

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 11/08/2021 AT 9am**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)
Mark Webb, Lay Member (Governing Body)
Anne Hames, Community Lead
Laura Whitton, Chief Finance Officer
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

**ATTENDEES PRESENT:**

Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care
Eddie McCabe, Assistant Director Contracting and Performance
Lydia Golby, Deputy Director of Quality and Nursing (representing Jan Haxby)
Caroline Reed, PA to Executive Office/ Note taker)
Julie Wilson, Assistant Director Programme Delivery & Primary Care (Items 7.1 and 7.2)
Amy Clarke, Care & Independence Programme Manager (Item 7.3)
Emma Overton, Policy and Practice Development Lead Care and Independence (Item 7.4)

# APOLOGIES

Jan Haxby, Director of Quality and Nursing

Brett Brown, Contract Manager

# APOLOGIES RECEIVED

Apologies were received as noted above.

# DECLARATIONS OF INTEREST

Item 5 Thrive. M Webb and A Hames declared an interest in their roles as Trustees of Centre4.

Item 7.1 GPOOH. Dr Raghwani declared an interest. The GPOOH provider is part of the same PCN as Dr Raghwani’s practice.

# APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 14th July 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 Matters Arising. 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.

J Mitchell advised that CPG are not responsible for managing the data added by primary care and confirmed that he will discuss this with J Haxby. A contract variation will be issued to extend the contract for one year.

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

The issue to be raised at the Risk Committee and Governing Body to formally recognise the risk to the organisation.

M Webb confirmed that this was raised at the Risk Committee and discussed at length. Confirmation was received by the Chief Executive that this has been recognised as a serious risk by the joint Leadership Team. A further paper is being created and will be delivered to the Risk Committee providing full details of the risk.

Item 6. Liberty Protection Safeguards.

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

B Compton confirmed that conversations are taking place across the four authorities and a co-ordinated approach is being taken.

Item 6. Liberty Protection Safeguards.

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.

M Webb confirmed that this was flagged as an issue at the ICS Partnership.

B Compton raised this at the NEL HCE Covid-19 meeting to advise that this is a system issue and needs to be addressed as a system; a culture shift may be needed. Children’s services are also involved in the dialogue. The LPS guidance is delayed, which will impact on the planned implementation date of April 2022.

Item 6.1. Developing Proposals around the ICP. 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. L Whitton and E McCabe to take this back to their transition meetings. E McCabe to liaise with other ICSs to establish what is being developed in their areas.

E McCabe and L Whitton confirmed that discussions are taking place with NLCCG around how CCGs will work together or separately going forward. A paper will be submitted to the Technical Contracting group meeting. An update will be submitted to the October CCC meeting.

**Action: Forward plan to be updated.**

Item 6.2. Tier 3 weight management.

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.

Conversations are taking place with NELC regarding the Tier 2 service. In the meantime, bids have been submitted for recurrent funding around teenage obesity, maternity and fertility and a £1m bid for a childhood service (age 5-16).

**Action: An update to be brought to the October meeting**.

7.1. CHC Staffing Structure and Development. 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. J Haxby to raise this as part of the ICP nursing conversations.

**Action: L Golby to pick this up with J Haxby**.

Item 8.1. Residential and Home Care Update. There has been an increase in Covid-19 positive cases in residential settings. H Kenyon to ensure that a consistent message is being shared with providers regarding guidance around the wearing of masks etc.

This action has been completed.

#  Items approved virtually since the previous meeting

**Thrive Social Prescribing Service**

M Webb and A Hames declared an interest in relation to their roles as Trustees of Centre4. They remained in the meeting as there was no decision required.

The Committee noted the virtual approval of the recommendation to continue with the Healthy Lives Together contract until the end of the contract period (end of July 2025) and to not enact the break clause in the contract, by those who were eligible to take part in the decision.

**6 ITEMS FOR ASSURANCE**

There were no items for assurance.

**7. ITEMS FOR DISCUSSION/DECISION**

**7.1 GP Out of Hours (GPOOH)**

Dr Raghwani declared an interest due to his relationship with the current provider (part of the same PCN). It was agreed that Dr Raghwani could remain in the meeting and contribute to the discussion.

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

* At the October 2020 meeting, the need for more time to work through plans regarding 24/7 urgent primary care access was discussed and agreed, particularly in light of the Covid-19 pandemic. The existing GPOOH contract with CCL was extended to 31st March 2022 (with the option to serve 6 months’ notice) to ensure consistency and stability during the covid response and to await the publication of the national revised Extended Access service specification, which could impact on requirements.
* The service was moved to Cromwell Rd PCC to support the pandemic response. The new Emergency Department at DpoW will include space for an Urgent Treatment Centre,/ Out of Hours area going forward.
* The three PCNs have developed an urgent primary care in hours response instead of a local Urgent Treatment Centre. This is due to go live with Meridian Health Group within the next two weeks; the other two PCNs will follow once processes and systems are in place. This will be reviewed towards the end of the winter period, to assess whether this is something that could work in the longer term or whether there is a need to reconsider an Urgent Treatment Centre.
* All practices were asked whether they wanted to remain opted out of OOH provision. All but one practice wished to remain opted out; therefore, the CCG will need to secure a service on the local practices’ behalf.
* The publication of the national revised Extended Access Specification has been delayed. This is now not expected to be released until the GP contract for the 2022/23 financial year has been negotiated.
* The contract with the current provider expires on 31st March 2022 and a decision regarding continued provision is required. This is not due to issues with the delivery or quality of the existing service; intelligence received (performance against KPIs, incidents, annual GP patient survey etc) has not highlighted any significant concerns.
* A process was set up to redirect patients from A&E to the GPOOH service; this is working well and is valued by NLaG.
* CCL are associate partners within the ICP and embedded within local partnership arrangements.
* The service benchmarked quite highly against neighbours in terms of value for money; this exercise is being updated to establish whether this is still the case.
* A number of options for securing the continued provision of GPOOH have been considered (detailed within the paper). The preferred option is:
	+ Renew contract with existing provider for a longer period (in line with renewal of other health contracts), pending further short-term work on benchmarking VFM, negotiation on financial envelope and clear expectation of evolution of service specification, as the urgent care system develops further following learning from the current in-hours urgent care access plans and considering new extended access specification. This would require an initial short-term extension of a further 6 months to 30th September 2022, to allow sufficient time for the negotiations to conclude during the winter period.

The Committee provided the following feedback:

* Previous feedback from GPs was that they did not want to deliver the GPOOH service but were not happy with the current service; is this still the position? J Wilson fed back that the context has changed and there is not the same level of anecdotal noise in the system around the service. The intelligence received does not highlight any significant concerns relating to quality and outcomes. It was noted that the current service is under pressure in terms of workforce and demand.
* Previous discussions for the development of a 24/7 Urgent Treatment Centre/GP urgent appointments service included in and out of hours; however, in hours and out of hours have been separated out at the current time. This does not preclude a different approach to be taken in the future.
* Additional GP capacity needs to be bought in across the system. The GPOOH service would buy in additional management and leadership for the service; however, provision would probably be local GPs; who are already stretched for capacity.
* A conversation will be needed around the long term location of the service.
* Further details were requested around numbers of patients seen by the service, busiest days/times, impact on the in hours GP service etc. It was confirmed that 11000 calls were handled by SPA in Quarter 1 with 5400 people requiring an attendance. There is not a lot of noise in the system regarding the service referring patients back to their GP. It was noted that small numbers of patients are referred back; some of which are necessary due to long term conditions.
* Clarification was sought around the contract arrangements for the preferred option (Option 3). It was confirmed that a contract extension for a further 6 months would be required to enable negotiations to conclude and allow sufficient time for a procurement process if required. Part of the discussions will focus on potentially agreeing a longer term contract with the provider providing there is the commitment to work on the items identified above.

**The Committee agreed to approve the recommendation to progress Option 3.**

**Action: An update to be brought to the December meeting**

**7.2 Covid Urgent Eye Service (CUES)**

A report was circulated for consideration. J Wilson provided an update:

* The service was set up during the initial response to Covid-19 in 2020 to ensure that people could access urgent eye care and to reduce demand on primary care and the pressures on the hospital eye services.
* Since September 2020, the service has provided initial contact, telephone triage, remote consultations, and where necessary face to face assessments. There were 505 referrals into the service between September 20 and May 21 with only a small number requiring the hospitalised service.
* Anecdotal evidence suggests that the service has prevented activity going through to general practice and A&E.
* The contract has operated on a 3-month rolling basis, with a final termination date of 30th September 2021.
* The average spend for the service is approx. £2700 per month, equating to £32k per annum; which is less than the originally anticipated £90k per annum.
* It is proposed that the service be continued due to the ongoing nature of the pandemic and the significant pressures on the urgent care system. A contract variation would be required, removing the fixed end date and allowing for the continuation of the 3-month rolling contractual arrangement, with a form of words that enables the absolute termination date to be agreed as things become more settled in terms of the pandemic.

The Committee provided the following feedback:

* How well publicised is the service and visible to Emergency Department staff? It was confirmed that the service is on NHS111. It was agreed that it would be helpful for the service to be re-publicised within primary and secondary care, eg, as part of key messages for people on shift in A&E.
* Is there just one provider and, if so, how were they selected? It was confirmed that the contract is with one body, Primary Eye Care Services (PECS) who have members across the Humber.
* **Action: J Wilson to clarify what the selection process had been.**
* Can an optician who provides the CUES service refer a patient in house? It was noted that only patients who would previously have been advised to go to the Emergency Department should be referred into the CUES service.

**Action: J Wilson to confirm the self-referral process.**

* Is this work linking in with HASR? It was confirmed that the work is linked in with HASR and fits in with the longer term ophthalmology work.

**The Committee agreed to approve a contract variation which removes the fixed end date and allows for the continuation of the 3-month rolling contractual arrangement, with a form of words that enables the absolute termination date to be agreed as things become more settled in terms of the pandemic.**

**7.3 Supported Living Plus**

A report was circulated for consideration. A Clarke and B Compton provided a summary:

* The original aspiration was to be able to have a service intervention from the age of 16 including both care support and an educational offer to try and divert some of the need going out of borough. This has not been possible due to some of the registration requirements around children, which has resulted in a change to the proposed model.
* A cost of care exercise has not been caried out on domiciliary care or supported living.
* At the December meeting, the wider support to the service was discussed, ie, education, training and skills and local networks. Work is taking place with children’s services to develop something at place locally for an education residential specialist service. Children’s services are taking this forward with Linkage. This should prevent people from going out of area in the first instance and will create a pathway from children’s services into the Supported Living Plus development. It will also enable support with education training and skills for those who it is appropriate to continue into adulthood.
* A benchmarking exercise was undertaken against neighbouring authorities; however, it was difficult to come to an hourly rate as the breakdown base rate is not available. There are varying price models for Supported Living Plus across the different Authorities. It is recognised that it has been difficult in the past to attract a specialist provider predominantly due to the local demographic and the low numbers of need compared with larger authorities. The proposal of £18.50 has recognised some of the historical issues. The specification details the additional requirements for this sort of service, eg, experience, specialism and leadership of the provider etc, which would attract a higher rate over and above that paid for the Supported Living service.
* The next steps, subject to Committee approval, are to seek expressions of interest from housing providers who will draw down the affordable homes funding and capital, to support the project with a developer and to go out for procurement for a specialist provider. The intention is to utilise an implementation period working closely with the housing provider, support provider, intensive support team, OT, social workers and individuals and their families to devise a model that meets the need, draws down the efficiencies around the staffing, achieves better outcomes and determines the most appropriate location.

The Committee provided the following feedback:

* Will the proposed hourly rate be sufficient to attract a specialist provider? It was emphasised that it is difficult to compare with other areas but noted that the rate is not the lowest and is similar to some other areas. A procurement process would test out what is available at that rate.
* Would a day rate be more appropriate than an hourly rate? A new approach might move away from an outdated time and task type model. It was confirmed that the model that is being aimed for would be a staffing hub with staff shared more freely. A base rate for 24/7 provision could be considered. It was noted that how care planning is framed is key, ie, a focus on outcomes for the individuals. It was agreed that this could be built into the model.
* It was acknowledged that the development of a pathway from children’s services into the Supported Living Plus development is a positive achievement.

**The Committee agreed to support Option A:**

**An open procedure procurement to secure the most advantageous provider based on their skills, knowledge and experience.**

**7.4 Micro-commissioning Policy**

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

* The purpose of the policy remains the same: to provide a decision making framework which results in provision of the best possible quality of care to those for whom the CCG is responsible, distributed on a transparent, equitable and affordable basis.
* It applies to all staff undertaking this activity on behalf of the CCG, eg, CPG, Navigo, focus etc.
* The policy provides guidance to staff on troublesome areas with the aim of improving the quality and consistency of decision making.
* Changes to the policy include:
	+ Ensuring that the latest version of the CHC framework is accurately captured.
	+ Inclusion of recent case law to highlight the importance of ensuring:
		- proper care planning for those who lack relevant mental capacity (‘McGuire’)
		- that informal carers are willingly offering support to their loved ones (Ali Raja’)
		- that the process of calculating a personal budget is transparent (‘CP’). This relates to a decision against NEL
	+ New references to the Adult Strategy, MCA policy, Preparation for Adulthood protocol, Direct payments etc. The direct payments policy has been removed and is now a separate stand alone policy.
	+ Details of the approach to be taken if a top up fails (negotiate with the provider to establish if the top up can be removed, negotiate for the individual to remain in the accommodation but in a cheaper room, relocate the individual to a cheaper home. The latter presents a particular risk if the individual is elderly/frail).
	+ Further guidance on the approach to individuals previously able to self fund their residential care, who then become entitled to means-tested support (same approach as above).
	+ Further guidance on the steps to take when an individual package of care at home costs more than a residential placement. As a last resort, support may be withdrawn from a capacitous individual who does not take the advice of practitioners that a residential placement is the only safe option (the CCG would not be obliged to fund care at home if it were deemed unsafe). This may be most liable to challenge.

The Committee provided the following feedback:

* Concerns regarding moving people to a lower cost room within a residential setting or to a different care home. This would need to be dealt with in a sensitive manner. It was noticed that care practitioners would handle this situation with sensitivity.
* The Committee discussed at length their concerns regarding the potential withdrawal of formal commissioned care when a capacitous individual will not take the advice to move to a residential placement. Concerns included: making an unsafe situation more unsafe, an increased risk of a significant event occurring, the cost being picked up elsewhere in the system, eg, secondary care, the CCG being culpable if something happened to the individual. Proposals included: the need for a very clear risk management process, a financial envelope to be agreed for an individual’s care and the individual to be advised that there will be no additional money for their care and the CCG would do what they can to minimise the risk to the individual.

It was noted that funding would be withdrawn only as a last resort after considerable dialogue between partners and that the individual would continue to receive visits from community nursing and social workers, who would continue to try to persuade the individual that a residential placement would be the safest option. There would also be mechanisms in place to manage the risk, eg, high risk panels consisting of all relevant partners.

* It was agreed that further work is required on the operational guidance/ risk mitigation plan so that the committee can be assured of the process that would have to be gone through prior to a funding withdrawal decision being made.

**Action: E Overton to work with B Compton, C Jackson and L Golby on the operational guidance/risk mitigation plan. An update to be brought back to the next meeting.**

11am B Compton and Dr Raghwani left the meeting.

**Action: the approval of the revised policy to be brought back once the above action has been completed.**

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

There were no items to escalate.

**8. ITEMS FOR INFORMATION**

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

**8.1 Residential and Home Care Update**

**8.2 Quarterly Report – Below Threshold Value Contracts Update**

**8.3 Procurement for Independent Advocacy Service**

The Committee noted the reports received for information.

**9. ANY OTHER BUSINESS**

**9.1 ICF Contract Award**

The report will be circulated for a virtual decision post meeting.

**Date and time of next meeting: Wednesday 8th September, 9-11am, MS Teams**