ATTACHMENT A

London Health and Care Integration Collaborative

5th August, 3 to 4.30pm

Richmond House

MINUTES & ACTIONS

Present:	
Martin Smith **(Chair)**	Chief Executive, London Borough of Ealing
Caroline Alexander	Chief Nurse & London region SRO for Integrated Care
Conor Burke	Accountable Officer, Barking and Dagenham, Redbridge and Havering CCGs
David Jones	Deputy Director (London Region), Department of Health
Dominic Wright	Accountable Officer, Richmond CCG
Jen Leonard	Head of Integrated Care, NHS England – London Region
John Wardell	Deputy Chief Officer, NHS Tower Hamlets CCG
Mark Spencer	NHS England – London Region
Peter Kohn	Director, Office of London CCGs
Sarah Sturrock	Interim Strategic Lead for Health & Adult Services, London Councils
Tamsin Hooton	Director of Service Redesign, Southwark CCG
Thirza Sawtell	Director of Strategy, North West London ICP
Tommy Denning	Policy Manager, Department of Health / London Social Care Partnership
Apologies:	
Geoff Alltimes **(Chair)**	LGA & National Collaborative for Integrated Care
Rachel Bartlett	Head of Out of Hospital Service Transformation, NHS England – London Region
Tom Coffey	GP and Chair, South West London Out of Hospital Programme Board
Grainne Siggins	DASS, LB Newham & ADASS London joint lead for health
Dawn Wakeling	DASS, LB Barnet & ADASS London joint lead for health
Guests:	
Andrew Webster	Lead, Integration, LGA
Jeremy Taylor	Chief Executive, National Voices
Also present:	
Elizabeth Comley **(Minutes)**	Integrated Care Programme Team, NHS England – London Region / London Social Care Partnership

Agenda Item	Minutes and Actions	Responsible
1.	**Introductions and apologies – Chair** Martin Smith introduced himself as Chair in Geoff Alltimes' absence. He made the following points by way of	

	introduction: • Welcomed CCG leads to the Collaborative and guests, Andrew Webster and Jeremy Taylor • Meeting had been organised for August to enable discussion on the CSR announcement around integration • Formation of the Collaborative was an opportunity through working collectively to deliver on the aspirations of integrated care for London and influence national developments. • Key challenge for the Collaborative is identifying where it adds value while avoiding duplication of effort / work and without preventing local initiatives from developing.	
2.	**Notes of first meeting and matters arising – Chair** **Attachment A** - The minutes of the meeting on 10th July were agreed. It was noted that most items covered on 10th July would be picked up in the meeting. **Attachment B** – Chair referred to this as containing updates on actions, which were not covered specifically on the agenda. These were the timetable on Pioneer application process, briefing on ASHNs and amendment to ToR to reflect that collaborative programme including capture and dissemination of learning from pioneers.	
3.	**National Update – Andrew Webster** The Chair suggested combining agenda items 3 & 4 and introduced Andrew Webster to provide a national update. Andrew said he would provide the update under 4 key headings, all of which were included in the slide pack provided (Jon Rouse presentation slides). **1. Background to the policy and how we got here** The key points made under this heading were: • The sign-up at a national level of a significant number of organisations to the shared commitments document published in May. • This remained the key statement in terms of underpinning national policy at a national level. **2. Spending Review – what happened and next steps** The key points made under this key heading were:	

	• The starting point for this was a flat settlement for the NHS and a 10% reduction in local authority budgets • The breakdown of the funding was as shown in the slides in **Attachment C,** with 50% of it from existing funding streams earmarked for joint working and the remainder reallocated from CCG allocations • This demonstrated a high level of ministerial and political will for integrated care which brings with it a great deal of attention • There are 7 conditions already identified in terms of what an integration plan must contain, including it must protect service levels in social care, common use of the NHS number and the implications for the acute sector must be set out • The development of local plans for 2014/15 to be agreed by Health and Wellbeing Boards will be key to the effective implementation of the pooled budget from 2015-16 • Plans should set out how localities will use this year to make progress on priorities and prepare for the implementation of the pooled budget. The deadline for publishing plans, and the assurance process, will be set out in the full guidance due for release in autumn 2013 • The £3.8bn pooled budget will only be released to local areas with agreed plans. • £1bn of the funding will be linked to outcomes achieved (a combination of locally and nationally set outcome measures. • Half of the funding will be paid at the beginning of each year (based on 2014/15 performance) and the remainder paid in arrears against performance in 2015/16 • The delivery of plans will be evaluated on national and locally developed outcomes. • Further guidance is due in the Autumn to allow for plans to be drawn up and approved by the end of 2013/14 In response to the points made by Andrew, the following areas were covered by contributions from others: • Did this mean that money would be taken out of the health system to protect social care services. It was acknowledged that this would cause concern across the health system and therefore should be addressed and clarity provided. • It was noted that using the money to sustain some social care services may enable the delivery of integration and that if this was the case locally then it should be detailed in the plans developed. • It was agreed that trust locally would be crucial to the development of local plans and for this to work. It was noted that health and wellbeing boards would be central to this and was more work needed to support	

	them in their role. • It was acknowledged by the Collaborative that whilst the process would be challenging it provided some weight and momentum to address the integrated care challenge. • Request that national colleagues provided as little guidance as possible with as fewer outcomes attached as possible. Instead, local areas should be given the chance to come together and discuss how they plan to deliver the aspiration of integrated care and this in itself was a powerful tool in securing the joint approach needed at all levels. • It was agreed that the Collaborative should now focus on what we can do in London to support this process. **Action:** **Comments from the collaborative by the end of August on what should emerge nationally in terms of guidance, conditions and measures etc. in relation to the SR pooled integration money with Peter doing something specific in relation to CCG feedback** **3. Pioneers** The key points under this heading were: • 98 applications received • Applications have been through an initial sift process – areas will hear soon whether they have been selected for the next stage • If successful, they will be invited to meet at least 2 members of the selection panel (early September) • Announcement of final pioneers expected in early October **4. Update on progress on other national commitments** Andrew described the national commitment to commission / develop things to help areas deliver integrated care including on contracting, leadership development and ways of developing new services that were laid out in the Shared Commitment. Specific areas being developed included: • NHS IQ are pulling together all information that is currently available on integrated care • LGA delivered 3 workshops and are developing a toolkit	**Peter Kohn**
5.	**Stakeholder Engagement – Jeremy Taylor**	

	The Chair made a couple of brief points introducing this item, including: • Update on discussions at the 10th July meeting noting the discussion had focused around the desire to keep a group together that is manageable in terms of numbers whilst ensuring that it engages with all the key players. • All members had been conscious of the value patient / user engagement would add given that person-centred care was at the heart of the agenda. • It was recognised that the Collaborative is not a programme board that is delivering integrated care across London but is trying to facilitate, through its deliverables work at a locality level and act as a link between the national and regional groups. He then invited Jeremy Taylor from National Voices to share his thoughts about developing a user/patient voice at the table. The key points made by Jeremy were: • Noted that the approach on service users would depend on what the Collaborative is aiming to do. He did not think that this was clear yet • He could provide advice to the Collaborative but important to remember that he is not a patient/user. • One option was that the Collaborative considers having more than one user / patient representative that would serve as a reminder to the Collaborative to focus on the end user. • A more important role for the collaborative might be to focus on supporting the type of service user input that is required at locality level **Action: Discussions to continue with Jeremy Taylor on who may be best to engage across London.** **Comments** In response the following contributions were made: • Caroline Alexander informed the group that there is already work being carried out in NHS England – London region to think through how best to bring user / patient voices together across London. • There was as part of this a discussion and agreement around a similar conversation being needed for other key groups, including providers. • It was concluded that discussions should continue between Collaborative members on the patient / user voice and engagement with other groups. Martin confirmed that stakeholder mapping would be useful. **Action:**	**Rachel Bartlett / David Jones**

	Caroline agreed to draft a paper on this and within that consider how the proposed NHS England initiative in this area might support this agenda. This paper would consider wider stakeholder mapping issues, in particular HWB's, Healthwatch and providers.	**Caroline Alexander/ Jen Leonard Integrated care programme team**
6.	**Emerging London Collaborative Programme Update (Attachment E) – Jen Leonard / David Jones** David Jones (DJ) introduced the paper as emergent thinking on what the programme can do. Jen Leonard (JL) described the background to the paper with a number of conversations taking place across various settings about what the programme could deliver that would be of use to the system. JL noted that the paper was an amalgamation of all this feedback whilst acknowledging the work underway nationally. Then there was a run through of the individual proposed deliverables and the key points from these are set out below: **1. Compelling Narrative** • It was acknowledged that people are often talking about entirely different things when discussing integrated care, therefore this is an important piece of work. • It was recognised that the Collaborative needs to take into account the national narrative when considering developing one for London. It was noted that the national narrative had been made deliberately generic and does need to be tailored with work already underway to tailor it to particular groups, e.g. children. • Suggestion that t a narrative for London would ensure that all partners have a shared understanding of what is meant by integrated care. It would also instil a level of confidence across London that leaders are referring to the same thing. • The Collaborative agreed that there would be value in developing a compelling narrative for London as the landscape in London is unique, especially due to the trajectory of acute providers. **Action:** **Consideration given to developing a narrative for London, which is an adaptation of the national one, identifying issues that are specific to London.** **2. Rapid Review**	**David Jones**

	• Discussions on carrying out a rapid review emerged from a meeting of the London Health Chief Officers Group. • We have reasonably good intelligence for London but not an in-depth understanding of London in its entirety that we can articulate. • The Collaborative agreed that this needs to be done but it must be light touch and not claim it is definitive. It is also important to be clear that the Collaborative is not making a judgement on systems and models. **Action:** **Will identify a couple of collaborative members to help finalise the process for the rapid review (what are the questions we need to ask for example of those boroughs who were not part of a Pioneer bid)** **3. Evidence Base** • It was noted that national work is beginning to pull together an evidence base for integrated care and that the London programme shouldn't duplicate efforts. • It was acknowledged that the evidence base for integrated care is not well developed and that this makes it challenging for systems to develop at scale and pace. • Any evidence should cover both improvements in patient / user experience and cost effectiveness. **4. Measurements** • It was noted that national work on measurements is expanding but that it was a crucial component, especially given the recent spending review announcement. • It was stressed that this is posing a particular challenges to local systems with people finding it difficult to measure outcomes around the series of 'I' statements in a robust way. • The Collaborative agreed that a 'menu of options' should be developed to ensure that various stakeholders are being made aware of what is being used elsewhere so enable them to see if it is relevant it to their locality. **5. Success Factors** • It was acknowledged that there were significant concerns about information governance issues and noted that work is underway to bring together professionals from across London to find out more	**Integrated care programme team**

	about the problems being faced, to identify solutions and any gaps. • Opportunity in London to look at community health services as contracts are up for renewal soon by CCGs. This will impact upon local plans for integration. • It was suggested that other areas to consider could include personal health budgets and year of care pilots. **6. National Links** All agreed this should be part of the programme. **Action:** **Pull together detailed programme plan to include these areas.**	**Integrated care programme team**
7.	**AOB – Chair** It was agreed that the wording around the role of the Collaborative in signing-off deliverables should be looked at in the ToR to ensure that there is no concern that the Collaborative is a top-down programme board for London. Martin thanked members for attending. **Action:** **Update ToR**	**Integrated care programme team**