Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 11th October 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG's
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Mike Abel – Lay Member, Walsall CCG
Alastair McIntyre – Portfolio Director, Black Country and West Birmingham STP

In Attendance:
Charlotte Harris – Note Taker, NHS England
Jonathan Fellows – Black Country STP Independent Chair
Laura Broster – Director of Communications and Public Insight

Apologies:
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Peter Price – Lay Member, Wolverhampton CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. Prof Nick Harding informed he had declared an interest in the Clinical Leadership Group Chair position.

1.4 The minutes of the meeting held on the 13th September were agreed as an accurate record. The minutes of the meeting held on the 9th August were agreed as an accurate record and signed off today as the previous meeting was not quorate.

1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 In regards to 091, it was informed the Clinical Strategy would be presented to the Clinical Leadership Group (CLG) later that evening. This will be brought back in December.

1.7 In regards to 114, it had been agreed that the Black Country STP will not be doing the review for Kiran Patel but will be carrying out a review on Provider Sustainability. It is also part of action 102.

1.8 In regards to 124, it has been impossible to convene all three applicants on one date. There have been three dates provided for applicants to attend.

2. MATTERS OF COMMON INTEREST

2.1 Place Based Commissioning Update – Dudley

2.1.1 Paul Maubach informed there has been a joint conference call with NHS England (NHSE) and NHS Improvement (NHSI). They have agreed and outlined a timetable with the regulators. They have agreed with the regulators to submit the commissioning components of checkpoint two of the ISAP process following the Governing Body meeting in November. The NHSI assurance process is that they will then need to take the providers through in order to develop the MCP. This is going to be a lengthy process to write the strategic pace for the MCP in the context of the Dudley system and what it means for providers in the system. They will require two produce LTFMs; one for Dudley Acute and one for the MCP. The mobilisation process for creating the MCP can then start. The whole process can take at least a year. The timeframe for establishing the MCP properly are aiming for January 2020, ready for April 2020. It was noted, if this had been a joint venture between the NHS provider and the GPs, the MCP would be place by now. However, this had higher risks. The levels of assurance in the chosen process have elongated the completion. There have been no applications to split a Foundation Trust before.

2.1.2 There were questions raised regarding the impact on Commissioning Intentions. Paul Maubach confirmed the contract cannot be awarded in April 2019 as previously intended. The Transition Board for MCP has been established which will bring all the partners together to manage the situation during the transition period. This will have to run for at least 18 months. A lot of work is required when creating an organisation. The biggest concern is that the General Practice will become frustrated with the long process as 93% have signed up to the creation of the MCP. The council will be equally exercised in regards to the timeframe.

2.1.3 Dr David Hegarty discussed the fact the MCP is the system solution to the problem with Dudley Emergency Department. In previous discussions, it was confirmed everyone wanted something done. There is an issue regarding how the system survives until the MCP is in place. There needs to be a workforce solution and a better relationship developed with the third sector.

2.1.4 Paul Maubach noted it would be beneficial to have collective support from the committee and the STP for the MCP model. There has been extensive consultations and questions raised but with no solution offered. If there is a consensus across the STP, it will make the case for the MCP stronger. There were discussions on the sustainability of Primary Care and the risk around this. The MCP can make a substantial difference to the population around outcomes. They can evidence where there will be improvements in specific areas but more can be done.

2.1.5 It was confirmed the time delays with procurement will not have an impact on the MCP. Workforce is an issue with each CCG. There needs to be some better solutions as the problem could develop before the MCP is in place. It was agreed the Workforce Strategy would be produced alongside the Clinical Strategy. There is a need to understand how far away the STP is from tipping point in Primary Care to try and prevent this from occurring.

Mike Abel suggested there are additional pressures on Primary Care that will need to be reviewed.

Action: An extended discussion to be arranged regarding the MCP and Primary Workforce Retention.

2.2 **Clinical Leadership Group Update**

2.2.1 The CLG is meeting later today to discuss the Clinical Strategy and Primary Care Networks.

2.3 **Performance**

2.3.1 Alastair McIntyre presented performance on a page for the Black Country. The information only runs until June 2018. The CSU tool is being developed and will be presented when available. There has been an improvement in RTT but there are 24 52 week waits that need to be reduced. In regards to the waiting list reduction to 0, this has been requested from NHSI. The CSU tool will allow a narrative for actions in regards to red ratings. With dementia, NHSE has escalation meetings with Sandwell & West Birmingham. IAP is improving. There was an assurance statement released yesterday; there is general improvement. There are some issues in Mental Health.

2.4 **Risk Register**

2.4.1 Paul Maubach, Jim Oatridge and Alastair McIntyre presented the first draft for the risk register. They have focused on risks that are relevant to the committee and would not be on the CCG risk register. The next step would be to review mitigating actions to deal with those presented. The list consisted of:

BC001 – the delegation to the committee is not legally sound
BC002 – West Birmingham is out of scope for the BC JCC in terms of matters for delegation
BC003 – there is confusion in decision making/delegation in relation to the BC JCC or that matters are not sufficiently clear as to be understood
BC004 – it is not clear on the agreed method of delivery or of assurance for such services as included in the joint commissioning intentions
BC005 – not all CCG Governing Bodies agree the proposed model of funding for TCP
BC006 – the different models for commissioning place based models of care impact on CCG ability to delegate to the JCC
BC007 – the BC JCC does not have legitimacy in the STP or with CCGs unless the governance and delegation are clarified

It was suggested that BC003 be re-worded to reflect that the committee will become irrelevant if noting substantial is delegated to it. It was noted with BC005, the funding for TCP has been agreed by the CCGs. This is still waiting agreement from the councils. There was a suggestion to re-word this to reflect a general risk around funding. Jim Oatridge noted a lot of these are easy to address; the committee would need to be disciplined.

2.5 **Sandwell & West Birmingham and Wolverhampton Integrated Care System and Financial Risk Discussion**

2.5.1 Matthew Hartland gave a recap from the previous meeting. The request had surfaced regarding any initial risks of the MCP on Dudley Group, place based models and future financial flows. For Dudley, half of the services would be subcontracted back to existing providers. Therefore, the impact is less material. There is limited impact on Dudley Group and Dudley and Walsall Mental Health Trust. For Black Country Partnership, there are more services contracted back so they will be less affected.

2.5.2 Paul Maubach informed the clinical model for the MCP was designed to reduce the risk to existing providers. There were questions raised whether this would jeopardise any long term outcomes. As a CCG, they will need to ensure the MCP collaboration is real. It was confirmed there are clauses in the contract to allow mutually agreed negotiation should there be a need to increase resource in the community services. As a commissioner, they are moving away from what service they want to what outcomes they require. There are mitigations should outcomes go the wrong way.

2.5.3 For Walsall, there is a similar process, with the need to define what is in and out of scope. They are not establishing a new organisation. There will be a lead provider. Everything in Walsall Manor will be in scope except the Emergency Department which is being reviewed. The plan is to be in shadow form by 2019/20 onwards.

2.5.4 With Wolverhampton, everything will be in scope under the alliance model. They are reviewing the boundary issues. This encompasses the entire economy and ensures financial transparency. There were discussions over GMS contracts within Wolverhampton. The partners are directly employed by the trust and hold themselves to account. The GPs are able to work across more than one practice.

2.5.5 The approach for Sandwell & West Birmingham will be different. As it stands, all will be in scope. There will be two alliance partnerships; one for Sandwell and one for Western Birmingham. These could be subcontracted down. They are not assuming double delegation and have kept GP contracts out. The Better Care Funds are a difficult element, and are currently split between the two. They are talking with West Birmingham colleagues about the approach.

2.5.6 It was suggested that the activity should be presented in the same way. It was suggested this could be presented as year one with additional information and changes for the future. There needs to be a consistent approach for the STP. It was suggested there is a need to understand the provider view and other areas of commissioning to have the totality of each provider to understand their full resilience.

2.5.7 Paul Maubach suggested the full picture is not being presented. The differences and gaps between numbers will need to be addressed. There needs to be a look at the whole system. It was noted that the provider landscape is changing which could change the financial flows. There is also a difficult position with the Local Authorities which could have an impact on health. This has revealed there is more work to be done to clarify approached and review where differences are.

Action: The financial analysis for each place to be updated to be presented in the same way with a year one position with additional information and changes in the future.

2.6 **JCC Executive Development Session Review**

2.6.1 There was good attendance and the session went well. Joint Commissioning Intentions was an action from the session; these were presented at the STP Stocktake meeting. It was suggested these need to go to individual Governing Bodies for sign off. An important piece of work that was identified was the need to commission West Midlands Ambulance Service (WMAS) differently. The trusts are under pressure; Russell Hall's had 30 ambulances arrive within one hour. The performance standards for WMAS are the best in the country but this is not working in the way the system needs. There is a need to support the work being done by Rachael Ellis. It was noted that Rachael Ellis will be attending on Monday's Partnership Board to present the information to the partners.

2.7 Latest Service Change List

2.7.1 Alastair McIntyre presented the latest service change list for the Black Country. At the next Accountable Officers meeting on 06 November, they will run through the timescales. NHSI will have conversations regarding the transactional process. There is a meeting with Specialised Commissioning later that day. It was noted that the Active Services Change Group review services changes brought to attention of NHSE. It was suggested, for the presentation to remove the word "Active" and change it to "Service Changes Being Considered". Cancer and Specialised Commissioned are being narrowed down.

3. FORMAL DELEGATION

3.1 Risk Register

3.1.1 This was discussed in 2.4.

3.2 Transforming Care Partnership (TCP)

3.2.1 Dr Helen Hibbs presented a report on TCP. The numbers are not good but discharges are being achieved. However, there are still admissions occurring. There was a meeting with Ray James where it was commented there are "green shoots of recovery". The provider model is mainly operational. The focus is to avoid admissions. There is work being carried out with the Care and Support Programme. There were discussions regarding a recent programme around this area which involved a patient from St. Andrews Hospital. The difficult process has helped lay a firm foundation for the Black Country.

3.2.2 Paul Maubach reflected on the Walsall case where the patient was being commissioned by Specialised Commissioning. From the Walsall CCG perspective, the CCG could have been more proactive. Dr Helen Hibbs discussed the lack of coordination between the CCG and Specialised Commissioning. Specialised Commissioning has high caseloads. Resource was offered to get additional support but they failed to recruit for case management.

Mike Abel left the meeting.

3.2.3 Laura Broster informed that the TCP public involvement is due to commence in November. They are undertaking the involvement exercise to seek public views on the community model, the reduction of inpatient beds and to influence the future location of the Assessment and Treatment Beds in the Black Country.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 CCG Collaboration – Areas for Consideration for Delegation to the JCC

4.1.2 It was suggested there needs to be a clear paper, such as the CAMHS paper for areas that are being worked on. It was suggested that each area be worked up on and brought the committee so there can be a review for options to discuss possible delegation.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 Response to Alison Tonge Letter of 28th September

5.1.1 Dr Helen Hibbs informed this letter was sent to all CCGs in the Midlands and North. This was around learning from the CCG merger for Birmingham and Solihull and the time taken to do so. It is a helpful document for those that are considering merging as it highlights the

steps needed and the issues with governance. It was agreed there would be a collective response from the Black Country to note they are not considering CCG mergers.

5.2 **STP Diabetes Prevention Programme**

5.2.1 Alastair McIntyre informed there was a webinar earlier in the week which noted that there needs to be a draft prospectus for the STP Diabetes Prevention Programme submitted by the 19 October. The new contracts will be on a STP footprint. Therefore a lead will need to be identified. Laura Broster noted there are experts available with Public Health colleagues. This will be presented at the STP Partnership Board on 15 October.

5.3 **Stroke Review**

5.3.1 Prof Nick Harding suggestions the Stroke Review comes to the committee for understanding. It was noted that the CSU can attend in November to give a presentation on Stroke Data.

5.4 **Meeting of Accountable Officers and Clinical Chairs**

5.4.1 Dr Helen Hibbs informed that it is not possible to organise a meeting between the Accountable Officers and Clinical Chairs before the meeting with Alison Tonge in November due to annual leave commitments and availability.

6. DATE OF NEXT MEETING

Thursday 8th November, 10:00-12:00, Stephenson Room, Wolverhampton CCG, Wolverhampton Science Park, Glaisher Drive, Wolverhampton, WV10 9RU

JCC Action Log

No.	Date	Action	Lead	Status Update
091	22nd Mar 2018	Clinical chairs to discuss CLG links into workstreams and the PMO to ensure there is no duplication of work.	Dr Anand Rischie	11/10/18 The Clinical Strategy is to be signed off. This will be brought back in December. The PMO will be in place by then.
097	10th Apr 2018	Local Authority representatives to be invited to the Clinical Leadership Group meetings.	Charlotte Harris	11/10/18 The Terms of Reference of the CLG is to be signed off.
102	10th Apr 2018	Prof Nick Harding to include clinically based commissioning for outcomes as an agenda item for the Clinical Leadership Group.	Nick Harding	13/09/18 This will be pending CLG approval and appointment of Chair
126	11th Oct 2018	An extended discussion to be arranged regarding the MCP and Primary Workforce Retention.	Paul Maubach	
127	11th Oct 2018	The financial analysis for each place to be updated to be presented in the same way with a year one position with additional information and changes in the future.	James Green and Matthew Hartland	