

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 08/07/2020 AT 9AM**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)

Anne Hames, Community Forum Representative

Laura Whitton, Chief Finance Officer

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

Mark Webb, CCG Chair

Bev Compton, Director of Adult Services

Dr Raghwani, GP Rep

**ATTENDEES PRESENT:**

Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care
Eddie McCabe, Assistant Director, Contracting and Performance
Caroline Reed, PA to Executive Office/ Note taker

**APOLOGIES**

Jan Haxby, Director of Quality and Nursing

Dr Ekta Elston, Medical Director

Brett Brown, Contract Manager

# APOLOGIES RECEIVED

Apologies were received as noted above.

# DECLARATIONS OF INTEREST

*Members to declare any individual or Practice interests that are likely to lead to a conflict or potential conflict that could impact (or have the potential to impact) on any items on the agenda. This should be repeated again at individual item(s) where it is considered a conflict is likely to or could potentially arise.*

There were no declarations of interest made in respect of today’s meeting.

# APPROVAL OF PREVIOUS MINUTES 11.03.2020

The notes of the previous meeting were agreed as an accurate record.

# MATTERS ARISING

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| The outstanding Matters Arising were reviewed.*Item 4 - Matters Arising - Item 8 - Prioritisation Cascade - process for approval -The national CQC State of Care report – the Committee agreed that a discussion by the Union would be helpful.* *H Kenyon to add to the Union Leadership Team agenda.* This action was put on hold due to the urgent work required regarding Covid 19. **Action: C Reed to forward the report to H Kenyon. H Kenyon** **and B Compton to take the report to the Leadership meeting and then to the Union Board.** *Item 5 - Rethink Crisis House, Lincsline and Mental Health SPA - L Holton to provide details of the number of calls to be provided as a Matter Arising.* An update was provided. M Webb to send some questions to L Holton.  |

# Terms of Reference

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| The Governing Body has requested that all Committee Terms of Reference be amended to include the paragraph detailed below: *Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Conflict of Interest Guardian or Chief Finance Officer on the action to be taken.*This followed a recent occurrence at CCC when a number of members had an interest in an item under discussion which impacted on quorum. The remaining members took a vote and referred the decision to the Governing Body for ratification. It was clarified that, in the circumstances detailed above, the Committee would make a decision, but this would not be ratified until it had been considered by the Conflict of Interest Guardian or Chief Finance Officer. The decision might be to escalate to another Committee or the Governing Body. *9:12am – B Compton joined the meeting.*  |

# Ophthalmology Update

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| A report was circulated for consideration. E McCabe provided a summary:* NLAG has a historic backlog of approx. 6000 patients across all CCGs.
* In November 2019 the CCC agreed for NLaG to source activity until March 2020 followed by a one year procurement from 1st April 2020. This was not delivered by NLaG. Slippage as a result of Covid 19 was identified as a one year system solution, however this will have a knock on effect into the system going forward.
* The CCG facilitated conversations with other providers across the Humber to identify a solution and Newmedica were asked to engage with the Trust. After a protracted process this was agreed on 22nd June with a clear finance envelope and definition of the scope, ie, to reduce the outpatient backlog only; the waiting list as a result of Covid 19 was not part of the programme.
* 70% of the backlog is at NL, therefore Newmedica is setting up a service at the Riverside Practice in Brigg to provide local provision.
* NLaG have indicated that social distancing will reduce capacity and that patients are still unwilling to go to the hospital for treatment, which may still leave a backlog issue. Despite this, the CCG is confident that some measurable progress can be made.
* The CCGs will be paying for this activity up to an agreed sum and will review progress on the scope and scale by September.
* Monthly meetings will be held with Newmedica; the Committee will receive feedback in a future report.

 The Committee provided the following feedback:* Clarification was provided that Covid funding has not been used to fund this; this is slippage on main contracts as a result of Covid.
* How are Newmedica able to clear the backlog (at Cromwell Rd PCC) if NLaG has indicated that patients are reluctant to attend appointments? It was noted that some patients are attending appointments at both sites and some patients are refusing to attend appointments at either site. The public may perceive the hospital to be a greater risk due to treating patients with Covid 19. Conversations are taking place with the different specialities in order to help people understand the prevalence of Covid 19 in the local area versus the risk to them of not receiving their treatment if they are identified as needing it. Green sites are also being established whereby patients are thoroughly tested and isolated prior to treatment; thus reducing the perception of risk.
* NHSE/I are currently working with the Trust and commissioners in preparation for the next visit from the CQC in order to try to ensure that the actions/recommendations highlighted within the CQC report are being addressed as well as possible in the current climate and to identify whether anything could be done more quickly, i.e, ophthalmology. The Committee noted that this was encouraging.
* The Trust is reviewing all patients on the waiting list in order to identify those requiring urgent treatment. Some patients have been removed from the list as part of this exercise. Trusts were instructed to stand down all elective activity other than urgent due to the Covid 19 pandemic; therefore patients would not have been able to be seen sooner.
* Humber Acute Services Review (HASR) are doing a piece of work around ophthalmology oversight. One of the potential issues is a lack of recognition of the market for this service. GPs in NEL refer regularly to the private sector because they are able to deliver; this is likely to be mirrored in NL as alternative provision is established there.

The Committee noted the update and agreed that an update would be helpful in September with details around how many people have been seen and transferred. **Action: Ophthalmology update to be added to the forward plan** |

# Review of Contracts Register 2020/21 and first half of 2021/22

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| A report was circulated for consideration. E McCabe provided a summary:* Contracts have been RAG rated. Very few have been identified as Red (urgent action).
* Voluntary and community services (Red) – waiting for direction from the service lead.
* Thames Ambulance Non Emergency Patient Transport Service – this was being discussed by the Union prior to Covid 19. NEL is the only CCG not using YAS for patient transport. Further discussions are required with a view to commence procurement no later than January 2021.
* A number of contracts have been extended for a 3 month period in light of the Covid 19 pandemic, eg, domiciliary care providers. Reviews will be undertaken in July.
* The NHS standard contract is Green as there are national arrangements currently in place. The likelihood is that the contract will be nationally mandated for the remainder of the year.
* Work is ongoing regarding the Navigo contract.

The Committee provided the following feedback:* Clarification was sought regarding the Carer Support Stroke Association contract. E McCabe confirmed that this was approved by the CCC Chair in January as a low value procurement extension. S Dawson has been tasked with conducting a review to establish that the service is delivering and to establish whether there are other providers in the area who could deliver the service. The likelihood is that a longer contract will be awarded to the Stroke Association.
* Is there adequate resource to complete the required reviews in July? E McCabe confirmed that contracts leads have been working on the contracts; mapping need and developing specifications and that there is sufficient capacity within the contracts team to support this. No radical changes are anticipated. It was noted that L Holton is the lead for a large number of contracts.

**Action: L Holton to be asked to provide an update on the contracts for the Committee to provide assurance regarding deliverable timescales.** * Concerns around contracts regularly being extended for short timescales or rolled forward. There is a feeling of “firefighting” and that contract extensions are becoming the norm. E McCabe advised that a lot of the extensions listed in the report were a direct result of the Covid 19 pandemic. It was noted that other contract extensions usually occur after considerable work has taken place behind the scenes, eg, soft market testing around price and alternative provision. Once the market test has been completed and it is clear that there is no other provider who can provide a better service, the contract is re-engaged. A change in language may be helpful to provide clarity.
* It was proposed that the contracts register be reviewed. A change in approach may be required around some procurements, eg, awarding longer term contracts to providers who give consistently good outcomes or are the only provider in the market or for individuals requiring specific packages of care (if an individual is satisfied with their provider and price, a process could be developed to identify that need is being met rather than going out to procurement and disrupting the service user). It was proposed that a robust independent evaluation built into the main contract to give evidence of effectiveness and efficiency could enable a longer term contract to be awarded and avoid the need to go out to procurement on such a regular basis. A cost benefit analysis would also be useful. The CCG needs to think differently around service models. It was noted that the Support at home contract gave providers the opportunity to develop the service within the contract.
* The Committee agreed that work is required outside of the meeting to look at how the CCG can work in a more intelligent and innovative way, whilst working within the contracting and governance rules and report back to a future meeting.

**Action: Update to be added to the Forward plan for September/October.** * The Covid-19 pandemic has necessitated the need for a review of contracting arrangements going forward, as activity is going to be different this year and in the future. Contracts may no longer be fit for purpose or economically sustainable.

**The Committee noted the update.**  |

# NHS Contracts under Covid 19 and future arrangements

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| A report was circulated for consideration. E McCabe provided a summary:* Discussions are taking place nationally and across the Humber to address the issues around delivery and sustainability of independent sector contracts under PBR rules against the need for increased capacity to address the backlog issues. CCGs may need to direct activity more explicitly to specific providers, which may impact on local choice.
* Procurement notice 04/20, the latest guidance indicates that commissioners should review all contracting arrangements and ensure that they are sustainable for the remainder of the financial year.
* St Hugh’s have moved to a national contact. Their ability to earn through PBR will be challenged due to a reduction in delivery as a result of social distancing. Other providers are effectively tariff based, eg, Virgin, Newmedica, In Health etc. Social distancing will impact on their ability to deliver their previous activity levels and therefor to their maximum contract value.
* Most providers have, as a result of lockdown, supported patients via non-face to face means, eg, phone, email and video calls. The CCG does not want to lose the benefits of this; however, the PBR methodology does not reward the same value for non-face to face support and does not therefore support sustainability for the independent sector. If providers were to be rewarded at an equivalent value for non-face to face, assurance would be needed that each call was valid and of benefit, that the clinician was able to identify the ongoing treatment and the same level of outcome was achieved.
* L Whitton has been having conversations with CFOs around funding for 20/21 at a Humber level. The view for the remainder of the year and in the longer term was to look at system first and collaborative working, which would include the independent sector. The aim is for the independent sector to work with commissioners and NHS partners to address the backlogs and waiting lists. Defining the providers market is key, identifying what is needed and how it can be achieved across a range of organisations. Contracting payment arrangements are being constructed to support this.
* A practical example might be with 360 NOUS - rather than having direct referrals, all referrals would potentially go through NLaG who would determine the clinical need around who needs to be seen first. That would have an impact on choice.

The Committee provided the following feedback:* Concerns regarding activity being sent to the acute Trust to manage, eg, 360 NOUS. GPs would be helping to manage some of the backlog via direct referrals. The independent sector may become inefficient if too dependent on Trust referrals. The focus should be on maintaining what is right for patients, which may be the independent sector.
* There is a need to think more innovatively, ie, how are we incentivising change across providers?
* Have any providers indicated that they will not be sustainable? If so, conversations should take place regarding how they can help to support the system.
* The Trust does not appear to have embraced digital technology as well as other providers, eg, Virgin, Thrive etc. It was agreed that lessons need to be learnt from those providers who have worked successfully with technology, eg, reducing referrals etc.
* Request for clarification around numbers in relation to “we have increased elective backlogs massively”.

**Action: E McCabe to clarify outside of the meeting.** * It was noted that operating on an ‘open book’ basis will require auditing and is a lot of resource. It was proposed that the terminology be changed as this is more about a frank conversation with providers around their costs, staffing levels etc. Where a provider has advised that based on the likely activity for the remainder of the year they may not be sustainable on a PBR contract they should be asked what would they need to be able to deliver given the additional time required for cleaning etc. The agreed figure could be given as a block and activity would be monitored where the provider is delivering an essential service. For example Virgin provides a critical dermatology and cancer service; therefore the CCG has a duty to work with them to ensure the service can continue to be delivered. It was agreed that an element of trust and pragmatism is required when agreeing acceptable payment levels. Providers would need to provide a clear model of how they will be delivering the service in a virtual world and their procedures for those patients who need to attend face to face appointments. Providers would receive a clear message that they would be expected to do as much activity as they were able within a Covid present environment; if they were not getting referrals through then the CCG would look at other elements that they could pick up from other providers (this would need to be at the CCG’s expressed permission); however they would not be paid more than the agreed budget.
* There may be a shift away from traditional treatments, eg, operations, as people look towards more non-invasive activities, eg, some physiotherapy which can be delivered via Zoom.
* Some services are resuming face to face options in order to address mental health issues, eg, isolation, anxiety. It was noted that, whilst there is still a need for face to face appointments, services are expected to continue to promote and enable access to digital appointments for reasons of both safety and innovation.
* The Committee agreed to support Option A, subject to any emerging issues around the allocations: “*Top up to the level they earned in the same month last year – in effect giving them a block contract for the year. If activity exceeds or meets the budget then no additional funding given. The deal for providers is that even if activity returns to a new normal they must manage capacity within the agreed budget for the year. Only by explicit authorisation could budget be exceeded, ie, to support elective position across patch where funding is made available*”.

**Action: E McCabe to draft a briefing for approval by H Kenyon, L Whitton, J Haxby around the finance and quality and safety of delivery of service.**Clarification was provided that, if a service was new and had low activity last year but was hoping to build on the activity, the CCG would have a specific conversation with them on that basis, ie, what they expected their contract value to be this year.  |

# ASC Contracts under Covid 19

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| A report was circulated for consideration. B Compton provided a summary:* In March the government announced additional funding for local government to help them respond to pressures resulting from Covid 19. Local Authorities were directed to consider putting in packages of support for ASC providers. Further funds were available through the Infection Control Fund (ICF) which has been ring fenced for social care.
* NEL’s support offer included:
* Signposting to advice and support regarding government grants and loans to businesses.
* Implementation of an electronic invoicing system
* Payment of a lump sum to enable providers flexibility to meet additional costs (staffing/ PPE).
* Provision of an income guarantee based on known activity levels in the months prior to the epidemic.
* Enhanced budget available to the “just checking” fund.
* The first tranche of money (close to £1m) was agreed via the NELC emergency decision making route.
* The ICF money was limited to cohorting staff to individual groups of residents but not designed for PPE.
* Phase Two provision – a decision has been taken to allocate the residual 25% of ICF funding for replenishment of PPE contingency supplies, Care at home provision and Supported living.
* There has been engagement with providers throughout this period. .A crude survey was carried out to establish what has been paid out and what should be done for the next round of funding. Providers who have accessed free PPE have been tracked. This has created some inequity in the system.
* The proposal for the next round of sustainability funding which is also to be taken through the councils emergency decision route is to move away from a minimum income guarantee and to offer a fee uplift. NEL’s epidemic curve has been low with low numbers of staff self-isolating (resulting in no significant additional cost); which has impacted on the uplift proposal. Some areas have offered 10%; however, the government funding would not be sufficient to cover this.
* The proposal is to offer a 5% uplift fee for in area care placements (residential care, support at home and supported living) and to adopt a similar approach across all placements irrespective of the funding source; whilst being mindful that providers are also receiving IPC funding. In area, non-contracted, non-commissioned residential care providers will receive advice and guidance as well as ICF support. In area, non-contracted but commissioned residential care providers will receive advice and guidance, ICF funding and we will offer a 5% fee uplift. Out of area placements - providers will receive a share of the ICF allocation from their host local authority. Fee uplifts will be considered on a case by case basis. In area, non-contracted community providers including direct payment support - providers do not have a direct relationship with the council/CCG, as they receive funding through individual direct payment arrangements. All providers have access to emergency supplies of PPE and can access additional advice and guidance if they run into difficulties.

*11:50am – M Webb left the meeting* * Block contract arrangements would continue on their current terms as with NHS contracts.
* Contingency funding of £100k would be held for targeted support to commissioned providers in significant financial difficulty. It is recommended that NHS support to the community/independent providers by following the same approach to the phase 2 provider sustainability. In addition it is proposed that there is an NHS financial contribution to phase 1 of residential care sustainability funding:

*12:10pm - Dr Raghwani left the meeting*The Committee provided the following feedback:* Agreement regarding the need to adopt a consistent approach across NHS and ASC. A lot of support has been provided from the Quality team around IPC training etc. An equivalent to a “benefit in kind” was done in the early phase; however, this may not continue going forward if the same level of input is not needed.
* Further work is required to understand the impact of the proposals on the health budget and to establish if it would be eligible for the Covid funding.
* It was clarified that the Haven Team is part of CPG and would fall outside of this arrangement.

The Committee agreed that a consistent approach should be taken in principle for providers that deliver both ASC and health services, but also recognised the different types of support provided to the service during phase one, it was agreed that subject to further work being done on the costings a consistent approach should be taken across health and social care for phase 2. |

# Future of NHS Acute Contracting across the Humber for 2020 onwards

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| A report was circulated for consideration. E McCabe provided a summary:* Work is starting to reconsider the management of the two acute contracts (NLaG - PBR and HUTH - aligned incentive) going forward as part of HASR. The acute contracts will need to be managed on a larger footprint in a two Trust arrangement.
* Work is underway on the contractual arrangements for next year. This has flagged up some of the Vanguard work around hospital groups and some of the learning.
* **Action: An update will be submitted to the September meeting.**

The Committee provided the following feedback:* Concerns regarding the statement that “For NLAG due to their financial distress, they are still operating on a PBR basis and have spent significant sums on consultants addressing coding issues to generate more funding while some fundamental transformational issues have not been addressed and efficiency improvements have yet to be made”. E McCabe clarified that this is a local system issue; change has not been delivered across the system to continue supporting people in the community and supporting early discharge. NLaG has focused on generating more income for the work that they do; however, this is in part due to being instructed to do so whilst under financial measures.

The Committee noted the update.  |

# NHSE Care Home Capacity Tracker Update

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| This item was deferred. **Action: Bruce Bradshaw to confirm the current capacity within residential care. The response will be circulated to the Committee.**  |

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

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| There were no items for escalation.  |

# Residential and Home Care Update

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| A report was circulated for information. |

# Quarterly MIFS Update

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| A report was circulated for information. |

# Items for Virtual Decision/Chair’s Action

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| Items for Virtual Decision/Chair’s Action• 30/3/20 - BPAS Contract Extension - Chair’s approval • 1/4/20 - Ophthalmology and Mew Medical - Chair’s approval • 30/4/20 - Bank Holiday GP Cover - Chair’s approval• 18/5/20 - IFR & Appeals Policy - Virtual Committee approval • 26/5/20 - COVID Urgent Eye Care Service - Chair’s approval • 22/6/20 - Complex Care Rehabilitation - Virtual Committee approval |

# ITEMS FOR INFORMATION

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| Minutes of Clinical Governance Committee - 06.02.2020 |

# ANY OTHER BUSINESS

There were no items of Any Other Business.

DATE AND TIME OF NEXT MEETING:

Wednesday 12th August 9-11am, Microsoft Teams