

###### Integrated Commissioning Board

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| **Date :** | Thursday 19 November 2020 |
| **Time :** | 09:30 – 11.00 |
| **Venue :** | Virtual via Microsoft Teams |

### MINUTES

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| **Present :** | |  |  | |
| Val Moore (VM) Chair | | Independent Chair | | |
| Caroline Townsend (CT) | | Head of Commissioning Partnerships and Programmes, CCC/PCC | | |
| Sue Beecroft (SB) | | Housing Board | | |
| Will Patten (WP) | | Service Director Commissioning, CCC/PCC | | |
| Mandy Staples (MS) | | Deputy Chief Nurse, CPCCG | | |
| Aleks Mecan (AM) | | Head of Community Services and Integration | | |
| Karen Hurst (KH) | | CPFT | | |
| Keith Reynolds (KR) | | Assistant Director of Strategy and Planning, NWAFT | | |
| Rob Murphy (RM) | | North Alliance | | |
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| **In attendance:** | |  | | |
| Sandie Smith | | CEO, Healthwatch | | |
| Shauna Torrance | | Head of Adult Social Care Commissioning, CCC/PCC | | |
| Elaine Overend (EO) (Minutes) | | Executive Assistant, CPCCG | | |
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| **1.** | Apologies | | |  |
|  | Received from J Webster, C Anderson, L Kamfer, M Nagra, C Black, J Farrow, M Moore, V Thomas | | |  |
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|  | VM reminded that the role of ICB, on behalf of Health & Wellbeing Board, is to support spending joint money in right places. Wanted clarity on commissioning landscape and development of an Integrated Care System (ICS) for local health and care system so able to understand and contribute. | | |  |
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| **2.** | Minutes of Last Meeting | | |  |
|  | Minutes of meeting held 22 October agreed | | |  |
|  | Minutes of meeting held 17 September 2020 agreed – to be recommended | | |  |
|  | Minutes of meeting held 13 August 2020 agreed – to be recommended | | |  |
|  | Minutes of meeting held 23 July 2020 agreed – to be recommended | | |  |
|  | Minutes of meeting held 18 June 2020 agreed. – to be recommended | | |  |
|  | Meeting not quorate | | |  |
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| **3.** | **Action Log** | | |  |
|  | Action Log of 22 October 2020 updated | | |  |
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| **4.** | **Matters Arising** | | |  |
|  | None | | |  |
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| **5.** | **Approach to Commissioning D2A Beds – Deep Dive** | | |  |
|  | The Government published a new “Hospital Discharge Service – Policy and Operating Model” setting out the continuation of the Discharge to Assess (D2A) which is force till 31 March 2021. Paper presented by S Torrance provides an overview of our system approach to implementing pathway changes to enable Pathway 2 (Short Term Community Bed Based Services) to become operational and planned next steps beyond March 2021. | | |  |
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|  | Allocation of pathways managed by single point of access with support from Brokerage Team. Worked jointly with health and local authority to understand how best transition people in an outcome focus way. Demand model forecast 161 beds for average 5 weeks. Reviewed what had in system and how use differently in more personalised and outcome way rather than isolated through social care - equated to shortfall of 20 beds to commission. | | |  |
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|  | Model aims to place people where require short term provision against need (either high, medium or low) and receive wraparound services with case manager allocated to individual to return home. Benefits include; good existing bed use utilisation and value for money; joined up and system approach of Pathway 2; with one conversation and defined pathway. | | |  |
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|  | This is short term solution to learn through the process. Longer term beyond March, assuming national guidance continues with learning from best practice. Then look at our local provision to commission a longer-term approach and take learning and experience from our patient users to inform that. | | |  |
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|  | ***The following comments/questions were raised*** | | |  |
|  | - Healthwatch England published report on experience of patients discharged from hospital. Can circulate to members –  <https://www.healthwatch.co.uk/report/2020-10-27/590-peoples-stories-leaving-hospital-during-covid-19>  Healthwatch locally are following up patients for their hospital discharge experience – to publish in December. | | |  |
|  | -Look at naming of pathway ‘0/zero’ in terms of public understanding, as people may interpret as no support, when voluntary sector is a key part. The Early Intervention Prevention (EIP) was noted, working in more integrated way to meet needs at both ends of spectrum. | | |  |
|  | -Contact SB for housing input and connections. | | |  |
|  | -Commented on our capacity as quite different to the national profile of discharges. ST responded that were at start of journey and percentages released national were almost optimum and we have a way to go - this is starting point to manage demand more effectively and push from use of pathway 3 to 0 with the national benchmark providing a target to work towards. Local Authority also have slight variation in national to local model definitions of pathways 3 and 1. From national perspective pathway 3 is optimum level and purely bed base, and that going home to domiciliary care is pathway 1. Locally pathway 3 includes going home to domiciliary care as well. Decision made locally as most efficient way. | | |  |
|  | -Queried if staff resources are available in these settings and whether primary care also involved. Responded beds already in place and staffed by CPFT and mobilised for wraparound. Take learning around input for medium and low-level therapy interventions. GP cover established for those homes will need to expand - CCG leading and looking at impact. CPFT recruitment ongoing and system wide working to move therapists for Pathway 1 and resource from Acute colleagues. CPFT also looking at redeployment of staff to support Integrated Care Worker (ICW) needs in pathway 1. Recruited 30 ICW but fell short of required amount and seeking some redeployment, going to gold command for approval. D2A needs additional investment - agreed by Recovery Oversight Group to include both therapy capacity and wider capacity of social care and brokerage. Recruitment underway for those posts. | | |  |
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|  | -Flagged pathway zero and people going out go through single point of access. Good links to British Red Cross in hospital. Need to make sure ward staff aware of different pathways and maximize pathway zero -opportunities to do more of this. | | |  |
|  | - Was there evidence nationally about what do from a commissioning perspective? Evidence that combined shared budget helps. Discharge viewed from Local Authority perspective is slightly broader than coming out safely from acute care. The focus for local authority is outcome of being independent and to maintain people’s wellbeing in the community. The commissioning goal for local authority is people not to go into acute in first place. The D2A being commissioned is very prescriptive about what can and cannot do. | | |  |
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|  | - Board recognised interim nature of the project and its opportunities. | | |  |
|  | -Healthwatch offered to help with an information leaflet for people with simple words describing the pathways. | | |  |
|  | -Questioned if new money and its quantity? Clarified that local authority beds commissioned to deliver short term for either community crisis or admission avoidance had been in place for a number of years. Extended funding for Covid to meet needs and this is retained. CCG also funds short term beds. Using existing services differently within existing budget. If not implementing it right, then cost benefit will reduce. This is a cultural change to ensure capacity for people to go home with higher levels of need well supported. | | |  |
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|  | Board thanked ST and requested a further update and monitoring to help drive developments in the Spring. | | |  |
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| **6.** | **Commissioning Landscape Workshop** | | |  |
|  | * *How is commissioning for integrated social care, NHS and public health services changing* * *Learning from working together during Covid-19* * *Shaping new arrangements for an Integrated Care System* | | |  |
|  | Key to be able to start to talk about provision in future and provide comment. | | |  |
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| 6.1 | **Perspectives: How it used to be, what it became and what it could become** | | |  |
| a | Local Authority | | |  |
|  | WP shared commissioning landscape including slide presentation | | |  |
|  | Pre-covid and during covid the commissioning intention outcomes, largely for older people, were not changed. Important focus on prevention to reduce demand and maximise independence. Reduce amount of hospital admissions and discharge quickly and appropriately to the right setting. Outcomes not materially changed. | | |  |
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|  | Environment has changed - taking learning from the approach to commissioning. Expect Covid to impact for next 18 – 24 months. Increased financial pressures and government funding has not matched the cost pressures. | | |  |
|  | Infection control measures impacted way services delivered and changed way Day Care Centre provided services, for example. People more reluctant to access traditional models leaving a challenge to how to respond. Latent demand and increased acuity, with people not accessing support at the right time has an impact of poor health and wellbeing. Review what commissioned and where. | | |  |
|  | Pre Covid, budgets were demand led and following learning from Neighbourhood Cares, Adults Positive Challenge (APC) work. We want and need to accelerate Place Based approach, under Think Communities banner – Prevent-Reduce-Delay. | | |  |
|  | Commissioning needs to align to needs of local communities in its wider sense but need to do so in full collaboration with partners and move away from current infrastructure in place. | | |  |
|  | Other principle taken from APC: invest in social workers to change community behaviours at scale and focus on obesity, education attainment, and volunteering in communities. Commissioning also needs to be place based and support with capitated budget. | | |  |
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|  | Overarching approach to recognize new environment and undertake learning from Think Communities and provided examples of how contribute; Care Suites; Micro Enterprise; Care at Home Pilot; and Market Sustainability. | | |  |
|  | Role for our ICP including development of multi-disciplinary teams (MDT) model in the community. Jointly commission where makes sense to. | | |  |
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| b | CCG | | |  |
|  | AM shared the CCG story. What we commissioned pre-Covid was relatively the same as we commissioned during Covid, with caveat that we changed some delivery models in order to comply with national guidance. | | |  |
|  | Most changes were around stopping or reducing non-essential service in order to increase hospital bed capacity. | | |  |
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|  | What has really changed was the speed of operations:   * On one hand things got slower i.e.  due to infection control bed capacity was reduced and as consequence, in times of increased demand, we could not off-load ambulances * On the other hand, we also manged to ‘drop’ a lot of bureaucracy; a great example is Community Hubs the CCG created with LAs - practical partnership working and good sharing and use of data available. | | |  |
|  | What we gained was focus on health inequalities. | | |  |
|  | What we lost is staff resilience which with time became more fatigue and the emotional and mental toll of working within pandemic. | | |  |
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|  | Going forward:   * We need to keep patients and staff as well at the heart of what we do * We need to keep preserving essential services and focussing on prevention * We need to commission outcomes based & place-based services, driven by reducing health inequalities and aiming to reduce digital exclusion across communities. | | |  |
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|  | In summary:  What we did – we stepped down services.  What we do now – is we prevent services.  What we need is more focus on our staff and their wellbeing, so supporting patient outcomes.  Future focus: Outcomes and place-based commissioning, driven by health inequalities data and supported by digital tools, that drive self-care & higher patient activation. | | |  |
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| c | Public Health | | |  |
|  | No representation due to current pressures. Important to consider at future meeting or provide briefing. Chair highlighted work on No Recourse to Public funding and on homeless support, as important pieces of work. CCG and PH have had discussion on other services jointly commissioned and this will resume when possible. | | |  |
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| 6.2 | **Discussion** | | |  |
|  | -Regarding Think Communities, what size of population, and was it in line with conversations in north re Community Hubs? Discussion on population size for communities continues and also relevant to primary care networks (PCN). Principle - to make local decision about community and vary from one area to another. Not to set on one size but be meaningful and affordable in size. To meet needs of population in particular communities. | | |  |
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|  | -PCN from health perspective have local population needs addressed at scale. | | |  |
|  | Inequality across Cambridgeshire and Peterborough is a huge challenge and concern getting right resources at community level, and also that PCN not match with District and County boundaries. | | |  |
|  | -Start to learn not think about boundaries but communities and their needs. These are our resources and where best target and change. Need to start and learn as go and accept flex and change. Keep in mind collective priorities and then boundaries become no discussion. | | |  |
|  | -Place based and capital budget – how to allocate resource to patient and population needs rather than historically? Allocate using weighting for deprivation, and put ring around CCG or PCN, but not have plan as to how its implemented. The motivation for this is where we have high deprivation, we know it creates demand for services. All comes back to Prevent-Reduce-Delay and to target those communities. If we make improvements then demand for resources reduce, it’s a virtuous circle, and then start tackling demand. | | |  |
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|  | *(RM left the meeting)* | | |  |
|  | - During covid there was joint working of data analysis. Regarding inequality we may see in 10 years’ time the effects of funding switches. ICS challenge for sharing of NHS and Social Care and information data analysis to understand market demand for care, monitoring resources and how to follow people, places and resources - an intelligence led cycle of provision. | | |  |
|  | -With Think Communities plea to ensure inclusion of excluded groups, eg. travellers, homeless, and those that move across communities, so don’t fall between cracks. Healthwatch successful in obtaining funding for gypsy and travellers peer approaches and provider training, but implementation delayed due to covid. Need for a focus of understanding developing effective communication between agents of care and socially excluded groups. | | |  |
| **8.** | **Next Steps and Key Communications** | | |  |
|  | Strong messages have emerged on wellbeing and prevention and more conversations needed at ICB around these important changes, including with public health colleagues. | | |  |
|  | Disseminate the information on Discharge to Assess model and schedule an update in Spring on how performed. | | |  |
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|  | Agenda items for next meeting: | | |  |
|  | Public health discussion at next meeting | | |  |
|  | BCF Reporting and review of spend/budgets. | | |  |
|  | Internal audit of BCF held and share report at next meeting. | | |  |
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| **9.** | **There was no other business** | | |  |
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| **NEXT MEETING** | | | |  |
| **9.** | Monday 18 January 2021, 13:00 - 14:00 via MS Teams | | |  |
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