

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 09/06/2021 AT 9am**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)  
Dr Jeeten Raghwani, GP Rep  
Jan Haxby, Director of Quality and Nursing  
Mark Webb, Lay Member (Governing Body)  
Anne Hames, Community Lead  
Laura Whitton, Chief Finance Officer  
Bev Compton, Director of Adult Services

**ATTENDEES PRESENT:**

Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care   
Brett Brown, Contract Manager  
Caroline Reed, PA to Executive Office/ Note taker  
Emma Overton, Policy and Practice Development Lead Care and Independence (Items 5 and 6)  
Rachel Brunton, Head of Finance (Adult Social Care and planning) (Item 5)  
Tanya Burnay, Commissioning Officer, Care & Independence (Item 7)  
James Ledger, Medicines Optimisation Pharmacist, NECS (Item 8)  
Lisa Hilder, Assistant Director for Strategic Planning (Item 9)

# APOLOGIES

Christine Jackson, Head of Case Management Performance & Finance, focus

Dr Ekta Elston, Medical Director

Eddie McCabe, Assistant Director Contracting and Performance

# APOLOGIES RECEIVED

Apologies were received as noted above.

# DECLARATIONS OF INTEREST

M Webb and A Hames declared an interest in relation to Item 9 Thrive in their roles as Trustees of Centre4.

# APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 12th May were agreed as an accurate record with the following amendment under Item 7 Supervision Policy:

“It was proposed that consideration be given to the development of a Principal Nurse supervisor role to support all practices and social enterprises. J Haxby to raise this at a Senior Nurse meeting” to be amended to “It was proposed that consideration be given to an aligned supervision approach and model within nursing. J Haxby to raise this and the concept of the principal social worker at a Senior Nurse meeting.”

# ACTION TRACKER

The action tracker was reviewed.

Item 4 - Quality Oversight with NLaG. J Haxby and H Kenyon to start to map out the meetings where quality oversight is being discussed and its attendees to ensure that there are no gaps.

This was discussed at SMT on 7th June. L Golby was tasked with coordinating a list of meetings where NLaG quality is picked up and noting where it feeds into.

Item 7 Supervision Policy. It was proposed that consideration be given to an aligned supervision approach and model within nursing. J Haxby to raise this and the concept of the principal social worker at a Senior Nurse meeting.

This was raised at a Senior nurse meeting and there was some interest and appetite in the proposal.

Discussions also took place around how to align approaches to other things, eg, mandatory training. This will be scoped out at future Senior nurse meetings.

**Action: J Haxby to report back on the progress of these discussions via the Quality Governance Committee update.**

Item 12 Any Other Business

Extension to Primary Care data quality service

J Haxby highlighted that there were some risks relating to some practices not managing their data control responsibilities appropriately. E McCabe to establish whether this is the same contract; and request further detail in the virtual report around the potential risks and what CPG are required to do to manage the data controls.

**Action: E McCabe to liaise with J Mitchell**

Out of Area Placements

Julie Wilburn to link in with C Jackson to discuss the arrangements in place for adult social care.

J Wilburn and C Jackson met on 7th June to discuss out of county placements and how they are monitored. An update on Navigo was shared. It was proposed that a member of the safeguarding team sit on the panel that oversees these patients and that a protocol or policy be developed.

**Action: J Haxby to liaise with J Wilburn**

It was acknowledged that NEL only has 30 out of area placements compared with other areas who have hundreds.

Item 12.1. Residential and Home Care Update

A letter to be sent from the Committee acknowledging the good work taking place in residential care homes. B Brown to produce the draft letter on behalf of the Committee.

A draft letter was shared with the Committee. It was agreed that the letter could be sent to care homes.

The agenda was reordered to enable report authors to attend.

**ITEMS FOR DECISION**

# 7 Review of the British Red Cross Contract

A report was circulated for consideration. T Burnay provided a summary:

* The combined British Red Cross (BRC) community response service commenced in September 2020. It is a 7 day, all year round provision, replacing the previous 5 day delivery which consisted of two separate elements, the ‘First Call’ service (which was all year round) and a winter ‘Discharge’ Service (which previously ran for 8 months) to assist with winter pressures.
* The Committee approved the new service and requested an efficacy review after a 6-month period and the development of KPIs.
* The service is working well; although the anticipated volume of people using the service has not been seen due to the Covid-19 pandemic and BRC not being able to access the hospital wards. They are now established in the hospital and numbers using the service are increasing.
* BRC have been acknowledged as a significant support factor in the increased rate of discharge.
* BRC are instrumental in getting people home following discharge and getting provisions for individuals.
* The Committee were asked to approve the continuation of the new combined service contract until 31.3.2022, to ensure resilience in the system through the next phase of the pandemic.

The Committee provided the following feedback:

* The increased cost appears low given the amount of additional work underway; is this sustainable? It was confirmed that there was considerable consultation with BRC in the design of the service and they believe that it is sustainable. It was noted that a lot of the work is carried out by volunteers; although it was also emphasised that there is a cost for DBS checks for volunteers.
* Acknowledgment of the good work being undertaken by BRC and the partnership working with the hospital.
* BRC is a national organisation; is that tied into the Humber acute review, eg, will there be a regional contract? It was confirmed that all areas in our ICS now have a BRC service and there is the potential to look across all areas to establish whether there is consistency and to look at best practice. NEL is linking in with the regional co-ordinator.
* The service user feedback was a helpful addition to the report. Is there any feedback from the hospital discharge team around the way the service is operating and whether there are any lessons to be learnt, any barriers or difficulties etc? It was noted anecdotal feedback has been positive; however, formal feedback will be sought for a future update.
* What happens after 2022? Can the contract be extended? It was confirmed that this will be discussed as part of the Contract Review update at the July meeting.

**The Committee agreed to approve the recommendation:**

* **The new combined service contract should be allowed to continue until 31.3.2022 to ensure resilience in the system through the next phase of the pandemic.**

# Humber Area Prescribing Committee Merger Proposal contract extensions / procurements required following on from the contracts register review

A report was circulated for consideration. J Ledger provided a summary:

* There are currently two Prescribing Committees in the Humber footprint (Northern Lincolnshire and Hull & East Riding). It is proposed to merge the two Committees to produce a Humber-wide area prescribing Committee. A working group will be established to manage the process.
* A singe area prescribing committee would have one joint formulary across the Humber and would reduce prescribing variation for patients. This is in line with what is happening within the ICS in North Yorkshire and York. There would be 2 area prescribing committees in our ICS.
* There may be contractual implications for providers.

The Committee provided the following feedback:

* There have been problems with getting sufficient attendance at prescribing area committee meetings in the past. Will a joint committee help with this? It was confirmed that there are no anticipated problems around attaining quoracy at meetings. The membership will be much wider, to include multiple trusts and multiple primary care organisations.
* One potential issue could be if patients go to Hull and get prescribed a new drug and NEL are responsible for monitoring it as Hull utilises different systems for pathology etc; how will safety be assured? It was confirmed that GPs in NEL would not be asked to prescribe more drugs than currently; this would be about having a joint formulary.

**The Committee agreed to support the recommendations:**

* **To support progression to a Humber-wide area prescribing committee ie, merge the Northern Lincolnshire and the Hull and East Riding Prescribing Committees.**
* **To support the establishment of a working group to manage this process.**

**6 Mental Capacity Act 2005 (MCA) and Liberty Protection Safeguards (LPS)**

**Liberty Protection Safeguards**

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

* There are currently two mechanisms of authorising a deprivation of liberty; from April 2022 there will only be one in the form of LPS.
* The LPS process is triggered as soon as it is identified that a deprivation of liberty is occurring or will need to occur to deliver care/ treatment to a patient. The responsible body arranges for assessments to be undertaken, the assessments are drawn together in a pre-authorisation record, reviewed by an independent person, and if appropriate, authorised.
* Key challenges include:
  + The system will require a more proactive approach than at present. The current system of authorising DOLS usually occurs once the deprivation of liberty is already happening. The Department of Health has emphasised its view that the new system will be easier to follow and paperwork should be ready before the deprivation of liberty occurs.
  + The authorisation of the functions will be pushed closer to the front line. The role of Best Interest Assessors (BIA) will be revised. The role of Mental Health Assessor will cease to exist.
  + Poor Mental Capacity Act (MCA) practice. There are still very significant challenges with enabling staff across health and social care to be confident that they understand what is required of them and are sufficiently supported. There is also a significant lack of capacity amongst teams in health and social care.
  + There are key shortages amongst professionals, eg, Independent Mental Capacity Advocates (IMCA), BIAs and Approved Mental Capacity Professionals (AMCP); the latter will be required to look at cases where there is an objection to deprivation of liberty.
  + With the absence of Mental health assessors, it is anticipated that GPs will primarily pick up the requirement for providing a MH diagnosis. Discussions have taken place with GPs who have fed back that they may not have the requisite expertise, knowledge and training to fulfil this function.
  + One of the responsible bodies (RB) will not exist from April 2022. Under the current DoLS arrangements there is only one RB, ie, the Local Authority. From April 2022 there will be a range of RBs; the LA will continue to do its own placements; the CCG was to do the health funded ones and NLaG will do their placements. Clarity will be required around how the ICS is going to be made responsible in lieu of the CCG. The DOLS team currently manage the mechanisms and coordinate the processes for authorisation. Feedback from HCV level meetings indicates that there may be a move to manage health related placements on a wider footprint, which may mean a change to the local integrated health and care approach to authorisation.
  + There are capacity constraints within the CCG to manage the new process. Some preparation work has been undertaken, eg, working with teams (CHC, DOLS) to trial the new processes. The community urgent care team are practicing how they might apply the new provision for making urgent placements where there is not time to go through the full formal LPS process. This work is hampered by the absence of the code of practice and regulations which will accompany the overarching legislation. The regulations will outline what qualification an individual will need to have to undertake a MH diagnosis assessment etc. There are significant gaps in this work, eg, NLaG and Navigo are unable to undertake some trial processes at the current time.
  + NEL struggles to ensure that everybody deprived of their liberty has an appropriate authorisation in place. The government’s position is that the new system will be more streamlined and quicker and there should be no rationale for not complying with the law.

The Committee provided the following feedback:

* Concerns regarding the current lack of compliance with the law; although it was noted that this is a national position. It was noted that one Local Authority was recently obliged to pay a fine due to not having an appropriate authorisation in place.

A significant piece of work was undertaken 18 months ago to determine what it would cost in terms of finances and resources to become compliant with the law. It was considered to be unaffordable at that time.

Has any legal advice been sought to provide assurance? It was noted that there is CCG attendance at national and regional groups that are focusing on this, and updates are received from a range of lawyers.

**Action: this issue be raised at the Risk Committee and Governing body to formally recognise the risk to the organisation.**

* Will it have to be GPs who will provide a MH diagnosis, or could some individuals be trained within PCNs to take a lead role? It is anticipated that the level of qualification required will be at the level of a Section 12 doctor as per the current Mental Health Assessors. There are two GPs in NEL who have recently trained as Section 12s; therefore, a local rota could potentially be created.
* Clarification sought regarding IMCAs. It was confirmed that IMCAs are trained in advocacy and are appointed if there is no family member or other appropriate person to support the individual through the process. The IMCA will support the individual through their deprivation of liberty journey, which could be for a number of years.
* A place based approach may be preferable to a wider HCV footprint as NEL have very good processes and practices and are more advanced in this work than other areas.
* If a patient was in NLaG, is the risk with NLaG or the CCG as commissioners? It was confirmed that, if NLaG had done their assessments and submitted their request to the DOLS team but the DOLS team had not responded, the responsibility would be with the CCG. From April 2022, NLaG will become its own responsible body and will be responsible. Commissioners will want assurance from NLaG that the appropriate infrastructure and processes are in place.

10:05 B Compton joined the meeting.

* The MCA agenda has not had sufficient attention. The senior level ownership and oversight of MCA needs to be elevated whilst on this journey to implementing the LPS. A paper has been taken to SMT as very senior level oversight is needed.
* Concerns around how the implementation of LPS is undertaken in an ICS environment, ie, to ensure that duplication of work and meetings are avoided. It was noted that, due to the LA responsible role, this lends itself to a place-based focus. LPS will become an ICS level responsibility after CCGs cease to exist. Work is required to ensure that, as part of the place-based arrangements, operational responsibility and joint working with the LA is pushed. The ICS is likely to want a single policy whereas NEL would want a place policy. It was proposed that Rob Walsh and other LAs start to have these conversations and start to influence the ICS around what currently works well.
* It would be more helpful for NLAG to have a joined-up approach with NL. It was confirmed that attempts have been made with NL to adopt NEL’s policy and learn from NEL’s ways of working; however, this has not resulted in any meaningful action. The aim was for one policy for NLAG to apply across its 3 local authority areas.

**Action: B Compton pick this up at the Humber level meeting**

The ICS/Humber Partnership need to understand that the situation is unacceptable now and that action is required. It is proposed that the ICS be informed that this is a shared problem across the whole region and a new answer to the shared problem needs to be found.

* The NEL policy could be amended and adopted across the ICS.

**Action: M Webb to raise this via the Humber Advisory Group**.

**MCA and deprivation of liberty policy**

The policy is applicable to all NEL Commissioners and commissioned providers and has been in place for some years. This could be expanded onto a larger footprint subject to the agreement of the other parties. Key changes are highlighted in the policy.

**The Committee agreed to support the changes to the policy.**

# 5 Tender for Direct Payment (DP) Support Providers

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

* CCC agreed in January 2021 to move to the delivery of direct payments via a prepaid card system. Service users were notified via letters in February and newsletters in April and May and updates were featured on the new Live Well page. There has been a small but significant body of disapproval regarding the move to prepaid cards.
* The implementation process has been more complicated than anticipated. The card company advised that an 8 week lead in time would be suitable, however this has turned out to be substantially longer (around 23 weeks). The work required to set up the card system has been complex and very time consuming, resulting in a revised card launch date of the beginning of July. As far as possible all new DPs will be paid via the card system from that time. Existing DP users will be transferred to the card system on a phased basis.
* Staff in CCF have received training this week and feedback on the system is positive. The interface to service users does not appear as easy as anticipated.
* The agreement with service users has been redeveloped to reflect the fact that there are two DP schemes (for those with capacity and those who lack capacity). Discussions with social workers has highlighted a significant amount of unease around DP. There is a programme of practice development work to do so ensure that staff are confident with the DP basics before adding on a new policy, agreements, DP cards and a tender.
* Liaison with DP providers has been largely positive and a memorandum of agreement has been signed. Providers are ensuring that their systems and staff are prepared for the rollout of the cards.
* There is no clearly assigned service lead for DP within the CCG; which has hampered progress on agreeing the vision and aims for DP.
* Next steps: the current timetable aims for a launch of a DP support provider tender in mid-September, with a view to the contract being in place from April 2022. To comply with that timetable, the following will need to be in place:
  + A clear model of required support
  + A specification to deliver that model
  + A price structure to reflect fair payment for delivery of that model.
* The report included a range of options for the Committee to consider to agree the next steps.

The Committee provided the following feedback:

* Acknowledgement of the complexity of the DP system. A range of decisions (approximately 200) had to be made for NEL regarding the prepaid card, eg, whether people could use it to withdraw cash.
* The level of resistance to the change needs to be understood.
* A DP is an enabler to a service; however, the system is not really embraced as people can be supported without the need of a DP. It was suggested that some people may struggle with the move away from the traditional way of funding care.
* Discussion around the option of having one DP provider or more. There are currently multiple providers offering support for DPs with multiple different service offers and price tags. This makes it difficult to establish who is getting what level of service for what price and whether service users are getting good outcomes or value for money. It was acknowledged that there were benefits to only having one provider; however the overall view of the Committee was that a limited market of two or three providers would be preferable as it would enable choice.
* Proposal to liaise with children’s services who also manage DPs. It was noted that attempts have been made to have conversations with colleagues in children’s services; however there has been no meaningful progress.
* Is there a model of best practice for DP in other areas? Some research has been undertaken; however, a model of best practice has not been identified.
* Proposal to identify a cohort of individuals who benefit from receiving a DP to work with the CCG to help to design the system. It was noted that requests for volunteers have been made; however; there has been no response at this stage.

**The Committee agreed to support Option C: Revise the tender timetable to allow for greater confidence in developing a local model, specification and price structure.**

**ITEMS FOR DISCUSSION**

# 9 Thrive

# M Webb and A Hames declared an interest in relation to their roles as Trustees of Centre4. It was agreed that they could remain in the meeting for the discussion.

A report was circulated for consideration. L Hilder provided a summary:

* Thrive NEL Social Prescribing Service has been operating since August 2018. The service delivery is led and coordinated by Centre4 with the support of Bridges Outcomes Partnerships. The structure of the delivery is through a Social Impact Bond. Payments for the contract to Bridges are on outcomes and there is a mixture of block and outcomes payments to Centre4.
* The service has developed and evolved in accordance with patient need and the wishes expressed by local primary care colleagues in respect of the conditions that are covered by the core Thrive social prescribing function. There were 5 conditions initially; this was expanded last year to include further conditions, eg, Chronic Heart Disease, Diabetes type 1, Epilepsy, Osteoarthritis, Osteoporosis and Fibromyalgia.
* The premise of the service delivery is that, by undertaking a programme of interventions (up to a period of 24 months), patients will improve their health and well being and also reduce their requirement for primary and secondary care. The programme is coming to maturity; 25 participants have successfully completed a full two year programme and have reduced their impact on the system in addition to reporting an improvement in their health and wellbeing.
* There have been many patients who have undergone the programme and either successfully left part way through or disengaged for other reasons.
* Savings have been made through secondary care. This will increase in the coming months as more people complete the programme. Some projections have been made regarding savings and cost avoidance going forward.

11am G Raghwani, J Haxby and B Compton left the meeting.

* Access to the right data for primary care has been a challenge; however, these issues are being resolved. It is likely that patients on the programme have reduced their numbers of appointments by 11% (1.4 visits per year). This is likely to increase as data collection is refined. The data mechanisms developed can demonstrate that a patient had x amount of admissions prior to the programme and x amount of admissions after the programme.
* Lessons learnt include: the programme works best when it is led by patients, and they feed back what works for them. The link worker team at Cetnre4 have developed expertise and are getting good outcomes.
* The Thrive core team provide the backbone of social prescribing in NEL; which provides a platform to link in the PCN social prescribing link workers and has enabled a key role in the development of green social prescribing; which is operating across HCV. NEL were instrumental in the success of the funding bid to provide a test and learn site for HCV on green social prescribing. Having an integrated model has placed NEL in a good position.
* Feedback from other areas where primary care link workers are isolated and attached to practices with no peer network is that they are not able to achieve good outcomes due to being lone practitioners. They do not have access to the right professional development or management supervision. The integrated model provides a more resilient and effective approach to social prescribing across the borough.
* The model is held up as good practice within the national social prescribing network. The Team leader receives a lot of enquiries from other areas.
* The contract with Bridges needs to be reviewed over the next two months with a view to how to approach contract renewal for August. The outcomes will continue to be measured using the wellbeing star. Work will continue with the National Lottery fund to negotiate the outcomes payments. The changing landscape of contracting in the NHS has implications on how the agreement with the National Lottery is constructed. The proposal is that the outcomes payments will be solely based on the wellbeing star outcomes. Conversations have taken place with the Cetnre4 Chief Executive in terms of how to adjust the outcomes measures linked to the PCN link worker caseload.

The Committee provided the following feedback:

* Further details requested around the cost to the CCG. It was noted that the cost of the programme in the first years is split 49% (Big Lottery Fund) /51% (CCG). This tapers off in later years so that the CCG will be paying solely for the cost of the programme by the end of the programme in year 7. The Big Lottery Fund programme will come to an end at that point. Costs will be added to the update report to provide the overall picture of costs going forward as the Big Lottery Fund intervention diminishes.
* A whole system view of the perceived cost benefit analysis will be needed going forward.
* Acknowledgement of the good outcomes being achieved by the programme to keep people out of the system. The outcomes are evidence that it is working well and has an impact. It will be interesting to see the impact it might have on the NLaG waiting well programme due to the backlog in planned surgery.
* The CCG will need to persuade the ICP/ICS of the benefit to continue with this service and the future benefits. It was noted that the principle of social prescribing is widely accepted within the ICS and there are other models across the HCV in addition to Thrive and the integrated model. The drive to apply for and utilise the green social prescribing programme adds weight to the argument. Moving from 6 locality based programmes to an ICS wide model will be a journey. There is an acceptance that one size does not fit all.

A report will be submitted to the July meeting for decision (M Webb and A Hames will be excluded from the decision-making process due to conflict of interest). The report will include the full costs of the programme to the CCG and how to square those payments as the tariff is not happening now, which will impact on calculations going forward.

*Post meeting note: the report will be circulated virtually due to the July meeting not being quorate for this item.*

**The Committee noted the update.**

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

The following was identified as requiring escalation to the Governing Body:

* DOLS

# 11 Items for Virtual Decision/Chair’s Action

There have been no virtual decisions/chair’s action since the last meeting.

# 12 Any Other Business

There were no items of Any Other Business raised by members.

# 13 ITEMS FOR INFORMATION

* Residential and Home Care Update

**The report was noted.**

Date and Time of Next Meeting:

Wednesday 14th July, 9-11am, MS Teams