NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP
CARE CONTRACTING COMMITTEE
ACTION NOTES OF THE MEETING HELD ON 13/04/2022 AT 9AM

MEMBERS PRESENT:
Helen Kenyon, Chief Operating Officer (Chair)
Christine Jackson, Head of Case Management Performance & Finance, focus
Laura Whitton, Chief Finance Officer
Jan Haxby, Director of Quality and Nursing

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)
Rachel Brunton, Head of Finance, Adult Social Care and planning (Item 7.1)
Bruce Bradshaw, Strategic Lead MCA (Item 7.1 and 7.2)

APOLOGIES
Dr Ekta Elston, Medical Director
Mark Webb, Lay Member (Governing Body)
Bev Compton, Director of Adult Services
Dr Jeeten Raghwani, GP Rep

1 APOLOGIES RECEIVED
Apologies were received as noted above.

2 DECLARATIONS OF INTEREST
There were no declarations of interest made from Committee members.

3 APPROVAL OF PREVIOUS MINUTES
The minutes of the meeting held on 9th March were agreed as an accurate record subject to the following amendment: E McCabe to be added to the apologies received.

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

4 ACTION TRACKER
The action tracker was reviewed. All actions were completed or on the agenda.

5 Items approved virtually since the previous meeting
There have been no items approved virtually since the previous meeting.

6. ITEMS FOR ASSURANCE

There were no items for assurance.

7. Items for discussion/decision

7.1 Utilisation of Covid Related Funding

A report was circulated. B Bradshaw and R Brunton provided a summary:

- Funding was issued by the government for adult social care (ASC) providers as part of the pandemic response in 2020-22 to support the implementation of specific measures to prevent the spread of the infection within care settings. £11.8m of funding in total was received to support providers.
- 11 funding streams were received to be directed to providers, including allocation from regional Humber Coast and Vale (HCV) to support workforce. Each funding stream had unique grant conditions. The grants were divided into general grant headings; 6 relating to infection control and rapid testing, 1 for workforce capacity, 2 for workforce recruitment and retention, 1 for Omicron support funding.
- Funding was allocated to care settings within the geographical area who were registered with CQC. This included providers with no contracting arrangement with the CCG. The data captured will help to provide better understanding and oversight of the whole care market, including self-funders.
- A working group was formed to design a process for the administration of the funding, including communications, legal agreements, reporting, compliance checking and audit. This has resulted in a total of 1500 payments to 93 providers, the issue of, and collation of provider reports on expenditure, and the submission of government returns. Weekly webinars and drop in sessions were also held.
- Some funding had to be returned to the Department of Health as unused or inappropriate spend. There were specified time limits within which expenditure had to be incurred and some providers were not able to meet the deadlines to accept and use the funds.
- Funding declined by providers was offered out to other providers to try to maximise the funds available.
- Admin and reporting requirements continue into 2022/23. There is one final return submission to the Department of Health; templates have been sent to providers to complete.
- The table in the report provides assurance that providers have spent the money in line with the stipulated grant conditions. There has been close engagement with the Audit team who carried out audit samples of each funding round.
- Formal thanks were given to the C&I administration team who managed a very complex issue very well and to the Finance and joint audit teams across NL/NEL

The Committee provided the following feedback:

- What is the impact to providers going forward following the withdrawal of the funding? There have been a number of benefits to providers, eg, improved building stock and infrastructure due to adaptations made to buildings (separate clinical areas etc) which should assist with any future outbreaks and new staff entering the system due to the workforce recruitment drive. Providers are also experiencing issues, eg, continuing to manage a high level of staff and resident sickness and being unable to continue to provide full pay to staff isolating; this could be detrimental to recruitment. It is anticipated that a number of providers will experience difficulties as a result of the withdrawal of funding; conversations will take place with them to try and provide support.
- What are the lessons learnt from the funding process, eg, could something be put in place locally to enable the CCG to be more responsive to a future crisis? There has been learning around the amount of time it takes to draft contracts and legal agreements and it would be helpful to have a more readily available and increased resource for legal support going

forward. Other learning relates to an increased understanding of non-contract provision. A NL approach to relationship building with these providers will be required.

- It would be useful to understand how many additional staff were recruited as part of the recruitment drives. This will be useful for the whole market approach, ie, how to build the additional staff into the bigger system.
  Action: R Brunton to share information on how many staff were recruited and how many were lost.
- Has the withdrawal of funding resulted in any recognised risk that needs to be documented/ acknowledged with a plan on how it will be managed/mitigated? It was agreed that the potential financial risk to the care system should be documented. It was noted that the risk might become more visible as a result of the fair cost of care exercise required before September for older people, residential and support at home settings. The exercise will include the current running costs of organisations in determining what is considered a fair price point.
- **A conversation to take place outside of the meeting to discuss the potential extension of the funding for the additional nurse in the IPC team currently funded by NELCCG and Public Health. Action: H Kenyon, L Whitton, J Haxby**

9:30 J Haxby left the meeting.

- Is there an analysis of how much funding has gone to each provider to better understand the pre-Covid position and the current position in terms of issues, pressures and to assist in forward planning as the system is effectively recalibrated? **It was agreed that this discussion would be brought to a future meeting**.
- Clarification was sought regarding the £4m difference between the total funding available versus the allocated funding. It was acknowledged that difficulties arose as a result of the criteria, conditions and timescales attached to the funding and the timing of outbreaks in NEL. Examples include difficulties in getting builders to do conversation work, the inability to utilise funding for physical changes to buildings in the second round, IPC funding being issued too late as action had already been undertaken to encourage cohorting, very few instances of the funding to send people for PCR testing being accessed once care homes became part of the national system etc.
- What is the position around recruitment and retention and the HCV regional funding to try and give people the living wage early to help retention? It was confirmed that this information is not available yet as the templates have recently been sent out. The living wage has been built into contracts/budgets going forward.
- A lesson learnt would be the amount of time and effort needed to support the funding process. It will be important to identify how to have a more balanced approach going forward, ie, the ability to act more quickly whilst acknowledging that some checks and balances are needed. It was noted that the process seemed over bureaucratic and governance heavy.
- Is there a risk that money will be clawed back by HCV if all of the funding has not been paid within the required timeframe? It was noted that the current approach is to ringfence any underspend to be used to support discharge and the wider market in 2022/23.

L Whitton shared a presentation providing an overview of the Covid funding received during 2021/22 based on the forecast spend as at month 11:

ITEM 7.1 - Utilisation of Covid

- The bulk of the funding was for hospital discharge (just over £3m) and covered patient transport, CHC, ASC discharge packages. Things put in place included additional beds to support the flow through the hospital, the red Covid beds, additional teams with Hales, funding to British Red Cross and Care Lincs etc.
- The funding has now stopped and there is no equivalent funding going forward into next year.
- Other funding included:
    - Vaccination cost funding for the rollout of vaccinations (non-recurrent spend).
    - Core funding for providers (predominantly community interest companies to ensure consistent treatment alongside NHS providers) which covered some additional staffing. An element of this funding will continue into 2022/23; conversations are taking place with providers to establish what elements will need to continue.
    - Non-concurrent funding particularly linked to primary care.
    - Covid expansion fund.
    - Long Covid funding.
    - ASC recruitment and retention funding that came via the health route.

The Committee provided the following feedback:

- The GP expansion fund figure does not cover the true additional cost for Covid for the NHS, eg, booster vaccinations. **An update will be provided for the next meeting to include the true cost of Covid for health and social care, including the provider sectors.**
- Discussion regarding the ongoing pressures in the system relating to Covid, eg, the NHS and social care still having to follow the IPC rules of regular testing and isolation, which continues to impact on workforce and the wider system. This will need to be factored into planning for next year, ie, continuing to look at the whole system and the flow through the system rather than looking at elements in isolation.
- Care provision appears to feel much more part of the system as a result of the continued work of the C&I team, Dr Elston and others. It was agreed that those things implemented as part of the Covid response which have made a real difference to the system will need to be embedded going forward. A collective conversation across the HCP is required to identify those things that are making a difference in the system; their cost and how to continue to support and foster and grow them. Things which have not worked well may need to stop in order that funding is targeted appropriately.
- The Committee extended their thanks to the teams who have supported this process but acknowledged that there is still more work to be done.

The Committee noted the the extent of resources contributed to meet health and ASC pressures and endorsed the process for distribution of funds.

7.2 ASC Market Position Statement (MPS) Refresh

A report was circulated. B Bradshaw provided a summary:

- The MPS has been done on a “light touch” basis due to the pandemic and capacity restraints, using data and intelligence already held, and insights and leadership input from service leads across the CCG and where applicable NELC. It will be published and shared widely to provide information to current and prospective providers of ASC services.
- The process has highlighted some gaps in intelligence and understanding of service capacity and demand, which has changed significantly throughout the pandemic.
- Some of the big drives include:
    - Links to live well, the no wrong front door approach and the home first approach.
    - Skills and workforce, trying to look across the whole system in order that skills could be equally deployable in ASC or health

- Continuing to develop the ASC dashboard to increase the understanding of the normal position and the position whilst under pressure and when things may need to be done differently.
- Continuing to work with care homes; a number of homes left the market during the pandemic, but occupancy rates have not changed significantly.
- The national process of the cost of care exercise. Trying to understand what is sustainable. Some care homes are vulnerable with the discontinuation of the Covid related funding.

The Committee provided the following feedback:

- Recognition that this is a light touch approach and the MPS is adequate for the current time; however, clarity will be required on the work needed over the next 3-6 months to get the wider system overview and to be fit for purpose going forward. From a planning perspective, clarity will be needed around the overall vision and the plans for the next 12 months and then the 3-5 year strategy.
- The Committee discussed a key area of focus going forward, ie, an increased understanding of system flows and dynamics with the aim of reducing unnecessary A&E attendance/ hospital admissions and identifying what can be front ended more. Useful data around discharge is available to demonstrate the different routes of discharge. Modelling work is ongoing to look at what would be needed in order to reduce admissions, eg, how people can be supported at home. A change in staff and procedural system behaviours may be required and parts of the system may need to be re-engineered in order to stop people going to hospital unnecessarily. The aligned clinical support (GP DES) with care homes is working well; work would be required to extend this to Support at home. Pilots are in place looking at enhanced needs. All of this work would be built in alongside the cost of care exercise to identify the base cost of care and what else is needed.
- The need to understand the resource already in the system was reiterated, eg, buildings, workforce etc; it will be important to ensure that it is being used in the most efficient, effective way. It was noted that smarter ways of working are already in place in some areas, eg, supporting an individual to remain at home rather than being sent out of area or into residential care.
- The learning emerging from the pandemic, ie, what has and has not worked well, will need to be taken forward, eg, the neighbourhood zones model has worked well for care at home.
- The MPS will need to become the detail behind the overarching Health and Care Strategy going forward. To show the connection between the Health and Care strategy and the MPS It would be helpful to include the simple statements that have been produced to encapsulate what we are trying to achieve as a system, eg, one team working together, hospital being the last point of care rather than the first point of care. This would provide clarity that ASC is part of the overall Health and Care system.
- It was agreed that the section on the digital agenda needs to be strengthened.
- The high level work should encompass the wider partnership to increase the understanding of the partnership and what each organisation can contribute to the wellbeing of NEL, eg, planners when dealing with applications for care homes.
- Discussion regarding workforce and the ability to alter the skills mix to better manage the vision for the future. It was confirmed that workforce, including developing mixed roles, is one of the priorities for the HCP and noted that the care sector would benefit from this change sooner. A current concern relates to people with complex needs being discharged and automatically sent to bed based provision. The development of more specialist teams with the wrap around of the GP and CUCT team would support those people to go home. The pilot with LQCS on enhanced roles is providing evidence that carers can deliver the extra element of

care supported by an enhanced care team. B Bradshaw is currently looking at the potential costings of a locally available advanced carer practitioner course (currently offered by Manchester CCG). Feedback indicates that there is an appetite amongst carers to develop enhanced carer skills rather than having to move out of care and into management. Enhanced skills would enable skills to be more transportable and transferrable.

- The MPS should also go the Health and Care Partnership for comment. The timeline to be confirmed.

The Committee noted the MPS. It was noted that the meeting was not quorate.
Action: J Haxby to provide any comments to B Bradshaw.

7.3 Contracts Update & 7.4 Proposals re Contracts
E McCabe and B Brown provided a verbal update:

Contracts for this year

- Sheffield and Leeds – schedules are being signed off. Work is ongoing with colleagues across the ICS to ensure a consistent message.
- EMAS – there is a significant potential financial gap due to increases in demand and activity over the past 2 years and changes as a result of Covid.
- HUTH and NLaG – the activity plan and finance details need to be collated and agreed.
- St Hugh's and Spire – agreement has been reached that St Hugh's will continue with work for Trusts. There could also be increased activity from patient choice via electronic referrals.
- Contract variations are being done for other partners:
    - CPG – SDIP is being updated.
    - Navigo - waiting for the finance schedule.
    - Core Care Lincs – the contract variation and extension will probably be done by 22nd April. J Wilson has met with CCL to agree some principles.
    - St Andrews Hospice – waiting for information from Lincolnshire (Associate Commissioner).
    - MSK – will be completed this week.

Update and proposals

- The annual contract review has been undertaken; contracts are in place through to 2023.
- The mapping has been completed for most of the corporate contracts. The next stage is to input all contracts onto the local health and social care corporate database, with a view to transferring to the HCV database once available.
- The provider selection regime is still out for consultation and is likely to be available in the Autumn.
- Conversations have commenced across the ICS on the oversight and governance approach for contracts held in multiple places, eg, NewMedica, Marie Stokes, e.g., will there be one contract with individual specifications for places? It was noted that similar arrangements already exist, eg, regional contracts for EMAS and YAS and health and social care contracts.
- A half-day session is being planned at ICS level in May/June to look through the database, identify common contracts, identify contracts at scale and at place and understand the role for contracting (leads, monitoring etc). It was noted that things would be unlikely to change immediately, and change would be rolled out over a 3-5 year period.
- The CCGs are currently going through a process of harmonising contract end dates for providers/services that currently operate across many of the places eg, PTS service and New Medica. Meetings have taken place and contract end dates agreed by CCGs. From those dates, a decision can be made on the way forward.

- It was emphasised that contracts will still exist in the new arraignments and will still need to be managed and information will continue to be needed for assurance and planning. Streamlining will be needed; however place information will still be required. The process will be iterative and will need to be tested.
- Is there a standard variation being produced? How will providers be notified? It was confirmed that an enacting document will be shared with providers. Providers will also receive information on where to send invoices.
- It was agreed that assurance needs to be provided to NELCCG and NELC as statutory bodies that a safe transition is being managed from the CCG to the ICB and that the services for the local population will continue to be in place post 1st July 2022.
- **A report to be provided for the June CCC meeting to provide assurance that all contracts have been reviewed and appropriate action taken and that there are no contracts with an immediate end date during the transition period.**

The Committee noted the update.

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

No items were identified as requiring escalation.

8. ITEMS FOR INFORMATION
(including Minutes from relevant sub committees)

8.1 Residential and Home Care Update

The Committee noted the reports received for information.

9. ANY OTHER BUSINESS

Date and time of next meeting: Wednesday 11th May, 9-11am