**CARE CONTRACTING COMMITTEE MEETING**

**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**HELD ON WEDNESDAY 22ND JANUARY 2020**

**AT 9AM**

**IN THE COUNCIL CHAMBER, GRIMSBY TOWN HALL, GRIMSBY**

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| **PRESENT:** | Helen Kenyon, Chief Operating Officer (Chair)  Mark Webb, CCG Chair  Christine Jackson, Head of Case Management Performance & Finance, focus  Dr Raghwani, GP Representative  Anne Hames, Community Forum Representative |
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| **IN ATTENDANCE:** | Councillor Margaret Cracknell, Portfolio Holder for Health, Wellbeing and Adult Social Care  Eddie McCabe, Assistant Director of Contracting & Performance  Brett Brown, Contract Manager  Caroline Reed, PA to Executive Office (Notes)  John Berry, Quality Assurance Lead (rep Jan Haxby)  Lisa Hilder, Assistant Director for Strategic Planning (Item 5) |
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| **APOLOGIES:** | Jan Haxby, Director of Quality and Nursing  Laura Whitton, Chief Finance Officer  Dr Ekta Elston, Medical Director  Bev Compton, Director of Adult Services |

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| **Item** |  | **ACTION** |
| **1.** | **Apologies** |  |
|  | Apologies were received as noted above.  Anne Hames was welcomed back to the Committee as the Community Forum representative.  Dr Raghwani was welcomed to the Committee as the new GP representative. |  |
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| **2.** | **Declarations of Interest** |  |
|  | The following declarations of interest were made:  **Item 5 – Social Prescribing Contract Review**  Anne Hames declared an interest as Chair of Centre4; Mark Web declared an interest as a Trustee of Centre4. The Chair agreed that they could remain in the meeting for the item and contribute to the discussion. |  |
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| **3.** | **Notes of Previous Meeting –11.12.2019** |  |
|  | The notes of the previous meeting were agreed as an accurate record. |  |
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| **4.** | **Matters Arising from Previous Notes – 11.12.2019** |  |
|  | The outstanding Matters Arising were reviewed.  *Matters Arising from Previous Notes – 13.11.2019*  *Item 11 - TASL and General Transport Update.*  *It was agreed that it would be helpful to have a strategy agreed by the Union by March 2020 in terms of procurement and wider system requirements. E McCabe to liaise with the new transport lead (C Duffill has left NELC).*  There was no update on this action. E McCabe to establish if the new NELC transport lead is in post.  *Item 8 - Humber Aligned Commissioning Policies*  *A gap was recently identified via the complaints portal regarding a policy for ADHD assessment for adults. E McCabe confirmed that there is no policy in the Humber region and NEL may need to develop its own policy. E McCabe to raise this at the next IFR meeting and to discuss with L Holton.*  It was confirmed that these cases are going through the IFR system; however a policy for prior approval will be developed going forward.  *Item 10 - Residential and Home Care Update - NHSE continue to promote their Care Home Capacity Tracker. Although this hasn’t been formally adopted by NEL, 25 per cent of homes in this area have registered. B Brown to monitor the capacity of the 25 per cent of homes who have registered. In 6 months’ time the Committee can review and decide whether to adopt NHS England’s Capacity Tracker. B Brown to liaise with B Bradshaw and provide an update to the Committee next year.*  B Brown confirmed that the data received to date only demonstrates a minimal impact. An in depth study will take place in April. An update to be brought to the May meeting.  *Matters Arising – 11.12.2019*  *Item 5 - Prioritisation Cascade – Further work is required around advanced care planning in hospital in order to improve discharge. H Kenyon and B Compton to raise the issues at the Discharge from hospital meeting (13/12).*  H Kenyon fed back that discharge planning has been agreed as a key priority for the organisation. There will be a team based approach for this piece of work, eg, J Wilson leading on the PCN element. Providers will be involved (NLaG, CPG, focus, residential and domiciliary care). It was agreed that it would be helpful to involve a member of Community forum in order to gain a community view. H Kenyon and A Hames to discuss and agree who the community rep supporting this work would be.  *Item 8 - Items for Escalation from/to: Delivery Assurance Committee (DAC) and Clinical Governance Committee (CGC) - The Committee discussed the links between the Committees and agreed that it would be useful to receive routine highlights from DAC and CGC. H Kenyon, L Whitton and J Haxby to agree a way forward of the meeting.*  This action is outstanding.  *The Committee agreed to ask the Clinical Governance Committee to look at the CQUINs for next year and identify any that are significant enough to initiate a withdrawal of payment for non-delivery. J Haxby advised that this would also need a discussion at the NLaG QRM meeting and raised at the Contract Transformation Board.*  J Berry advised that the Quality team is looking to establish a system to ensure that all of the CQUIN reconciliation discussions for the providers will be kept on one database. The team will ensure that the outcomes are all recorded on this database which would be reviewed by the quality leads and discussed at the Effectiveness Group. Assurance could then be given to the Clinical Governance Committee and exceptions could be reported to CCC.  **The Committee noted the update.** | **E McCabe**  **Forward plan**  **H Keyon**  **A Hames**  **H Kenyon**  **L Whitton**  **J Haxby** |
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|  | *9:15am Dr Raghwani joined the meeting* |  |
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|  | **FOR DECISION** |  |
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| **5.** | **Social Prescribing Contract Review** |  |
|  | A report was circulated for consideration. L Hilder provided an update:   * NELCCG has been working on a social prescribing offer since 2015, co-producing a model with the local Voluntary and Community Sector (VCS); taking advantage of a Big Lottery Fund grant (c. £1.1m) to deliver a social impact bond in partnership with Bridges Outcomes Partnership. * In 2017 Centre4 was procured to be the local delivery partner (Thrive NEL). 248 patients have been referred or self-referred since the start of the service in August 2018 and undertaken a range of activities in addition to their medical support in order to manage one of five selected long term conditions (diabetes, asthma, COPD, hypertension and atrial fibrillation). These were selected as they generate significant demand on local primary and secondary care services. * The impact of the activities is measured on improvements in scores on the Long Term Conditions Wellbeing Star and patient usage of primary and secondary care. Outcomes evidenced are paid for on a tariff basis via the lottery grant. * The programme works with patients for up to two years in order to securely embed healthy lifestyle choices and to develop trusted relationships with the link workers. * NELC’s Wellbeing service runs alongside the programme offering short term interventions, eg, weight management, smoking cessation. Patients can access both services. * In 2019, NHSE made a commitment to the concept of social prescribing and a financial offer to PCNs to fund link workers over and above existing provision. PCNs could employ these workers directly or via VCS organisations (a payment of £1200 per worker would be paid to cover management overheads). * Positive outcomes for individual patients have been achieved. There has been a high level of self-referrals, indicating good public awareness. GP referrals have been low and there is some scepticism expressed linked to the limitations of referrals to patients with certain conditions. A “case finding” approach linked to Dr Kumar’s practice has resulted in higher referrals from this practice. Publicity around the NHSE funded posts has generated a higher level of GP referrals. * Some delays experienced at the start of the programme and low initial take-up has reduced the maximum amount of grant available from the lottery. The programme ends in October 2022 with last payments to be made by March 2023. * GPs are keen to expand the scope and scale of the programme, eg, to include isolation and loneliness and other long term conditions. * Patients referred to date have had limited prior admissions to hospital and therefore savings due to prevention have not yet been optimised. Targeted work is required to identify savings on those patients who had previous high admissions. The case finding approach will assist with this. * Work is underway to join up the wellbeing team with Thrive and to base the PCN funded workers with Thrive. * The contract for the social impact bond was set up on a 2 year plus 5 year basis with the option of a break clause during February 2020 (7th to 14th) should the CCG wish to terminate. * The maximum potential savings to date based on the patients who have been through the programme is £136k. Savings are measured through tracking each patient through the system, ie, prior usage of secondary care services and subsequent usage following their engagement on the programme. Primary care usage will be measured once the necessary reports are generated from SystmOne (the relevant read codes have been entered onto SystmOne). The report details the profile of outcomes payments per year of the programme, ie, what is to be paid by the lottery fund and the CCG. There were initial additional costs linked to IT elements; changes in the system resulted in separate funding with Care Plus Group. * Options for consideration: * Terminate the contract and service using the break clause. This would instigate a six month wind down of the Thrive service. Outcomes payments for patients currently on the programme would be payable until the end of the contract. It would reduce the amount of money to be claimed by the lottery grant. It would reduce the money available for NHSE funded link workers as the money is only available for additional workers (determined by a baseline taken in April 2019) and cannot be used to replace workers. Benefit and learning from the existing programme would be limited. * Continue the contract and the service in its current form. New and existing patients would benefit from the service. The service could continue to interact with the wellbeing team to ensure that patients benefit from both services. * Continue the contract and expand the scope and scale utilising NHSE link worker investment. The 3 elements (Thrive, Wellbeing service, NHSE funded link workers) could be integrated to create a single point of access that the public and GPs could refer into. Patients would be directed to the most appropriate link worker/ wellbeing worker. It would provide the opportunity to extend the scope of the programme to other medical conditions.   The Committee provided the following feedback:   * Concerns regarding the absence of another break clause in the contract. It would be helpful to have another break clause in order to be able to collate more robust data and to better evaluate outcomes. * Concerns regarding insufficient data. It was noted that once the read codes are working, it will be possible to identify how many GP appointments a patient had prior to and after engagement in the programme. This will evidence the reduction in pressure. It was requested that PCNs have access to those returns. * Is there any noise in the system from extra Tier 2 providers? It was noted that Centre4 has encouraged grass root services, eg, sewing groups, men in sheds group to contribute to overall wellbeing. Existing services are supported and new groups developed. Age UK expressed an interest in providing Tier 2 services but were prohibited due to the restriction on age. * The restriction on age and health conditions have been identified as key issues. It would be helpful if people over 65 and those with other long term conditions could benefit from the programme. It was noted that there would be the opportunity to expand the scope via the amalgamation of the three elements. The age restriction is within the terms of engagement of the Big Lottery fund; therefore there is unlikely to be flexibility within that element; however the NHSE funded workers should be able to offer the services to people of different ages. It was noted that the state pension age has risen from 65. A frequent service user group has been set up to look at top ten attenders in A&E on a monthly basis; it was proposed that this information be used to expand the health condition criteria. * It would be helpful to have the link workers based within primary medical centres (it was noted that this would not be full time). Reception and admin staff could navigate patients directly to the link workers; patients would not have to travel. * Read codes have been entered onto SystmOne; it was noted that EMIS practices will need to refer differently. * The CCG finance team has challenged whether the savings figures are accurate or whether the programme has created a cost into the system. Further work is required, eg, targeted work on specific patients to identify savings. * Have PCNs formally agreed that the PCN link workers will form part of an enhanced service with Thrive? It was noted that PCNs have indicated that this is the desired direction of travel; however there has been no formal agreement at this stage. * A piece of work is required at a later date to look at other links into the service, eg, IAPT and IAPT accreditation. * It would be helpful to monitor the workforce benefit (capacity releasing), along with the financial and wellbeing benefit. * It would be useful to have PCN involvement throughout the whole process, not only at the start, eg, system monitoring. It would also be helpful for the Discharge team to be integral to social prescribing discussions. * L Hilder informed the Committee of the Life Chances fund which provides grant subsidy for activity such as social prescribing or other social impact bond activities. The CCG might want to consider this as an option.   The Committee agreed that a decision would not be taken at this meeting due to the concerns raised above (insufficient available data and future investment). As two members declared an interest relating to this item a decision will be required by **all** members of the Committee at the February meeting.   * The Committee requested the following actions to be completed prior to the next meeting: * L Hilder to inform Bridges that the CCG is satisfied with the programme; however this Committee has raised significant concerns regarding making a decision on the future of the contract due to incomplete data and future investment. The Committee has requested an additional break clause later in the contract. A letter of support from PCNs could be included. * L Hilder to request an extension to the age limit for the programme due to the change in retirement age. It was noted that the over 65s could not be included in the Big Lottery fund claims but could be included into the programme. This would enable Age UK to potentially become a Tier 2 provider. * A formal agreement to be reached by PCNs prior to 12th February regarding the PCN link workers being part of an overall service. * L Hilder to look at the scope of the contract and the “bolt ons” which would run alongside the existing programme but outside of its scope, eg, extended scope of referral. * Work to continue around getting data for primary care usage. * Consideration to be given to additional activity providers. | **L Hilder**  **L Hilder**  **L Hilder/**  **J Wilson**  **L Hilder** |
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| **6.** | **Virgin Care Dermatology Contract Extension** |  |
|  | A report was circulated for consideration. E McCabe provided an update:   * The contract ends on 31st March 2020 and has a two year extension option. NL and NELCCG would like to extend the contract until 31st March 2020. Both CCGs are satisfied that the service is working well for patients, safety and quality.   **The Committee agreed to take the option to extend the contract for two years until 31st March 2022.** |  |
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| **7.** | **Primary Care Rebates Policy** |  |
|  | The updated policy was circulated for consideration.  **The Committee approved the policy.** |  |
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|  | **FOR DISCUSSION** |  |
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| **8.** | **Support at Home Procurement Update** |  |
|  | A report was circulated for consideration. B Brown provided a summary:   * 19 parties expressed an interest in the tender; 5 bids were received. The interviews for bidders took place on 14th and 16th January. Providers are now awaiting notification of the tender outcome. * The process was very robust and inclusive. Three preferred providers have been identified using a scoring mechanism. * The Committee was asked to approve the procurement process and confirm that they were satisfied that the process was robust.   The Committee provided the following feedback:   * The amended process is a direct result of the Union and improved joint working. Both organisations are thinking about people in a different way. * B Brown and all those involved in the process were thanked for their hard work.   **The Committee approved the procurement process and expressed assurance that the process was robust.** |  |
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| **9.** | **Monthly Update – NLaG Cost Improvement Plan** |  |
|  | NLaG is currently on track to achieve its overall QIPP target. |  |
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| **10.** | **Contracting** |  |
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|  | **Update on Contract Negotiations** |  |
|  | E McCabe provided a verbal update:  **NLaG**  Weekly meetings are ongoing; there continues to be a significant gap across the system. There is more challenge in NL due to their overtrading going into next year. Financial plans are due to be signed off in early February; a meeting has been scheduled to drill down into the transformation programmes. Agreement has been reached on the modelling and initial purposes using a PBR contract. The transformation will then be taken into account. CFOs are currently having those conversations.  The Committee provided the following feedback:   * Are CFOs taking the opportunity to inform providers that a block contract will be agreed and the savings made as a result of transformation will be deducted? If the savings are not realised, will there be a PBR reflow back into the system? * The CCG is having discussions with the trust about the type of contract to be entered into for next year and is looking at a block type arrangement which might be helpful for all parts of the system next year, recognising NHSI’s requirement for the trust to be paid for all activity undertaken.   **EMAS**  Conversations are ongoing. EMAS have requested additional monies in order to deliver targets due to the increase in activity. Commissioners do not want to invest any more money. The A&E Delivery board is monitoring the situation.  **Independent sector (St Hugh’s, NewMedica etc)**  The CCG is asking providers whether they can operate within a set financial envelope. A level of cash flow would be guaranteed. This would assist the overall system. An update will be provided at the next meeting.  A report was requested for the next meeting detailing the status of the main contracts (baselines and transformation impacts).  **The Committee noted the update.** | **Forward plan** |
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|  | **Change to NHS standard contract** |  |
|  | A report was circulated for consideration. E McCabe provided a summary:   * The deadline for contracts to be signed has been extended to 27th March. * Key proposed changes to the contract include: * Integrated system working with PCNs. * Alignment of Community Mental Health Services with PCNs. * System wide Working and accountability. It was agreed that commissioners need to include this in their discussions with independent providers. E McCabe to send this clause to H Kenyon. * Some of the key policy changes affecting specific clinical services may present a challenge for providers, eg, Nlag and the Better Births standard. These challenges will be picked up as part of the contracting meetings until an agreed position is reached.   **The Committee noted the update.** | **E McCabe** |
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| **11.** | **Items for Escalation from/to:**   * **DAC** * **Clinical Governance Committee** |  |
|  | There were no items for escalation. |  |
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|  | **FOR INFORMATION** |  |
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| **12.** | **Residential and Home Care Update** |  |
|  | A report was circulated for information.  Home care – there were no issues or blockages during the difficult Christmas period. Positive feedback was received regarding domiciliary care providers.    Hospital in reach – roll out is on hold until early February. |  |
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| **13.** | **Quarterly Updates from Sub Groups**   * **Risk and Quality Panel** |  |
|  | A report was circulated for information.  The updated ToR will be submitted to the February meeting for ratification. | **Forward plan** |
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| **14.** | **Items for Virtual Decision/Chair’s Action**   * **Extension to Amvale Contract – approved**   The Committee provided the following feedback:   * Will a full procurement be carried out after the contract extension come to an end (31st July 2020)? It was confirmed that there will not be a full tender but the CCG will go out for quotes. * Details on feedback would be helpful, ie, was it anecdotal or formal? * Clarification sought regarding costings. It was confirmed that the costings were a set value for a shift (cost of a vehicle for 12 hours for 2 individuals). * A MADE Event will take place in February to focus on improving processes relating to discharge (eg, increased discharges earlier in the day) |  |
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| **15.** | **Primary Care Commissioning Committee Minutes – 26.11.2019** |  |
|  | Circulated for information. |  |
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| **16.** | **AOB** |  |
|  | **Information Governance Service**  The CCG currently purchases its IG support and specialist expert advice from EMBED. As the EMBED contract is due to end on 31st March 2020, meetings are taking place in order to explore other models, eg, provide some of the support internally, receive some support from NELC and only buy in specialist IG expertise as required. A specification is being worked up in order to have something in place from 1st April.  **The Committee noted the update.** |  |
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|  | **Date and Time of Next Meeting:**  **Wednesday 12th February 2020, 9-11, Bremerhaven Room, Grimsby Town Hall**  **Apologies: Mark Webb** |  |
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