

NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

**CARE CONTRACTING COMMITTEE**

**ACTION NOTES OF THE MEETING HELD ON 10/03/2021 AT 9am**

**MEMBERS PRESENT:**

Helen Kenyon, Chief Operating Officer (Chair)  
Christine Jackson, Head of Case Management Performance & Finance, focus   
Bev Compton, Director of Adult Services  
Dr Jeeten Raghwani, GP Rep  
Jan Haxby, Director of Quality and Nursing  
Mark Webb, Lay Member (Governing Body)  
Dr Ekta Elston, Medical Director

**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  
Bruce Bradshaw, Mental Capacity Act Strategic Lead (Item 5)

# APOLOGIES

Anne Hames, Community Lead

Laura Whitton, Chief Finance Officer

# APOLOGIES RECEIVED

There were no apologies received.

# 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

Following discussion, it was agreed that one section of the minutes of the meeting held on 10th February 2021 needed to be amended and would therefore be brought back to the next meeting for sign off. The rest of the minutes were agreed as an accurate record.

# ACTION TRACKER

The action tracker was reviewed.

Item 6 Annual Assurance Report to the Governing Body on Activities - IFR oversight

J Haxby confirmed that NECS collate information on IFR. The Committee agreed that this would be shared with the Committee on a bi-annual report to provide assurance. An exception report would be shared if there were any notable spikes in demand.

**Action: IFR report to be added to the Forward Plan on a bi-annual basis.**

**Action: CCC ToR to be updated to reflect the change.**

Item 8 - Contract extensions / procurements - CPG

E McCabe to liaise with colleagues and to pick up at OLT to capture information for the Commissioning Intentions letter. This work is ongoing.

Item 9 - Items for Escalation from/to Clinical Governance Committee

J Haxby to forward the CPG provider profile to E McCabe. This has been completed.

Item 11.1 Fee setting

Further information was requested on the CHC element.

A report was circulated to the Committee after the meeting for virtual approval. The ASC and CHC fee rate elements were approved; however, further discussions were requested regarding the CHC Enhanced payments element. It was noted that H Kenyon and J Haxby had a positive meeting with R Brunton and J Elliot (CHC lead) around creating a more standardised approach for determining individual CHC packages of care funding; and it was agreed that further work was required around benchmarking etc to enable the Committee to be able to make an informed decision. A report will be submitted to a future meeting.

**The Committee noted the update.**

# Residential Care Market Sustainability/Occupancy

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

* The Covid-19 pandemic has presented a number of challenges and opportunities for the residential care home sector. The system has, overall, responded well to support residential care provision. A strategic support group has been running during the pandemic and a comprehensive action plan has been delivered in its entirety. Work is now underway to identify the learning and next steps.
* The fair cost of care exercise undertaken in 2019 enabled NEL to move to a better quality baseline of provision and meant that provision at the start of the pandemic was good. It was acknowledged that there continued to be overprovision in the market.
* A number of factors have contributed to potential instability in the market during the pandemic, for example, fewer people wanting to go into residential care, people unable to go into residential care due to restrictions and the significant losses of people in that age group and cohort within residential care.
* The capacity tracker has helped to provide numerical information and comparable data across the region during the pandemic.
* The pandemic hit NEL differently to a lot of other areas, ie, there was a small outbreak locally during the first wave; however, the second wave resulted in a significant loss of life in a short space of time. This had a significant impact and recovery has been a challenge for some providers.
* Financial support has been made available to the sector during the pandemic, via an initial lump sum payment and numerous grants.
* Positives during the last year include: the positive relationship between care homes and PCNs, the community nursing offer, the ability for the CCG to have more appropriate discussions with homes around issues and potential solutions and the implementation of more technology into care homes.
* Care homes have, overall, adapted well to the challenges and changes, eg, ensuring staff are trained to use and access PPE.
* The pandemic has not resulted in a significant variation in occupancy levels; there continues to be over provision locally. Conversations are taking place with providers around sustainability; some providers have temporarily “shuttered” buildings or wings. The conversations have been more constructive and transparent. If all providers who are currently engaging with the CCG were to withdraw from the market, there would still be sufficient capacity within the local system.
* Levels of engagement with providers have improved significantly during the pandemic. A high number of providers regularly dial in to the fortnightly webinar and the Support to care homes work has now been completed. A number of care homes are working on developmental pilots despite the pandemic, eg, working on the EPaCCS system (EoL recording), working with a new digital provider to look at connected technology.
* The medium- and longer-term effects of the pandemic remain unknown; however, the mortality rates have reduced due to the vaccine roll out. Staff are starting to feel more confident and are dealing with outbreaks in a more confident and measured way.

The Committee provided the following feedback:

* The change in relationship between the CCG and providers is positive with the residential care home sector being seen more as partners rather than contractors. It would be helpful to include them more as part of the health and care family.
* It is important to build on the good work already achieved during the pandemic, eg, webinars, support around technology etc. It was noted that the strategic support group meeting on 11th March will undertake a stock take following the completion of the action plan to identify what has worked well, what needs to continue etc. The webinars may continue but on a less frequent basis.
* The issues of overprovision and sustainability remain; could “shuttering” be explored as a permanent measure to manage capacity, in a similar way to mothballing a business? It would require a certain amount of cost.
* Consideration may need to be given to a potential increase in the demand for residential care as a result of the pandemic, ie, people who did not feel safe in their own home may want to move to a quality setting. It was noted that work is still required to consider how much residential care is wanted in NEL. There are other options available, eg, care at home, extra care housing which would potentially cost less, be more enabling and achieve better outcomes for individuals. During the conversations around CHC, it was highlighted that people are often placed into residential care and given 1:1 provision at a very high cost, when the 1:1 provision could be delivered in a person’s home. This shift away from residential care and institutionalisation could be very transformational.
* Consideration needs to be given to the emotional impact on staff, due to the pandemic and potential redundancy, although, it was also noted that this is a country wide issue across a number of sectors.
* The furlough of staff and a new potential cohort of staff provides a unique opportunity to better market jobs in the care sector, ie, the roles can be fulfilling and rewarding.
* Some work is underway looking at a potential system re-engineering as part of a longer-term whole system and workforce strategy, eg, a discussion with the support at home providers around what an enhanced support at home service might do. The aim would be to sustain people at home longer and to move to a less institutionalised approach. Some providers are already looking to do that. The next step would be to pilot some of the enhanced support. Feedback from those already doing enhanced support has highlighted that staff like doing some of the more enhanced work; it also frees up district nurses. It was noted that there has been a considerable shift in the past ten years towards helping people to remain at home and be supported in their own environment.
* Families and some health colleagues can be averse to keeping individuals in their own homes due to the perceived risk. Social workers are key in emphasising that the risk can be mitigated as much as possible. Children’s services use “Think Family”; a similar approach could be adopted for adult services. It is also key to develop a supporting culture, eg, for those without families. A small group of looked after children created a postcard campaign for residents in care homes during lockdown. Mutual support is very positive and links to the shared lives model.
* Work is needed to identify how to move social care from access to statutory services only to becoming a checking and support function and one that ensures that people have got the right services and are thinking about the future. It is important to understand people’s wishes before a crisis arises. Social work has a part to play in this. It would be helpful for the Committee to receive evidence of whether SPA is working, ie, are opportunities being maximised at the front door? It would also be helpful to receive assurance around the value being gained from social work practice and to have a discussion around how to invest in community development.
* The emphasis should be on meeting the needs of individuals and creating teams to achieve this, rather than getting /creating a service.
* It was agreed that work is required to bring the various bits of work that have been discussed together, eg, EPaCCS, live well, life planning etc.

**The Committee noted the report.**

10:06 J Haxby left the meeting.

# KSS Standards for Social Work Supervision

C Jackson provided a verbal update:

* In December 2018, the Department of Health & Social Care published “Post qualifying standards for social work practice in Adult Social Care” which set out the knowledge and skills standards that should be in place for all individuals who provide supervision.
* The chief social workers requested that Research in Practice for Adults (RiPfA) undertook some training. Training was rolled out in regions. Training dates for NEL were February to May 2020 but were cancelled due to the pandemic. NEL was one of two regions who did not receive the training.
* Two places were secured for social workers from Navigo and focus. Training recommenced in January 2021. A working group has been formed to establish how to implement the training to ensure that all social workers are receiving appropriate supervision.
* It is proposed to develop a common supervision policy across the three social enterprises with buy in from the voluntary sector. The policy could be submitted to CCC for ratification.

The Committee agreed to support the development of the supervision policy and noted:

* The policy could be built in as a contract requirement.
* The requirement to adopt the policy could be built into the Commissioning Intentions letter for CPG and Navigo.

**Action: C Jackson to forward a paragraph to E McCabe to be added to the letter.**

**Action: The supervision policy to be added to the May agenda.**

# Procurement Consultation Document Update

A report was circulated for consideration which highlighted the key proposals contained within the NHS Provider Selection Regime Consultation Document and initial responses to the questions raised. E McCabe provided a summary:

* The Procurement consultation document forms part of a suite of proposed changes to the NHS.
* Patient Choice remains a key element of NHS policy.
* The recent framework contract extended the number of Any Qualified Providers (AQP). Decision-making bodies would not be able set their own criteria for services where patients have a right to choose; patients would be able to go where they choose. This might mean an increase in the number of services; providers without contracts would be able to attract activity and funding.
* Going forward there would be 3 ways to commission a service: 1, commissioners could extend the contract of an existing provider without going out to procurement if they are satisfied with the provider; 2, commissioners could decide who to award a contract to without a procurement process; 3, commissioners could undertake a standard procurement process.
* Transparency and scrutiny would be key. Judicial review would be available for providers that wanted to challenge the lawfulness of a decision. The document recommends an annual audit on every decision made, with the audits going to a Board for sign off. E McCabe flagged concerns that the absence of legal rules and regulations could make it difficult to evidence that all decisions were made in the best interest of patients, were providing value for money etc.
* The consultation asks for comments regarding not having to go through a competitive procurement process.
* Within the draft response highlights the potential increased risk of judicial review and potential conflicts of interest around both terminating a contract and establishing new services, noting it would be important to know who will makes decisions on which party would be best to provide the new service, whether there would need to be an independent view, ie, to ensure that the best provider or new providers are brought in for services as necessary.
* Overall the comments support the freedom to award contracts; however, they highlight the need for clear and robust governance processes and protection from judicial reviews and the importance of ensuring that there will still be the holistic delivery of services under a new ICP with innovation. More guidance would be helpful to clarify what could be done at a local level to evidence that all providers have been given a fair chance.
* The responses to the consultation questions from our CCG will be combined with the responses from the other 3 CCGS across the Humber to then be included in an ICS response.

The Committee provided the following feedback:

* The Committee agreed that strong governance and decision-making processes are essential. Most successful judicial reviews are around the process taken to reach the decision; rather than the decision itself.
* Robust contract management is important, eg, if a provider needs to be exited from the market or extended.
* The Committee discussed how the ICS/ICP will make decisions around provision of services and how they will manage conflicts of interest and ensure a fair and independent view. It was noted that the aim is for the ICS/ICP to work as a system and acknowledge when one part of the system would be best placed to deliver a service. It was proposed that the need for checks and balances be fed into the ICS/ICP constitution.
* It was noted that the way in which the ICS/ICP will be given their funding will be different from how it is currently, which will impact on how decisions around service provision are reached.
* A lot of work is underway within NEL on the establishment of the ICP and what its relationship with the ICS and Local Authority will look like. It was proposed that a forum similar to CCC would be useful as part of the new infrastructure.

10:34 – E Elston and G Raghwani left the meeting.

**The Committee agreed:**

* **E McCabe to reflect the comments received during the meeting in the ICS return and submit the document on 12th March.**

# Any contract extensions / procurements required following on from the contracts register review

# E McCabe provided a verbal update on contract extensions/procurements:

Contract extensions

# CPG – discussed at the last meeting.

# InHealth pain management solutions - on a framework contract.

* Illumina - a contract for NOUS has been awarded under the framework contract.
* 360 Care – a one year extension has been awarded. They did not get onto the framework; however, national guidance allows awarding contracts to providers who previously had a contract. This will enable 360 Care to get onto the framework during the year.
* St Andrew’s
* St Hugh’s – on a framework contract for 6 months under the regulations. This is being worked on across the system as part of the IS.
* TASL - conversations are taking place around a one-year extension.
* ABL Health Tier 3 weight management – discussions are taking place. NL have extended to April 2022. Volumes have increased significantly and there is a demand for the service from young adults (the current service is for aged 18 plus). A conversation will take place at SMT and OLT following a request for an additional investment of £100k. The obesity strategy may identify funding. An update will be brought to the April meeting.

Procurements:

* Advocacy
* Supported Living Plus
* DP providers

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

# It was agreed that the Residential Care Market Sustainability/Occupancy report be shared with the Union Board/ Governing Body and Scrutiny as a good news story.

# 10 Items for Virtual Decision/Chair’s Action

Fee Setting 2021/22

* ASC Fee uplift – approved
* CHC uplift element – approved but needs to be shown as a consistent base uplift, awaiting the FNC uplift notification, rather than a lower % uplift.
* CHC Enhanced payments – further work is required; a report to be submitted to a future meeting.

# 11 Any Other Business

There were no items of any other business.

# 12 ITEMS FOR INFORMATION

* Residential and Home Care Update

**The report was noted.**

Date and Time of Next Meeting:

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