

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 14/07/2021 AT 9am**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)
Jan Haxby, Director of Quality and Nursing
Mark Webb, Lay Member (Governing Body)
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 6.3)
Julie Elliot, Specialist Nurse Continuing Healthcare (Item 7.1)

# APOLOGIES

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

Dr Ekta Elston, Medical Director

Dr Jeeten Raghwani, GP Rep

Bev Compton, Director of Adult Services

# APOLOGIES RECEIVED

Apologies were received as noted above.

# DECLARATIONS OF INTEREST

There were no declarations of interest made from Committee members. It was noted that on-going declarations of interest stood for every Care Contracting Committee meeting and were publicised on the CCG’s website.

# APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 9th June were agreed as an accurate record.

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

# ACTION TRACKER

The action tracker was reviewed.

Item 4. Action Tracker. Aligned approach and model within nursing (supervision, mandatory training etc) to be scoped out at future Senior nurse meetings. J Haxby to report back on the progress of these discussions via the Quality Governance Committee update.

J Haxby advised that conversations have not taken place around general supervision; however, safeguarding supervision is being picked up at a joint Safeguarding group, which includes representatives from health and social care. There will be opportunities to look at the alignment of approaches to supervision with the move towards an ICP way of working. Updates will be taken to the Governing Body as part of the ICP updates.

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 around the potential risks and what CPG are required to do to manage the data controls. E McCabe to liaise with J Mitchell

This action is outstanding. **Action: E McCabe to provide an update.**

Item 12 Any Other Business. Out of Area Placements

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. J Haxby to liaise with J Wilburn.

Conversations have taken place with L Holton and J Wilburn. J Wilburn will be engaged with this work going forward and action will be taken to ensure that safety measures are in place.

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

This issue be raised at the Risk Committee and Governing body to formally recognise the risk to the organisation.

This action is outstanding. **Action: to be raised at the next Risk Committee meeting.**

The aim was for one policy for NLaG to apply across its 3 local authority areas. B Compton pick this up at the Humber level meeting

There was no update available. **Action: B Compton to provide an update.**

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. M Webb to raise this via the Humber Advisory Group.

The ICS/Humber Partnership has not met since the last meeting. **Action: M Webb to provide an update.**

#  Items approved virtually since the previous meeting

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

**6 ITEMS FOR ASSURANCE**

# 6.1 Developing Proposals around the ICP

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

* There is currently no overarching contractual agreement or framework against which the ICP can be managed. The established contract for each provider will exist as they do currently and any overarching ICP arrangements will have to be agreed with partners, but with no legal standing on the operation of the original contracts. Memorandums of understanding do not have legal standing in the contract.
* An ICP contract has been developed for use at a smaller scale on a service perspective, eg, a contract could be awarded to a provider to manage a whole service area, eg, discharge.
* ICP partners will be asked to sign up to structures and protocols developed through the Board. Agreement will need to be reached around sanctions and how to manage behaviours if partners do not adhere with the agreed structures and protocols.
* The ICP is working on an “admission policy” for those providers currently not part of the ICP as it stands but may want to join. Discussions are also taking place to agree a removal process if a provider needs to be removed from the ICP.

The Committee provided the following feedback:

* Concerns regarding a potential lead provider for the ICP. As part of the establishment of the joint committee and the LA as host, would it be possible for the LA to be the main contract holder? It was noted that all current legal contracts would need to be terminated and given to the host LA who would need to allocate sub contracts. There would also be the issue of whether the LA would issue NHS contracts. It was proposed that this could be considered towards 2023/24 as there will be a different commissioning landscape and there will be clarity around provider performance etc. There could be a moratorium on all contract extensions and with all contracts being awarded for 2023/24.
* It was reported that Dudley CCG were challenged when moving towards an ICP type system due to the legal framework being vague.
* Is there an ICS contract team in place who are looking at contracts which will run beyond 2022 and who could outline intentions around contracts? It was confirmed that conversations are taking place with colleagues across the ICS footprint. The general consensus is to refrain from action until April 2023 as 2022 will be a development year with staff and organisational changes. This would allow time to agree what is needed across the footprint, eg, PTS, the commissioning of NECS for some of the shared services, eg, IFR, data etc.
* Could all contracts have April 2023 as a review date? It was confirmed that some contracts go beyond that date. There is the assumption that the white paper around the future procurement rules will outline that commissioners will have the freedom to make a case to a governing body explaining why they would like to take a certain action rather than go out to procurement, however commissioners are acting with caution until the guidance is available.
* Concerns were raised regarding a lack of leadership from the ICS in terms of contracting. It was proposed that the 4 or 6 CCGs as statutory bodies make a standard decision on contracting as an ICS footprint in the absence of a joint committee. This would form part of the ongoing ICS development work.

**Action: L Whitton and E McCabe to take this back to their transition meetings**

**Action: E McCabe to liaise with other ICSs to establish what is being developed in their areas**

# 6.2 Tier 3 Weight Management Contract Update

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

* ABL have agreed to a one-year extension from 1st July 2021 to 30th June 2022 with a new service specification. Finances have been agreed with the CCG finance team for a block of 180 patients at £1125 each, equating to £202,500 for a full year to 30th June 2022. After June 2022, the contract will need to be reviewed in light of the ICS.
* Discussions have taken place with Public Health colleagues; all parties are aware of the need to work together as a Union system.
* ABL will be working with PCNs to actively find referrals for the Tier 3 service and to help clinicians direct individuals to the appropriate level of support.
* There are several digital options for individuals: the LiveWell digital wellbeing tool, a weight management DES (targeting people to a digital platform) and the NHS Digital Weight Management Programme (online programme providing an alternative way of accessing weight management support).
* Conversations have taken place with ABL around fertility issues linked to obesity. Women already on the programme who find out that they are pregnant are encouraged to focus on a healthy lifestyle and a change in behaviours.
* Further work is required around obesity services for children and 16-18 year olds.

The Committee provided the following feedback:

* The report states: “An overall plan and pathway for obesity will be developed in the longer term and will link into the NHS obesity strategy”. Concerns were raised that this issue has been continuing for a number of years (particularly people going straight to Tier 4 bariatric surgery) and a good pathway/strategy has yet to be developed. It was confirmed that the key objective of the ABL service is the avoidance of Tier 4 and that bariatric surgery is not currently a priority for Hull due to the overall backlog in elective surgery. The NHS Obesity Strategy is due to be published this year; CCGs will need to ensure that they are complying with the strategy, and this will need ICS ownership going forward. Conversations with Public Health have provided clarity that there is no duplication occurring in terms of weight management services and support.
* Is there information available regarding whether people have managed to sustain their weight loss and what the long term impact of the service is? If people are not able to sustain the weight loss, they may be referred to the same or another programme; therefore, incurring ongoing costs. It was noted that this data is not yet available but should be available from the planned work with Primary Care around case finding. PCNs will follow an individual through their whole journey. It was agreed that a more structured programme with robust systems and processes is needed to be able to evidence that savings have been made and people supported to make long term change.
* A piece of work is required to articulate how people will move between the services and how people are being supported at the earlier point (LiveWell). If people need to go up and down through the Tiers, it would be helpful for them to remain engaged with LiveWell whilst the changes in lifestyle and mindset are being embedded (capacity permitting).

**Action: G Rogers**

* It was agreed that the Joint Committee of the Union would be the appropriate meeting for this to be picked up and pushed, as weight is a key lifestyle factor for overall wellness and creates a significant cost to the system, eg, Type 2 diabetes.

**The Committee noted the update.**

# 6.3 Review of Contracts Register

# A report was circulated for consideration detailing contracts due to end in 2021/22. This was also picked up under Item 6.1. B Brown, E McCabe and J Wilson provided a summary:

* N3i DSPT advice and guidance – further information is required.
* CPG IT data – awaiting a response from J Mitchell.
* Sussex House MH crisis beds (rolling contract) – awaiting a response from L Holton around whether to extend or whether another approach is required.
* Open Door TB service – this is usually rolled over on an annual basis. D Redhead to confirm.
* KeyRing Community Living Support LD – this is usually rolled over annually. L Holton to confirm whether the network support is still required.
* Foresight Day Care – L Holton to confirm a strategy.
* Alzheimer’s society – L Holton to confirm a strategy.
* Anchorage and Cranwell Court Enhanced Residential units – B Bradshaw to provide a strategy. Consideration is being given to whether to spread enhanced care across a number of homes or to continue with the two specialist homes.
* TASL – a finance offer was made (0.5% uplift for one year); however, TASL formally requested an additional £72k and a 24 month contract. The proposal is for the CCG to make a counter offer to extend the contract to April 2023 with no additional monies. April 2023 would align with ERCCG and Hull CCG in terms of awarding PTS contracts. If the offer is rejected, urgent action would be required to secure YAS as an emergency provider for October and beyond. Lincolnshire CCG are currently procuring for PTS which could present a risk. It was noted that there are currently no significant issues around service quality with TASL and the expectation is that they should be able to make efficiencies.

**The Committee approved the recommendation to offer an 18 month contract to TASL with no additional monies.**

* Amvale – the contract would be aligned with the TASL contract, ie, 18 month extension offer.
* Primary Eyecare Services Community Urgent Eye Service (CUES) – the service was set up in October 2020 as a response to the Covid-19 pandemic to help existing services to cope with additional demand/backlogs. The service was well used and the contract was extended for six months until September 2021. The aim of the service was to prevent people going to emergency services for eye complaints; anecdotal feedback indicates that there was also a benefit to general practice. Data collection is ongoing to provide evidence around the impact.

NLCCG have requested to join the contract. There is also the potential to pick up an additional service for post-operative cataract reviews, traditionally done by NLaG, as part of the contract; although this would signify a change to the contract.

The Committee discussed noted the risk to changing the contract requirements at this time due to other providers in this market locally.

**The Committee noted that the contract expires in September 2021 and agreed that a formal paper detailing usage and cost etc will be circulated to the next meeting or virtually in order to enable a decision to be made around continuing the service and extending the contract.**

* GP Out of Hours (GPOOH) – the current contract with CCL ends in March 2022. Work was completed with practices around whether they wanted to opt back in to deliver OOH; all but one practice indicated that they wanted to remain opted out. The service would need to be secured on their behalf. There have been no significant discussions since that time. The national review of extended access has not yet been issued in light of the Covid-19 pandemic response; it is anticipated to be available in early 2022. The current options are:
	+ to procure an OOH service as it currently exists. The provider would be asked to work with the CCGs and PCNs to develop the service.
	+ to start discussion with PCNS to establish if they would like to deliver the service on behalf of the practices.
	+ to extend the current contract in light of the discussions regarding the ICP.

**Action: A formal paper will be provided at the August/September meeting with the options.**

* Freshney Pelham Community Nursing – as the CPG contract has been aligned to April 2024; it is proposed to extend FP to the equivalent date. A revised contract and extended Commissioning intentions will be required to set out an extended plan. Discussions about finance are underway. It was requested that feedback from discussions with other PCNs around community nursing be provided.
* Virgin Care Dermatology Virgin Care Dermatology – this is a big contract; Dermatology is being considered by the ICS - a cross patch meeting took place last week. The intention is to extend the contract once the guidance is available in the White paper around future procurement rules. A paper will be brought to a future meeting for decision.
* Newmedica Ophthalmology – The contract has an extension option of 1 year; the proposal was to enact the option.

**The Committee agreed to approve the extension** due to the size of the backlog and the fact that other providers would not be in a position to pick up the activity.

**The Committee noted the update.**

**7. ITEMS FOR DISCUSSION/DECISION**

**7.1 CHC Staffing Structure and Development**

It was noted that the report provides details around the “business as usual” in terms of the service and structure of the CHC team and provides options for expanding the team. The approval of expanding the team would not be a decision for CCC, but endorsement for expanding the remit of the team is requested from CCC.

J Elliott provided a summary:

* The rationale for the proposed changes and improvements within the CHC team structure is to support and develop the service and quality in managing highly complex patients and to improve education and training to care homes and providers in managing people with higher complexities of care.
* The role of CHC nurses would be developed to include Nurse Educator roles and functions which could help to support nursing and care homes and domiciliary care. This would effectively create a new arm to the service.
* Local services would be supported in managing more complex patients, eg, those who require ventilators, CPAP, tracheostomy care and suctioning which is above standard nursing care. A CHC nurse recently supported two patients discharged from hospital with pegs due to a lack of capacity within other nursing teams. The Nurse Educator could deliver PEG training and ensure that other nursing teams have the appropriate competencies. There would also be opportunities to ensure that other nursing teams have the capacity and competencies to provide End of life care.
* The development of the team would also enable CHC to support LPS going forward.

The Committee provided the following feedback:

* The CHC team is well placed to support the Nurse Educator role. The Community Urgent Care Team (CUCT) have often provided training; however, they are stretched for capacity, and it would not be appropriate for them to continue to pick up the Educator role.
* The CCG will need to ensure that the CHC team have the right skills and competencies to support the system. This should then free up the CUCT team to provide the urgent response.
* Clarity would be needed around the Nurse Educator as the role would also include hands on intensive support in emergency situations in addition to training. It would be building on the concept of the Haven team. It was noted that a clear description will be provided.
* The development of the team would support the enhanced care pilot in domiciliary care which will include PEG feeding. PEG training will be required.
* There is some confusion around roles and responsibilities in relation to nursing teams, eg, CUCT, Haven, Freshney Pelham, CPG, PCNs, CHC etc. It was agreed that it would be helpful to map this out.

**Action: J Haxby to raise this as part of the ICP nursing conversations.**

* It would be helpful to understand how much time this will require in order to be able to deliver the function, ie, number of full time/part time hours.

**The Committee agreed to support the development of the CHC team and authorised J Elliott and J Haxby to work up the details of what is needed. The proposal will need to be approved by SMT.**

**7.2 Supported Living Plus**

This item was deferred to the August meeting.

**7.3 Review of Committee Workplan**

The draft workplan was circulated for consideration. A key role for this Committee will be to manage the transition from CCG to ICS. It was noted that a discussion is required by the Senior Team around how to manage the contracting and commissioning process during the transition phase.

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

Governing Body - There were no items to escalate to the Governing Body.

Risk Committee - Mental Capacity Act 2005 (MCA) and Liberty Protection Safeguards (LPS) to be raised.

**8. ITEMS FOR INFORMATION**

**(including Minutes from relevant sub committees)**

**8.1 Residential and Home Care Update**

A report was circulated for information. B Brown provided an additional update:

* Orchards care home has now closed; the last resident moved out last week.
* There has been an increase in Covid-19 positive cases in residential settings (19 residents and 24 staff). There are no issues relating to PPE or capacity and no additional support is required at this time. It was agreed that this needs to be closely monitored.

**Action: H Kenyon to ensure that a consistent message is being shared with providers regarding guidance around the wearing of masks etc.**

**8.2 IFR Annual Report**

The Committee noted the reports received for information.

**9. ANY OTHER BUSINESS**

There were no items of any other business raised.

**Date and time of next meeting: Wednesday 11th August, 9-11am, MS Teams**