**Black Country STP meeting 30/08/2016 6.45 pm Village Hotel J10 M6 Walsall**

**Present:**

Dr.Uzma Ahmad (UA) Walsall LMC Medical Secretary

Dr.Basil Andreou (BA) Sandwell LMC Medical Secretary

Dr.Tim Horsburgh (TH) Dudley LMC Medical Secretary

Dr.Gurmit Mahay (GM) Wolverhampton LMC Medical Secretary

Dr.Bhavin Mehta (BM) Wolverhampton LMC Chairman

Bill Strange (BS) Birmingham LMC Chairman

Dr.Raymond Sullivan (RS) Sandwell LMC Chairman

Andy Williams (AW) Accountable Officer – Sandwell and West Birmingham CCG/

Black Country STP Lead

In Attendance: Carolyn Andrew/Executive Officer – Walsall LMC

**Background**

* UA advised that this meeting had been arranged in response to a letter dated 11th August 2016 received from Andy Williams in which he invited LMC Chairs from Birmingham and the Black Country to participate in the Black Country Sustainability and Transformation process
* On 24th August 2016, representatives of the West Midlands Local Medical Committees (LMCs) and the Midlands Faculty of the Royal College of GPs (RCGP) met to discuss the implementation of the Sustainability and Transformation Plans (STPs) across the West Midland area. The aim was to understand the degree of involvement of primary care and general practice in the development and potential delivery of STPs. Present were either the Chair and/or Secretary of every LMC in the region, all the recently appointed RCGP STP ambassadors and the Chair of the Midlands RCGP
* Birmingham LMC had summarised the discussions at the meeting and also provided recommendations in a letter to Professor Maureen Baker – Chair RCGP and Dr.Chaand Nagpaul – Chair BMA GPC entitled “Plans being made about us, without us”. The letter had been copied to LMCs on the listserver for the West Midlands LMCs Liaison Group
* BS advised that there may be a press release to follow from Maureen Baker
* General view was that not all areas were aware of the STP or involved in it and that people had been trying to engage with the STP but had not been allowed to

**Main meeting**

UA thanked AW for agreeing to attend the meeting and asked him to speak about how the STP process had started for information of those present and then the meeting would be thrown open to questions.

**AW**

* STP has, to date, been shrouded in mystery, largely by central dictat. The Black Country STP has 18 partners, there were initial difficulties as all 18 felt that the Black Country configuration was wrong but options were either to continue to argue against the configuration or to get on it with it and go with what was there. There seems to be a variable appetite across the country for working at STP level.
* Difficult task to get 18 organisations together into the same space – most were very sceptical to begin with
* A set of principles was agreed, one of the major ones being subsidiarity – already extensive co-operative working in Walsall/Wolverhampton/Dudley and Sandwell/West Birmingham. Decided to only focus on things that could be improved through the STP and to maintain inclusivity with neighbouring area STPs and preserve longstanding relationships between areas
* Rapid progress in agreeing principles and coming together as a group but less success in setting up the machinery of the STP - didn’t want to be seen to be creating something that would override local structures. Decided to use local communication routes
* Birmingham story is quite different, very strong preference for one identity for Birmingham. No comms group or engagement process but did start work on triple process
* STP Lead asked to approach Black Country LMCs – hence the letter of 11th August
* Serious limitations to role of STP Lead, tried not to overstep the mark and act only where there is a clear mandate and the support of all parties involved
* Partners have recognised the crucial role of GPs and other clinicians in making the STP a success and would value input into the following groups:
* Sponsoring Group
* Vertical Integration Transformation Group
* Horizontal Integration Transformation Group
* Mental Health and Learning Disabilities Transformation Group
* Maternity and Infant Health Transformation Group
* Workforce Enabling Group
* Maternity health inequalities are a major issue with infant mortality being a defining characteristic, also pressures in managing the demand for secondary care. There are well developed plans for these which are working
* Define the challenges and try to arrive at solutions which may include:
* Commissioning by place/outcomes – Dudley is probably the most advanced with this but it is happening in other areas
* Vertical integration – bringing services together by place
* Consistency/efficiency built around the 4 hospitals – thinking about the way things work efficiently without compromising patient access
* Maternity – infant mortality is a critical issue having a major impact in Walsall but also a problem in other areas. Major killer in Sandwell also
* Mental health – Black Country Partnership has reached out for a stability partner, Birmingham. Potential to reduce out of area dependence. Work done by Norman Lamb has produced clear information to show that we are not sufficiently focussed on the early stages of mental illness. This leads to patients experiencing poor care and produces higher costs for later stages of the disease

Other issues:

* Workforce in its own right – make this area the place of choice for people to come and work in
* Infrastructure – maximise efficient use of estate
* The way in which services are commissioned going forward – Black Country has 10 separate statutory commissioners
* Have tried hard to keep things real and grounded, now close to a plan that is realistic and deliverable
* It is the right time for LMCs to engage – GP input is crucial. Keen to hear views from LMCs

**BS**

You speak about communication and engagement but the birth of this plan in secrecy does not promote confidence

**AW**

We are still operating under the directive that we cannot share the plan

**BS**

Are you saying that we are dealing with you as an honest broker but may come up against another layer behind you that is still insisting on secrecy?

**AW**

Yes but, “Right care right here” process has been an ongoing, inclusive and open process for many years and I believe that work like this that areas have been working on has been picked up and incorporated into the STP plan

**BS**

GPs/LMCs are expecting STP to deliver on GP Forward View – will it?

**AW**

GPFV is new so as the STP plan goes forward it will have to accommodate this and we will have to demonstrate that it will respond to GPFV – LMC/GP input may well change the draft. I think that the direction of travel is the correct one but it will have to reflect things like the GPFV

**TH**

This cannot be all about secondary care (largely PFI) debt and balancing the books. In order to deliver changes we have to develop the capacity of community delivery. 25% of population are children/young people with long term issues such as obesity, alcohol abuse, drug abuse etc. We have to focus on the community not on the acute sector – this is an opportunity to make the community voice heard

**AW**

This is billed as “the triple challenge” but the biggest of those is financial balance. Every work stream is an opportunity but we have to explore ways to refinance the PFI burden (an issue for everywhere in the Black Country except Wolverhampton) and are working with local government on this.

A different strategy is also needed for recruitment/retention.

**TH**

Acute sector debt is closely related to the number of elderly people requiring care and we have to look at where the workforce is needed the most. Need to ensure that workforce work stream has the appropriate representation from primary care as 25% of the GP workforce will be retiring in the next 5 years. We have to think about growing the workforce to support delivery of GP services

**RS**

Andy, could you give us your view on the state of primary care?

**AW**

This is all about resource – the fundamental basis on which primary care is based is transitioning

GM

GPFV came about because of the crisis in primary care – there is no mention in the STP about any of these measures having a positive impact on primary care. If the frontline filter gets blocked then the system will collapse and hospitals will very quickly be overwhelmed

AW

Under all of the financial planning is a substantial investment programme but it is conditional on achieving a state of balance

**GM**

There has to be a sustainability element – if a work stream is found to have a negative impact on primary care then it should not be signed off

**AW**

That is a helpful point and one I will take back

**TH**

S&T funds coming into primary care – there is an element of access to these funds and a fundamental difference in the approach of primary and secondary care. Where best to put the money? – we have to do something different. How much influence will we have over where the funding streams are used?

**GM**

Consultant numbers have increased hugely over the years but productivity has not – further proof that throwing money at secondary care does not work

**AW**

The essential dilemma that every STP faces – all 18 organisations have to deliver on various fronts, including political aspirations

**BS**

We have to prioritise – primary care should be at the top of the agenda. A traffic light tool was proposed at RCGP/WM meeting for rating processes. GPFV talks about delivering resources now to make GP working life better now – what is your plan?

**AW**

My understanding is best about Sandwell/West Birmingham, but there are similar plans in other areas. There will be solid investment for primary care - £20m over three years just for Sandwell/West Birmingham. We are unable to impact on GMS as this requires a national solution but we can augment it

**RS**

The problem with GMS is that GPs are the last resort across hospital, social care etc. Patients are discharged from hospital/social care with no follow up plan and end up at the GP

**AW**

As I explained, we cannot influence GMS but a new contract is on the way and we are starting to build accountable care arrangements based on place. We will be giving resource and asking providers to deliver on a set of outcomes

**BS**

Are you able to influence other organisations that are dumping work on general practice that is not GMS and therefore not resourced?

**AW**

Yes but this will be a bumpy road with intense pressure

BS

I would have thought that part of engagement (and part of your role) is getting a sense of the pressure people are under?

AW

I want to keep this in a place where we can move forward together and am always happy to listen to colleagues

BM

If you make sure that the basis of every plan includes the impact on general practice and make clear the savings that will be made in the acute sector and where these savings will be spent then GPs will be able to see the resources coming and assist with the transformation

AW

If the issue is to understand the impact and showing how resources move across the system then this is a good idea and one which I will feedback

**UA**

There has been no involvement of the Black Country LMCs in the STP to date. LMCs are there to safeguard the profession and if we do nothing then general practice will not survive. We have had no involvement on vertical integration, neither have we had any information. CCGs have had a letter from NHSE in which they have been told to engage with LMCs – are you able to influence this?

**AW**

There are limitations – the STP is a voluntary alliance over which I have no authority. I wasn’t previously aware of this but am now and will pick it up with colleagues

**UA**

Is there an STP Board and if so is it possible to have LMC Involvement on it?

**AW**

Yes, it is a sponsorship group which brings together leaders of the 18 organisations and their deputies. It would be most useful to have LMC representation on it

**TH**

Realistically we are not going to get a larger workforce i.e. more doctors and nurses but should be encouraging secondary care colleagues to come out into the community more. We should be supporting the development of community care, using people more effectively – sustainability, MDT approach. A transformation steer from the top will help with this

**GM**

Vertical integration – what form will it take?

**AW**

Bringing together people who work across a patient pathway in the community to a single place. Could do it by taking general practice into hospitals, using MCPs and federations.

We have to move away from PbR as this is a fundamental problem

**RS**

Do you have a plan B? You are constantly looking for more from less – general practice is failing because no-one currently wants to come to work in it

**AW**

I have been asked to work with colleagues to develop a strategy to cope with a certain reduction in resources in the future – there is no plan B

**BM**

Vertical integration – when general practice talks about VI we mean general practice contracting to work with secondary care. What do you mean by VI?

**AW**

I don’t mean general practices working for hospitals; it is more about bringing people together into a place

**TH**

It is more about massaging the system to try to get unified care lower down the pyramid

**BS**

It’s about promoting self care

**AW**

It is about independence and control over your own life – the higher up the pyramid you get the less independence/control you have

**TH**

One of the gaps in your diagram is the voice of the patient. We have to inform patients that they cannot expect to see a GP for all things in the future

**AW**

I agree and this is a big limitation. How are you supposed to engage on a plan that you cannot tell anyone about? We have made a start by engaging with Healthwatch and we have a comms plan. The secrecy aspect should change soon and the STP is applicable to the boundary of the four CCGs registered populations

**TH**

Are the local authorities going to join?

**AW**

There will be combined authorities – this presents a good opportunity for a regulatory framework

**GM**

New Midland Metropolitan Hospital – which hospitals are closing to fund it?

**AW**

City Hospital is already substantially closed and Sandwell DGH will be transformed into a community hospital. Midland Metropolitan will be the main hospital on the Sandwell/West Birmingham border

* UA thanked AW for the interaction and said that an action plan was now required
* She advised that the Black Country LMCs would nominate representatives/deputies for the Sponsoring Group and the other working groups and notify AW
* TH asked who was the best contact for the STP and was advised to contact AW, John Dicken or Helen Cooper
* UA enquired whether there were any resources available to support GPs attending the meetings
* AW responded that there was not much resource available but to inform him if it was required and he would look into it
* UA noted that Helen Cooper did not have email contact addresses for all of the Black Country Chairs and Secretaries and promised that Walsall LMC Office would provide them
* AW asked for details to be sent to himself and to Helen Cooper and added that he would be happy to attend more meetings of this kind or to speak to colleagues on the telephone

Meeting concluded at 8.25pm. An additional meeting then convened to elect representatives and deputies.

Meeting concluded at 8.45pm

**ACTION POINTS FROM MEETING:**

1. Request that every initiative is considered in terms of positive impact on general practice and not signed off unless it has – Dr.Uzma Ahmad
2. Send thank you email to Andy Williams – Dr.Uzma Ahmad
3. Provide contact email addresses for all Black Country Chairs/Secretaries to Helen Cooper & Andy Williams – Carolyn Andrew
4. Notify representatives/deputies for Sponsoring Group and working groups to Andy Williams and Helen Cooper – Carolyn Andrew
5. Follow up with Andy Williams about backfill for GPs attending STP meetings – Dr.Uzma Ahmad

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| Name of Group | Representative | Deputy |
| Sponsoring Group | Tim Horsburgh | Uzma Ahmad |
| Vertical Integration  Transformation Group | Bob Morley | Bill Strange |
| Horizontal Integration  Transformation Group | Ray Sullivan | Basil Andreou |
| Mental Health & Learning Disabilities Transformation Group | Gurmit Mahay | To be confirmed |
| Maternity & Infant Health Transformation Group | Basil Andreou | Ray Sullivan |
| Workforce Enabling Group | Uzma Ahmad | Sanjiv Sinha |