Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 8th November 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton 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
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG
Alastair McIntyre – Portfolio Director, Black Country and West Birmingham STP

In Attendance:
Andrew Hood – CSU
Charlotte Harris – Note Taker, NHS England
David Frith – CSU
Jonathan Fellows – Black Country STP Independent Chair
Laura Broster – Director of Communications and Public Insight
Lucy Heath – RightCare, NHS England
Pavinder Bhangu – NHS Leadership Academy, Dudley CCG
Simon McBride – Black Country STP Clinical Lead for Stroke
Wendy Macmillan – Black Country STP Programme Manager, Planning

Apologies:
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. None were declared.

1.4 The minutes of the meeting held on the 11th October were agreed as an accurate record with the exception of a missing action for item 2.5 stating "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." Matthew Hartland confirmed that issues have been identified and this will be updated on at the next meeting.

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 action 102, three dates have been set for the interviews of the chair of the Clinical Leadership Group (CLG). Dr David Hegarty will be attending as part of the panel at two of these. One interview has been completed. The others should be completed by the end of the week commencing 12th November. The CLG was cancelled for November.

2. MATTERS OF COMMON INTEREST

2.1 Place Based Commissioning Update – Dudley MCP Discussion

2.1.1 Paul Maubach presented on the Dudley MCP progression to date. There are significant challenges around disease, changing conditions and increased demand. The place based solution for Dudley was a Multi-speciality Community Provider (MCP). The key issues and agendas were managing demand of long term conditions and the coordination of complex needs, supporting Primary Care, population health management, and the MCP providing a mechanism for addressing ensuring the right services are together. This will involve working as a partnership with a single leadership and organisation being brought together. The Multi-Disciplinary Teams (MDTs) were part of the increased collaboration. Dudley wanted the sole purpose of the organisation to be the integration agenda. For the hospital and MCP there will be 50/50 funding.

2.1.2 The care model for the MCP and its evolution was discussed. The MDTs will move into an Integrated Care Team (ICT) with two per locality or Primary Care Network. This will enable a Dudley wide clinical communications centre to focus on out of hours, handovers and business intelligence. There are a couple of practices that are large enough to have their own ICT. This could be the vehicle to access hospital based services. This is still developing in terms of funding and organisation decision. However, there are some areas in place such as central medicine management. The outcomes framework for GPs that replaces QAF and the outcomes framework for the MCP were outlined.

2.1.3 The MDT impact was reviewed and it was noted there is increased productivity. The links to the voluntary sector is important and should be utilised as there are more complex needs that are not just to do with the person's health. The personalised care planning looks at long term conditions and setting own goals to increase resilience and activation of the patient. There has been a single focus on hypertension where diagnosis has increased and mortality decreased. There has been an impact on the individual patient level with the risk of admission reducing.

2.1.4 Paul Maubach outlined the progress so far around extensive Primary Care access, improved long term conditions management, care coordination, and improved staff and patient engagement. However, there are still 40% of patients being taken to A&E and them being admitted. There is a need to review the workforce model and Primary Care at scale. The Healthy Life Expectancy (HLE) trajectories are progressing in the wrong direction. In regards to recruitment retention, there has been a 16% reduction in GP capacity. This is having an impact on A&E attendance, non-elective admissions, cost, and outpatient departments. This has led to a net increase of 12% in demand.

2.1.5 There is a need to build resilience in Primary Care to reduce the impact on A&E. It was noted, there has been a reduction in practices. The existing practices have absorbed the demand. This could lead to the system collapsing. The solution is to have Primary Care at scale to increase resilience. HLE is declining. There were discussions on an improved Dudley health and wellbeing through advanced population health and wellbeing

management. Projections of this reverse HLE by 5 years. This ambition only comes with Primary Care being at scale. An ambition of Dudley is to have fully integrated care. This will bring together the people working on the same issues with the same population. They can set same outcome objectives and introduce shared population responsibility. There will be incentives and services at scale.

2.1.6 It was noted the commissioning approach is a whole population budget. It is a ten plus five year contract with an outcomes framework. 10% of the contract value will be linked to outcome delivery. The contract obliges the MCP to deliver a national mandated care model. There have been two judicial reviews on the contract, with one still in appeal. The single organisation and single contract will be held account. The CCG will be transferring resources to the MCP and scaling back its nature. There will be risk and gain share with providers.

2.1.7 The services in scope includes; all of general practice, some outpatients at the hospital mainly long term conditions, prescribing budget, public health services commissioned by the council, community services for adults and children, costs in the hospital associated with ambulatory care sensitive conditions, continuing healthcare, mental health and learning disabilities, and adult social care is included in the procurement but the council are going to phase this in. The planned contractual arrangement is the CCG or Council will contract to the MCP. There will be subcontracts to providers from the MCP and an integration agreement with the GP practices. The timetable of the MCP was discussed from the MDTs being developed in August 2014 to the MCP beginning from April 2020. The ISAP checkpoint two and transactional review with NHSI was discussed.

2.1.8 Paul Maubach outlined the other organisational forms that were considered instead of the MCP. The MCP/PACs being a division of Dudley Group FT was declined as the GPs did not support the proposal and it would invalidate the procurement process. The MCP as a joint venture as a Community Interest Company was declined as it would lead to a £3 million VAT liability. The MCP forming from a “vacant” provider was rejected by NHSI due to the time it would mean the organisation being a shell company. Other than repurposing an existing trust, creating the MCP by splitting an existing foundation trust was the only allowable route. One criticism of this is the STP will see the MCP as an additional provider within the Black Country.

2.1.9 The financial arrangements of the MCP were discussed with the MCP receiving £240 million and Primary Care receiving £42 million through an integration agreement. £131 million will be funded to Dudley Group FT. There are discussions around how a risk/gain share agreement between MCP and Dudley Group FT will work. It was noted the MCP fits with the STP strategy as it sets out place based provision. The MCP builds up from practice population with no cross border financial flows. It does not include acute services which might form part of the Black Country acute network. Mental Health and Learning Disability services are in scope but it allows services that will form part of joint Mental Health arrangements to be subcontracted from Mental Health providers.

2.1.10 Andy Williams raised questions around the challenge of managing risk once the MCP is established, the residual providers carrying risk with the gap of demand and resource, and ensuring the MCP success does not negatively impact the trust. Paul Maubach noted the initial set up of restructuring the system reviewed having enough capacity and ability to deliver without destabilising the providers. The balance of direct and subcontracted finances will protect existing providers. There is a need for sophisticated oversight. The current pressures in the system were discussed and the balance of investment in the system needing to stabilise the whole system. Providers collaborating can make a difference with them sharing the risk between them rather than being at the CCG level. Matthew Hartland outlined the new contracting budget for Dudley Group FT and the contracting mechanism in

place. There were discussions on how a shared control total for the acute hospitals could make them stronger as they will come together to resolve issues.

2.1.11 Dr David Hegarty noted that it was not sustainable to continue as is and the risk of having no change. There is a reduction in clinical sessions and availability of workforce. The workforce is also ageing. Individual GPs spending time in MDTs saw benefits as they were caring for patients in a better way and reducing patients continually attending. The ambition is to have the workforce working a bit longer in the system. There were questions raised as to why it required a new organisation to improve GP recruitment and retention. It was noted that GPs were against the MCP/PACs being a division of Dudley Group FT and the GPs did not want to be taken over by the hospital. There is greater resilience in larger practices. There is now one IT system. This can allow appointment sharing and enable people to work a bit longer with different roles being available when needed or wanted. This has increased engagement into Primary Care. Paul Maubach noted the lifespan of a CCG is limited. There needs to be a greater understanding of Primary Care. It is imperative to create an organisation that will have a Primary Care voice as this is not currently adequately represented at scale. Primary Care needs a long term voice in the system. The culture and risk model needs to empower the individual.

2.1.12 Mike Abel questions whether the work on HLE went far enough and whether there needed to be more involvement from wider public services to reduce a boundary around the health system. Prof Nick Harding noted the timescale has meant that other organisations will be able to catch up on progress without facing as much challenges. This could result in a national programme without the need to split up foundation trusts. Jim Oatridge noted the length of time and energy put in to establish the MCP. The timetable for legislative change is shorter than proving the MCP works. There were questions raised whether future legislation can be influenced to facilitate more rapid capability. Paul Maubach informed this will be presented to the Health Select Committee and MPs. The report is currently being finalised.

Action: Paul Maubach to share the report for the Health Select Committee regarding the benefits of legislative change.

2.1.13 Paul Maubach noted it would be beneficial to have endorsement that the MCP is consistent with the wider strategy and there be support as arguments develop around legislative change.

Andrew Hood, David Frith and Simon McBride entered the meeting.

2.2 **Stroke Data Presentation – CSU**

2.2.1 Andrew Hood informed as part of the strategy and programme board, there is a need to improve the services of stroke. There has been a focus on acute and modelling. They have estimated likely changes in demand and reviewed current STP plans. The planned changes are around Thrombectomy centres, Acute Stroke Units and Hyper Acute Stroke Units. For the Black Country, they have planned for the consolidation of Sandwell into the Midland Metropolitan Hospital. They reviewed the baseline, demographics, prevention and efficiency savings to result in final activity, demand and flows. The modelling factors were presented and the impacts of prevention on stroke incidence. The projected changes by the STP were moderate. There were alternative scenarios shown for acute configuration which were modelled as either Midland Metropolitan or Dudley Group. There was a comparison of modelled activity for the scenarios. Alastair McIntyre informed there had been a conversation at the CLG regarding the steer. Kiran Patel has been drafting an email regarding this work.

2.2.2 Prof Nick Harding questioned whether the inputs were correct with the modelling and whether there had been CCG input. There is a need to model the types of stroke going into

hospitals as these have different rehabilitation needs. Due to the demographic area, the information modelled may not be a true reflection. There were questions raised over the drive time percentage to get the first unit to be dealt with and the review of the quality impact. There is data required on the cost and staff driver before a decision can be made. Andrew Hood noted there is parallel work around workforce occurring. This is being led by a Public Health representative. This will include potential impacts but there may be a need for a greater focus. The demographics include population growth not ethic group. Simon McBride noted for the Hyper Acute Stroke Units and rehabilitation has been in imbedded in. Workforce and sustainability in the future is important. There needs to be the right resource and the right time. Technology has progressed and there is a need for stroke consultant expertise.

2.2.3 Dr Salma Reehana noted there is a lot of the prevention aspect being reviewed in the CLG. There is a need to review the community rehabilitation pathway. Andy Williams suggested the need to model the impact of the new configurations on the ambulance services and the relationship between services such as Specialised Commissioning needs to be understood. Dr Helen Hibbs suggested the need to join up with the provider vulnerability and sustainability review. There needs to be clear reasons for a case for change. Dr David Hegarty informed Prof Nick Harding chaired the stoke review for Birmingham and Black Country. The suggestion did not progress due to the capacity issues at University Hospital of Birmingham.

2.2.4 Simon McBride will take these views back to the Stroke Board. The recommendations back to Kiran Patel will be to explore another perspective.

Andrew Hood, David Frith and Simon McBride left the meeting.

2.3 **RightCare Programme**

2.3.1 Lucy Heath presented on the RightCare programme and the National Priority Initiative for MSK. There has been a baseline assessment for each CCG to assess whether they meet the components. Walsall and Wolverhampton are at 96%, Dudley is at 92% and Sandwell and West Birmingham have been increased to over 90%. This has been approved at region. In regards to a system readiness to make changes, it was suggested the Black Country was somewhere in the middle. Alastair McIntyre and Dr Helen Hibbs have made a request of resources suggesting they would benefit from the support. It was noted an executive lead for MSK needs to be identified. Dr Helen Hibbs confirmed they are reviewing appointing leads to the programmes of work.

2.3.2 Lucy Heath gave an update on the work that the CCGs and STP has done with support from RightCare over the last two years. Lucy Heath has been supporting the CLG and Clinical Strategy. There are working groups for respiratory, cardiovascular disease (CVD) prevention, frailty, MSK, children and young people, and cancer. There has been a suggestion that potential work could be carried out in diabetes. This could come under CVD prevention. Within the Clinical Strategy, there can be chapters added regarding cross cutting pathway components such as IAPT for long tern conditions, personalisation and physical activity. They are looking at tools to gain a wider understanding. This could result in training and business case templates.

2.3.3 Paul Maubach discussed at scale business solutions such as the MCP and whether there is something similar for the acute hospitals. There is a need for at scale intelligence as some services are not delivering to the pathways. There is also a need for live tracking of problems as there is a disservice to patients if they are unaware that problems are arising.

3. FORMAL DELEGATION

3.1 **Transforming Care Partnership (TCP)**

3.1.1 Dr Helen Hibbs gave an update on the TCP work. There has been a lot of work within this area. Numbers are still providing a challenge. There has been acceptance that the number at the end of the programme will not meet the trajectories set; there will be 20 for CCGs not 16 and 35 for Specialised Commissioning not 27. It was noted following the Walsall case being in the media, there is additional focus on children and young people and learning disabilities. There is a commissioning team and case manager half day event in December. The PMO support in TCP will need to continue. This may be absorbed within the STP PMO. Dr Helen Hibbs noted it is not just about numbers. The Black Country has the highest rate of discharges but admissions are still occurring. The Black Country is leading the quality outcomes dashboard. The patients need to have good experiences of care and be better in the community setting. It was noted the judicial review in Walsall should not affect the timeframes.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 There were no comments made.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 It was agreed the December meeting would be used as a Chairs and Accountable Officers development session. Due to board commitments, it was agreed the future meetings would be extended by half an hour, to commence at 09:30 moving forward.

6. DATE OF NEXT MEETING

Thursday 10th January, Boardroom, 2R, Kingston House, 438-450 High Street, West Bromwich, B70 9LD

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.
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
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	
128	8th Nov 2018	Paul Maubach to share the report for the Health Select Committee regarding the benefits of legislative change.	Paul Maubach	