**CARE CONTRACTING COMMITTEE MEETING**

**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**HELD ON WEDNESDAY 12th FEBRUARY 2020**

**AT 9AM**

**IN THE CROSLAND SUITE, GRIMSBY TOWN HALL, GRIMSBY**

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

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| **Item** |  | **ACTION** |
| **1.** | **Apologies**  |  |
|  | Apologies were received as noted above.Quorum for the meeting is 50% of members. 4 out of 9 members were in attendance; therefore quorum was not met. It was noted that any decisions would need to be made virtually after the meeting. H Kenyon to review the quorum section of the Terms of Reference.  | **H Kenyon** |
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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. It was agreed that A Hames could remain in the meeting for the discussion but would be excluded from the decision making process.  |  |
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| **3.** | **Notes of Previous Meeting – 22.01.2020** |  |
|  | The notes of the previous meeting were agreed as an accurate record. |  |
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| **4.** | **Matters Arising from Previous Notes – 22.01.2020** |  |
|  | The outstanding Matters Arising were reviewed.*Item 4 - Matters Arising from 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).*E McCabe is organising a meeting with Clive Tritton; however initial feedback indicates that a discussion will be required by the Union leadership team in order to gain approval as an integrated transport approach will need considerable investment. L Hilder proposed making contact with Adam Fowler (Environment forum) who has carried out work with Stage Coach around bus routes etc. The TASL contract ends in October 2021 and a vision would be required by Autumn 2020. It was noted that commissioners have been asked to review whether patient transport should be put back with the ambulance service. It is important to note what Lincolnshire are doing in terms of transport and to establish how NEL can work with them going forward. H Kenyon to add Transport to the ULT agenda. *Matters Arising – 11.12.2019**Item 5 - Prioritisation Cascade – Further work is required around advanced care planning in hospital in order to improve discharge. 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.*A Hames proposed that Discharge be added to a Community forum agenda for a broader discussion. J Haxby to email out to workstream leads looking at discharge in order to generate some questions to be taken to Community forum. *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.* It was agreed that separate reports are not necessary as this is coordinated via the Governing Body. The minutes of the meetings will be circulated for information as part of the Escalation update.  | **H Kenyon****J Haxby****C Reed** |
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|  | **FOR DECISION** |  |
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| **5.** | **Social Prescribing Update**  |  |
|  | A report was circulated for consideration. L Hilder provided an update:* Following the January CCC meeting, further work has been undertaken to negotiate with Bridges Outcomes Partnerships and the local PCNs in relation to developing the proposed future model for social prescribing in NEL.
* Bridges have agreed to an extension to the initial period of the contract for a further 18 months. This gives an initial contract period of 3.5 years.
* Four out of the five PCNs have agreed to an integrated model of working (the NHSE funded link workers to be added to the model). The fifth PCN already have a link worker in post and have utilised 0.8 of the allocated WTE. They would be willing to put in the additional 0.2 WTE. Conversations would be required regarding employment arrangements as employment of the link workers would be hosted by Centre4.
* Agreement has been gained with Bridges and the PCNs to look at extending the scope of referrals in terms of types of conditions and age. Bridges are confident that the Big Lottery Fund will be agreeable to this change.
* Referrals would be made from GP practices/ PCNs and other agencies and also from self-referrals into a single point of community access (this would need to be clearly marketed in order to avoid any confusion with the current SPA). Individuals would be reviewed, triaged and assigned to a Thrive link worker, a PCN link worker or the wellbeing service, depending on the type of intervention required. Patients would be supported through their journey, their improvement and usage of primary and secondary care would be monitored and reported back through the Healthy Lives Together Board as required.
* The Impact & Delivery Board (IDB) will meet quarterly to review the data and identify potential improvements to the service. It will consist of stakeholders across the model.

The Committee provided the following feedback:* Are the wellbeing service and Thrive NEL costs fixed from a service provision point of view or will there be an additional cost per patient referred into the service? L Hilder confirmed that workers are already fully funded and there is no expectation to spend additional money. It was agreed that the CCG needs to ensure value for money. It was noted that the new model should result in increased numbers of people utilising the service which will increase value for money. There is currently a cap on the outcomes payments payable by the CCG and subsidised by the Big Lottery Fund; however this could be revisited at a later date.
* Confirmation that the costs detailed in the report are the cumulative cost for the first period of the contract (3.5 years). The figures show a pro rata increase following the extension of the contract from 2 to 3.5 years and is not an increase over and above what the CCG was expecting.
* Has the eligibility criteria been revised? It was confirmed that this has been agreed in principle but not formalised at this stage. It is proposed that there should be full access to the integrated element of the service in order to identify the nature of the issues and the need.

It was noted that four Committee members would be excluded from this decision making process due to their involvement with social prescribing (M Webb, A Hames, Dr Raghwani, Dr Elston), leaving 5 members to approve the recommendation. The three members in attendance (and non-voting member Cllr Cracknell) were satisfied that the issues raised at the last meeting have successfully been addressed and agreed to support the recommendation:“That the CCG proceeds with the contract with Healthy Lives Together and optimises the local Social Prescribing service offer by integrating the new NHSE funded link workers with the existing service and working even more closely with the NELC wellbeing team.”  |  |
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| **6.** | **Risk and Quality Panel ToR**  |  |
|  | The revised Terms of Reference were circulated for consideration. The Committee provided the following feedback: * Request for the “Aim” paragraph to be reworded to provide more clarity on the aim of the panel, ie, for a lay person. The updated ToR to be circulated to the Committee as a Matter Arising.
* Further discussions are required regarding transition; previous conversations have taken place with C Ward and C Jackson. There could be an opportunity for the panel to receive awareness of a complex or costly package that will transition to adults in order to enable pre-planning. H Kenyon to pick this up with Joanne Hewson.
* The Committee to receive the Terms of Reference following each annual review.
 | **C Jackson****H Kenyon****Forward plan** **(Dec 21)**  |
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| **7.** | **Rethink Crisis House, Lincsline and Mental Health SPA** |  |
|  | A report was circulated for consideration. H Kenyon provided a summary:* Rethink currently provides the NEL Field View Crisis House and, under the same contract, the Lincsline (mental health helpline) and an integrated mental health SPA function. The contract was extended for a year in 2019, and comes to an end on 31st March 2020.
* It is proposed that the service specification would go out to “mini-tender” to the 3 providers previously approached to deliver the service (Rethink, MIND, Navigo) for one more year, after which point the service will be reviewed with a view to going out for a formal tender for a 4 year service.
* Increased investment is being sought due to an increase in costs, including £60k for a fourth crisis bed.

The Committee agreed that additional information is required prior to a decision being made. H Kenyon/E McCabe to liaise with Leigh Holton to determine whether a comprehensive update can be brought to the next meeting or whether a virtual decision will be required. The update would need to include: * Details of any potential overlap with the Mental Health Investment.
* Clarity regarding the rationale for the one year £65k investment in the MH SPA being non-recurrent? What would be the longer term solution for this? (ie, is the investment non-recurrent for a year because there is a plan to go out for procurement after this period?)
* What is the rationale for the extra crisis bed (there is no activity to support this). Is an additional bed currently being utilised elsewhere?
* Clarification regarding the rationale for the service being 16+. Does it include the crisis bed element or would this only be for the call element? Have the pre-existing services for children been considered?
* Clarification regarding the rationale to go out to “mini-tender” with three providers, ie, rather than to extend the current contract with Rethink.
 | **H Kenyon****E McCabe** |
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| **8.** | **Prioritisation Cascade - process for approval**  |  |
|  | L Whitton provided a verbal update:* Discussions have taken place at CoM and the weekly planning meetings regarding where the CCG should invest/ disinvest in order to achieve financial balance, eg, proposal to hold waiting lists at a consistent level.
* The February Planned Care Board highlighted that the required improvements are not being achieved by the Trust, eg, large backlogs in some areas. It is proposed that the new referrals be slipped in order to reduce the backlog; this would not increase the overall cost. An assurance process would be required to ensure that urgent cases were seen in a timely manner. For some specialities further work is needed; a minimum wait may be introduced where there is no clinical urgency. This could buy additional capacity and not incur costs to either party.

The Committee provided the following feedback:* It is important to ensure that clinicians are supportive of the proposals, eg, holding back waiting times. It is important to clarify to clinicians that this would not be at a cost clinically to patients. H Kenyon expressed confidence that clinicians are on board following discussions held at CoM. CoM were supportive of the aim to achieve a maximum 26 week wait.
* The expectations of the public and primary care need to be managed carefully via clear messages.
* The national CQC State of Care report highlighted an increase in patients not being able to get access to the right sort and amount of care. 1.4m people are estimated as not having their needs met. 1 in 8 patients were choosing not to take a GP appointment and opted to go to A&E. The Committee agreed that a discussion by the Union would be helpful.
* Importance of ensuring that the CCG is delivering against the requirements, minimising the risk of challenge and keeping patients safe.

**The Committee noted the update.**  | **H Kenyon** |
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|  | **FOR DISCUSSION** |  |
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| **9.** | **NLaG CQC Update** |  |
|  | J Haxby and H Kenyon provided a verbal update: * The CQC inspection report for NLaG was published on 7th February. The overall rating remained the same: Requires Improvement.
* Effective, Responsive and Well-led were rated as Requires Improvement; Caring was rated Good and Safe was rated as Inadequate.
* Concerns were raised regarding waiting list backlogs and the potential for harm. If a decision is taken locally to hold waiting lists; it will be important to articulate the rationale and to provide assurance that patients would be safe and that there is confidence regarding the clinical risk.
* It has been agreed that the 4 CCGs in the Humber will work together in relation to their approach to the CQC report, NLCCG have produced a report for their Board; this will be adapted for use by the other CCGs including NELCCG Governing Body.
* The report has attracted very little media attention.
* Discussions are ongoing to determine the 4 Humber CCGs approach going forward (how some of this will be managed differently) and to understand what NHSE/I are going to be doing differently to address some of the issues.

It was noted that any requests for a contractual view, eg, re-procuring a service, additional capacity or extending/changing a contract would need to be submitted to this Committee. Quality will be monitored by the Clinical Governance Committee.  |  |
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| **10.** | **Monthly Update – NLaG Cost Improvement Plan**  |  |
|  | L Whitton confirmed that NLaG are still on track for the current year.  |  |
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| **11.** | **Update on Contract Negotiations** |  |
|  | An update was circulated for information.  |  |
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| **12.** | **Items for Escalation from/to Committees** |  |
|  | Delivery Assurance Committee (DAC) – there were no items for escalation. Clinical Governance Committee (CGC)* The National patient strategy published in 2019 includes expectations to be implemented over the next few months; this may include changes to contracts, eg, SI reporting.
* CQC report – close work will be required between CGC and CCC.
* Bradley complex care’s CQC rating has moved to Good. The CCG was thanked by the CQC and NHSE for its work in assisting this improvement. Joint monitoring remains in place.
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|  | **FOR INFORMATION** |  |
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| **13.** | **Residential and Home Care Update** |  |
|  | An updated was circulated for information.  |  |
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| **14.** | **Quarterly Low Value Procurement Update**  |  |
|  | An updated was circulated for information.  |  |
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| **15.** | **Items for Virtual Decision/Chair’s Action** |  |
|  | H Kenyon took chair’s action to approve the Stroke contract (detailed in the low value procurement update).  |  |
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| **16.** | **AOB** |  |
| **16.1** | **Charging Update** |  |
|  | R Brunton notified the Committee that a report will be circulated for virtual approval regarding the fee uplift for residential and domiciliary care as a decision is required by the end of February. R Brunton provided a summary: * There is a gap between ASC funding and financial commitments.
* The government has announced an increase in the national minimum wage; which is higher than anticipated. This has impacted on fee setting, particularly in supported living and care at home. The increase also impacts on senior staff whose wages will be increased proportionally. Current rates of RPI and CPI will be detailed within the report.
* Fee planning and market engagement meetings have been held with providers.
* The fair cost of care exercise for residential care was carried out in 2019 and a methodology agreed. The quality premium pay element was removed with homes now required to meet minimum agreed standards. Those not meeting the standards are required to use a self–assessment tool. The residential care fee rate is currently in the lower range across the regional cohort.
* Support at home was subject to a tender in 2019/20. There is a new framework with 9 providers. There has not been a fair cost of care exercise for support at home.
* Domiciliary care was subject to a tender in 2019. The current rate is one of the lowest rates in the locality. It was noted that the local model results in less travel which impacts on wages.
* Overall occupancy of homes was at 76% in January 2020. This is being monitored.
* CHC are a part of fee setting. The rate for CHC is in relation to the basic rate for social care with added on funded nursing care.

The virtual report will include 4 offers and a table will outline the overall percentage uplifts. The anticipated cost is approximately £2m gross expenditure. There should also be an increase in income. The net impact is approximately £1.5m. CHC costs are additional (approximately £350k). |  |
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|  | **Date and Time of Next Meeting:****Wednesday 11th March 2020, 9-11, Crosland Suite, Grimsby Town Hall** |  |
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