular contract oversight meetings. All quality issues for NLaG would be overseen at one meeting chaired and led by NHSE. This does not provide commissioners with the opportunity to drill down into the detail and is creating difficulties in receiving assurance around quality and potential clinical harm, eg, around waiting lists.

It was agreed that J Haxby needs to be invited to all relevant meetings or be better sighted and assured of discussions at these meetings.

**Action: H Kenyon and J Haxby to have a discussion outside of the meeting and do some mapping. This will be taken to the Risk Committee.**

# 12 ITEMS FOR INFORMATION

* Residential and Home Care Update

**The report was noted.**

Date and Time of Next Meeting:

Wednesday 12th May, 9-11am, MS Teams