Appendix A: Minutes of the Financial Planning Group, 25th September and 17th October 2013

Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 25th September 2013
NLBP
16.00 -17.30

Present:
(KK) Kate Kennally (Chair), Director for People, London Borough of Barnet (LBB)
(JH) John Hooton, Assistant Director of Strategic Finance, LBB
(JM) John Morton, Chief Officer, Barnet Clinical Commissioning Group (CCG)
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(MK) Mathew Kendall, Assistant Director, Adults & Communities, LBB

In attendance:
(JB) John Baker, Head of Local Public Services, Ernst & Young (E&Y)
(MH) Matt Huxley, Senior Manager, E&Y
(KJ) Karen Jackson, Adult Social Care Assistant Director, LBB
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB
(IF) Ian Fisher, Director of Transformation, Barnet CCG
(IB) Ian Bacchus, Project Manager, LBB
(MT) Marshall Taylor, Interim Head of Prevention & Well-being, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB

	ITEM	ACTION
2.	**<u>Update on actions</u>** Kate Kennally (KK) introduced the additional HWB Financial Planning Group meeting, organised to review the work being done to design the integrated care model for Barnet ahead of 2014/15. This modelling work was commissioned to develop the strategic direction for integrated care in Barnet, and guide the development of the individual business cases that need to be produced to underpin this overarching model. The design work for the model needs to happen immediately to help the Financial Planning Group decide how the Integration Transformation Fund will be used in Barnet next year. The model needs to inform the integrated locality plan for 2014-16, that the Health & Well-Being Board needs to sign off in January 2014. KK referred to the minutes of the previous Financial Planning Group meeting when it was agreed that a business case outlining the arrangements needing to be in place before Winter 2013, to the value of £500k, should be presented to	

	the group at this meeting. KK suggested that the additional business cases bought to the meeting today needed to fit into the overarching model and that those that did not clearly support the integrated care model should not be signed-off by the group.	
3.	**<u>Model for Health and Social Care Integration</u>** Ernst & Young (E&Y) presented the model for integrated care that they have developed for Barnet. They explained that their presentation today would outline the design principles for integrated care, driven by the vision that has already been developed in Barnet. Their presentation also covers observations about how integrated care has been developing in Barnet so far, and describes the future programme of work required to take the model forward. The content of the presentation came from both Ernst & Young and the views collected at a local stakeholder workshop. The Financial Planning Group noted that the model presented needed to account for prevention more clearly. The group's discussion centred around Ernst & Young's observations of the development of the integrated care programme in Barnet so far: E&Y suggested a 'single programme approach' was needed in the Borough. - Dawn Wakeling (DW) reflected that Barnet had created the vision and principles for integrated care but hadn't yet been clear about what the model that needs to be built actually looks like. She confirmed that there needed to be work completed between the vision and the individual business cases to bring the programme together and drive future activity. - Kate Kennally (KK) agreed that the E&Y diagnosis was correct and that the group now needed to decide on the treatment. - John Morton (JM) commented that there have been historical tensions between partners in the programme that have hindered progress. - E&Y commended the energy and enthusiasm in Barnet to develop integrated care, and suggested that it is a project/ programme management issue that needs resolving (including sorting out issues of who controls what within the programme). E&Y also mentioned that Barnet is trying to work at pace to develop the integrated care model and that the group needed to secure stakeholder buy-in to make the model a success. John Baker (JB) from E&Y commented that other areas had developed similar programmes in 2-3 months, as the group is trying to do in Barnet. E&Y commented that the financial envelope to support the programme needed to be identified. - KK reminded that the existing savings projections from the Council and the CCG needed to feed into this modelling. - John Hooton (JH) reflected that the business cases currently being presented at this group do not account for the financial savings required clearly enough. - DW said that the financial projections needed to be presented	**E&Y**

	alongside activity projections to make the projections meaningful and focused on outcomes. E&Y also suggested that a decision still needed to be made about which groups of Barnet's population the model would be seeking to support. The group then had a discussion about the future programme of work needed to take the model forward. - In terms of designing the integrated care model, the group agreed this needed to be led by commissioners. The group agreed that although Central London Community Healthcare (CLCH) had been commissioned to develop the recent CCG business cases, the model should not be positioned as a CLCH model and should instead be presented as a 'system-wide model'. - KK stressed that social care needed to be built into the current CCG business cases - JM suggested that the model needed to map the future financial flows that are required to make an integrated care system work (that incentivise providers in a helpful way) - **The group nominated Maria O'Dwyer (MO'D), JM, Karen Jackson (KJ) and DW to work with E&Y to revise the current business cases and come up with amended proposals to bring back to the group, to reflect the proposals in the overarching model that is developed.** The group agreed that a very clear model for integrated care, including the methodology to cost the model, was needed by Christmas 2013. MH from E&Y confirmed that E&Y had the resources remaining in their current contract with Barnet to move forward with the model on the group's behalf. **KK confirmed with E&Y that they would continue to work on the model design (accounting for outcomes) ahead of the 17th October Financial Planning Group meeting. At this meeting the group would then decide on next steps.** **KK recommended that the group look through the entire presentation from E&Y and feedback their thoughts to E&Y over the coming weeks.**	**E&Y** **HWB Financial Planning Group** **E&Y** **M'OD, JM, KJ, DW, E&Y** **HWB Financial Planning Group**
4.	**<u>Full business case for the shared care record</u>** KK suggested that the business case in its current form did not meet this outline, and noted that the business case had not factored in social care. JM agreed that the plan did not account for social care as much as it should. **The group agreed that this business case should be supported in principle**, but that more information about the benefits of the work and how it supports the integrated care model would be needed in future for the proposal to be signed off. E&Y confirmed that this business case did align with the	

	strategic direction of the overarching integrated care model, and should be supported in principle. KK also questioned the high spend on resourcing the project (over 50% total costs). **Mathew Kendall (MK) agreed that his team would work on a full business case that linked to the design principles of the integrated care model. The group agreed that MK should meet with Ian Fisher (IF) and E&Y to take forward the development of a full business case ahead of December 2013.**	**MK, IF, E&Y**
5.	**<u>Health and Social Care Integration Programme Office (PMO)</u>** MK introduced the business case and explained that the Joint Commissioning Unit (JCU) would face a significant programme management gap from December 2013 when Agilysis's contract with the Council comes to an end. JH questioned how the JCU was linked to the Council's corporate insight team and what governance arrangements were in place to support the PMO. DW confirmed that the Health and Social Care Integration programme had not been managed to date through the One Barnet PMO. MK explained that his team has been in conversation with Tom Pike in Corporate Performance, and that he plans to discuss how the programme will link up with the Corporate PMO and what Capita are delivering for the Council. KK expressed her concern about the lack of clarity in the business case about the purpose these posts would serve, and questioned the direction of overall leadership in the programme. MK explained that he hadn't concluded these needed discussions about the programme's leadership with the CCG and Council so he couldn't be clearer about the final leadership arrangements at this stage. **The group agreed to allocate £40k S256 money for the PMO.**	**MK**
6.	**<u>Home Truths</u>** **The group agreed not to progress with a discussion about allocation Section 256 money to the Home Truths project at this time**. Karen Ahmed (KA) explained that the implications of this decision are that Barnet won't be able to join the October 2013 programme, but could possibly join a future cohort.	
7.	**<u>Update on CCG finance recovery plan</u>** JM explained that the CCG Recovery Plan needed revisiting, resulting from errors in the benchmarking work that was done by a third party. JM explained that the CCG had shared this information with NHS England and they are discussing how to move forward together. JM stressed that the consequence of this is that it will take longer than	

	expected for the CCG to recover its financial position. The CCG is now the most financially challenged in the country, and in future would receive lower allocations from NHS England than other areas because of their deficit. KK suggested that the group needed to understand the CCG's position and NHS England's decision to allocate the CCG less money in more detail, so that the group can lobby NHS England for more support.	**HWB Financial Planning Group**
8.	**<u>Integrated Care Proposals</u>** Based on earlier discussions at this meeting (about the need for business cases to fit in to the overarching integrated care model, and the previous agreement that the business case to support winter pressures would total £500k), **KK explained that the group would not be agreeing this business case in its entirety.** KK asked what the critical elements of the business case that would support the BEH clinical strategy were. JM explained that the CCG needed to make progress with the shared care record to support the Barnet, Enfield & Haringey Clinical Strategy and avoid operational issues over Winter 2013. KK questioned the total value of the business case (£1.5 million), and referred to the previous meeting's minutes when the group agreed that a business case to the value of £500k should be bought to the meeting outlining the support needed to mitigate winter pressures, which was also explicitly linked to the forthcoming integrated care model requirements. JM & MO'D suggested that extending the service to manage long-term conditions, and the development of the rapid response service, were the critical components of the business case. KJ also suggested that moving forward with rapid response was key but that social care (domiciliary care) needed to be factored in. KK recommended that the social care costs be added to the business case to reflect the true costs. KK suggested that the ear-marked £500k should account for initiating the single point of access and rapid response service as in the current business cases. JM pointed out that money for reablement was also required alongside the £500k. KJ confirmed that contracts could be mobilised to support the development of a reablement offer as part of this business case. **KK proposed that £700k (500k CCG-led project; 200k LBB enablement project) of section 256 money is allocated for rapid response, long term condition management (single point of access), and social care reablement. The group agreed with this proposal.** **KK suggested that KJ and MO'D work up the social care enablement sections, and develop a schedule to append to the Section 75 agreement.**	**JM/ M'OD** **KJ, M'OD**

	KK proposed that flexibility should be exercised when developing this programme of work so that it could be amended to reflect the findings from the E&Y work, when it is finalised.	
9.	**<u>Agreeing the Section 256 submission to NHS England</u>** JM explained that not all of the 2013/14 section 256 money had yet been committed. **The group agreed that the unallocated 2013/14 Section 256 money should be used to develop the integrated care model- it is likely all of S256 will be allocated but work is still underway to finalise this (NB the £700k allocated in the meeting to progress with the integrated care proposals will come out of the S256 pot of money).**	
10.	**<u>Any other business</u>** N/A	
11.	**<u>Date of the next meeting</u>** **Thursday 17th October, 10am-12pm, Board Room, NLBP**	

Minutes from the Health and Well-Being Board – Financial Planning Group
Thursday 17th October 2013
NLBP
10.00am -12.00pm

Present:
(KK) Kate Kennally (Chair), Director for People, London Borough of Barnet (LBB)
(JH) John Hooton, Assistant Director of Strategic Finance, LBB
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(HMG) Hugh McGarel-Groves, Chief Finance Officer, Barnet CCG
(IF) Ian Fisher, Director of Transformation, Barnet CCG

In attendance:
(MH) Matt Huxley, Senior Manager, Ernst & Young (E&Y), E&Y
(EW) Edith Wellwood, Advisor, E&Y
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB

Apologies:
(JM) John Morton, Chief Officer, Barnet Clinical Commissioning Group (CCG)
(MK) Mathew Kendall, Assistant Director, Adults & Communities, LBB
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB

	ITEM	ACTION
2.	**Minutes of the previous meeting** The group reviewed the minutes from the previous meeting and agreed them for accuracy. The group confirmed that the action on page 3 of the previous meeting requires the design group to review business cases in light of the integrated care model, when it is finalised. Regarding the shared care record on page 4 of the minutes, John Hooton (JH) confirmed that Tom Pike and Mathew Kendall (MK) have had several discussions about Capita's role in supporting the development of the shared care record. JH explained these discussions were on-going. Regarding the CCG's financial position (on page 5 of the minutes), Kate Kennally (KK) agreed to circulate the briefing that she and Ian Fisher had put together for Councillor Hart, to the group, for information.	**KK to circulate paper**
3.	**Model for Health and Social Care Integration** Ernst & Young (E&Y) presented the updated model for integrated care that	

	they have developed for Barnet- the output for phase 1 of the work. <u>Update on progress</u> Maria O'Dwyer (MOD) suggested that the model was still lacking a transformational element. She referenced the example of Canterbury in New Zealand and suggested their radical re-profiling of community services was, among other elements of their model, a more transformative model of integrated care. The group reflected that Phase 2 of the model design work would involve a gap analysis, and the design of a programme of work to fill these gaps. This gap analysis should consider opportunities for transformation. Kate Kennally (KK) acknowledged that the group needed to reflect on whether they are all clear about what the future of integrated care in Barnet looks like, and agree what needs to be done to fill any gaps that emerge when a clear view is reached. KK reiterated that Phase 2 of the work would move the model forward into discussions about commissioning intentions, using the Integration Transformation Fund. In terms of developing a single programme approach to integrated care, Dawn Wakeling (DW) stressed that more work needed to be done to make sure the business cases align to the overall model. Ian Fisher (IF) proposed that a good audit trail was needed, to track the decisions being made about the integrated care system, schemes within it, and attached funding, so that it is clear to everyone what has been decided and where it fits in to the model. Regarding the development of the financial envelope underpinning the model, Matt Huxley (MH) acknowledged that the spend and activity analysis needs to develop in phase 2 of the work. In terms of wider engagement, MOD mentioned that she was talking to GPs about the model and capturing their comments. She mentioned that Dr Debbie Frost thought the model fitted in with her expectations for integrated care, and had made helpful comments about how the model should develop. <u>Programme of work- overview</u> MH explained that the next phase of the work will involve agreeing shifts in spend, and by how much the layers of the model should expand/ contract. He also advised that phase 2 would also consider workforce development issues. Dawn Wakeling (DW) confirmed that the product of phase 2 will become the decision-making tool for use of the Integration Transformation Fund <u>Identifying changes in spend</u> MH explained that this slide had been presented to the wider group of stakeholders already, who explained they didn't have enough information to make decisions about how the spending patterns should change over time. MH explained that E&Y had broken down the current spends as far as possible and presented these in the slide pack, but he acknowledged that more granular information about spend would be necessary e.g. staffing vs. care costs in social care.	

	DW argued that NHS England's spend in primary care also needed to be accounted for. KK agreed that a number of other funding streams should also be accounted for, and referenced the 'Prevention Matters' work in Buckinghamshire which has focused on building community capacity as part of the health and social care integration model, but wasn't a health and social care-led intervention i.e. was funded from elsewhere Hugh McGarel Groves (HMG) pointed out that the NHS budget referenced in the model was in fact the total CCG budget rather than the relevant sub-sections of the budget, and needed to be changed. KK suggested the group still needed to come to a decision about the scope of funding that should be covered (e.g. *are physical disabilities in the over 55 age group in or out of the model?*). <u>Vision for services</u> JH suggested the modelling needed to consider phased investments at particular points in time to secure positive outcomes, rather than just a gradual shift of funds over time. DW pointed out that the model needed to consider demand management/ containing costs, rather than just an assumption that spend could be reduced. Ian Fisher (IF) argued that the current PbR system of payments to acute services would not necessarily support shifts of funding and activity out into the community. He suggested that the CSU could provide useful support to E&Y to understand the current contracts with acute providers. MH suggested that new models for working with providers were emerging nationally, and that the modelling work needed to consider how to incentivise the movement of money across the system (which would need to involve working collaboratively with providers). Edith Wellwood (EW), who will lead phase 2 of the work, recognised that this sort of scenario modelling (including return on investment and dependency predictions) was missing from the current model. MH suggested that in phase 2, a finance representative from across health and social care commissioning should be involved in taking forward this modelling. KK suggested the CSU needed to be much more involved with this work in phase 2. KK also agreed that a finance representative needed to be involved in the design group in phase 2. KK also pointed out that shifting activity from a high cost setting to a low cost setting won't immediately result in cost savings. Demand management also needs to be considered. For example, shifting social care activity out of acute services will actually be a cost pressure for social care ie there will be more need for social care services. The questions that need to be unpicked in phase 2 is how does LBB move to supporting a sustainable number of residents in social care services in the community, and how do social care work with primary care and others to develop self-management initiatives.	**IF agreed to consider CSU's role in phase 2** **JH agreed to think about an LBB finance rep**

KK argued that there might be a longer period of time before some cost savings are realised (and in social care these timeframes may be longer than in health).

JH asked if the savings that could be made from joining-up teams were referenced in the model. KK suggested the savings that could be made from this area (back-office rationalisation) were marginal, and was being considered through the MTFS savings plans. However, MOD pointed out that New Zealand's case study of integration had identified savings from coordinated working eg having 1 carer rather than 3. KK agreed that considering *how* teams work together is an important aspect of this modelling work.

HMG suggested there should be value-for-money solutions at each stage of the integrated care pathway.

<u>Integrated health and social care model</u>

The group discussed the outline model and made the following comments:

- The group wasn't sure that the diagram used to present the model was clear
- The self-management section needs to be stronger, and include/ account for families
- The 'health and wellbeing services' section needs to reference the LBB universal offer to residents, and also public health's contribution
- There could be a step between 'health and wellbeing services' and 'access services' that accounts for preventive social care, primary care, housing, later life planning etc
- The 'access services' section needs to make sure that the services within it account adequately for building resilience
- In terms of 'community based intensive services', the focus needed to shift to make it clear that most of a person's care needs can be managed at home (and wording changed from "maintain people at home for as long as possible" to "maintain people at home")
- In terms of 'residential, nursing and acute services' the wording should be changed to "services are drawn on as a last resort" to "services are drawn on as they are appropriate"
- The model needs to be clear that not all social care assessment sits within this model. Before people become very ill, health is 1 of 4 reasons people need social care. As they become very ill, it becomes the main reason. This shift needs to be accounted for in the model
- The story of Mr Dale and how he accesses clinical services needs to be developed further

<u>Key enablers</u>

The group reviewed the key enablers and discussed the following:

- Need to consider clinical practitioner development/ involvement (and the future design group should involve a GP such as Dr Debbie Frost/ Dr Jonathan Lubin)
- Need to consider the low-pay part of the workforce and the development of new roles/ career opportunities (including those for carers)

	- Learning from Bexley Care Trust was that co-location didn't automatically result in better outcomes/ that communication was more important. Co-location may be appropriate for some but not for other teams- this needs to be explored and the evidence reviewed as this model develops. - Need to mention local leadership, relationships and trust - Integrated governance needs to cover: the level of support/ buy-in needed; contract monitoring arrangements DW gave an update on the Integration Transformation Fund. She explained that ministers were due to agree the available indicators to support the fund, but this still hasn't happened. The LGA and NHS will issue letters to local areas on things that won't change in the plans for the ITF, but there won't be national guidance. KK argued that Barnet should take local ownership of this agenda, and that the group wouldn't be looking out for a nationally imposed model before it makes progress with local plans. <u>Next Steps- phase 2</u> EW talked through phase 2, which she will be leading. The group discussed the evidence base that could support phase 2. DW explained that there is no one best model of integrated care. She also explained that as part of the national programme on integration, a searchable evidence base is being developed. HMG asked E&Y to reference examples of good practice from elsewhere. IF asked about the demographic modelling that would take place in phase 2. JH suggested some of the PSR data would be relevant for demographic/ scenario modelling. KK advised that the model needed to be capable of responding to the Care Bill etc, as set out in the original brief for this work. The group thought the scope of phase 2 needed to be changed to reflect the discussion. The group agreed they were happy to continue working with E&Y provided phase 2 of the work included scenario and demand modelling, and have a more granular description of how services should work within the model. **The group agreed that the resource could be found internally to scrutinise existing business cases, and to set up the programme once the model is ready (e.g. the governance/ programme management arrangements). The group also agreed that E&Y should draw on experiences from elsewhere in phase 2, and should benchmark their projections of activity/ financial changes.** **The group agreed to continue with E&Y using the remainder of the £100k that was committed for the work, on the basis that the scope of phase 2 was amended to reflect the group's requirements.** **KK agreed to take forward the discussion with E&Y on behalf of the group.**	**E&Y to reference good practice examples** **E&Y to make changes to the model based on the comments made at the meeting** **KK to scope phase 2 with E&Y**

4.	**<u>Shared Care Record Business Case</u>** DW introduced the revised business case and explained that E&Y confirmed that it aligned to the overarching model DW explained that the business case had been revised so that the costs are £200,000 lower than originally estimated. KK questioned what role Capita had to support this work. DW explained that her team has been working with Capita very closely on this. IF suggested that the business case should be reviewed before the entire project is implemented. **The group agreed to allocating £115,000 in 2013/14 to take forward the project but that there should be a gateway review before implementation in phase 1, to assess the future investment that should be made.** **KK suggested that the gateway review be completed by people outside of the financial planning group, including LBB and CCG finance leads, as well as Jenny Obie, Carole Furlong and the CSU.** **The group also agreed that Mathew Kendall (MK) should take the business case through the customer and information management enabling board at LBB** IF will confirm the CCG lead for the review, and when this should be taken to the CCG Board for GP buy-in	**MK to take business case to enabling board** **IF to confirm CCG input**
5.	**<u>AOB</u>** DW explained that the Section 256 money was not with the Council yet, but the paperwork is ready to submit to NHS England- John Morton (JM) needs to sign this when he returns from leave. MOD explained to the group that she and Karen Jackson (KJ) had not yet developed the schedule for the S75 agreement, as was agreed at the previous meeting. MOD explained this work was in hand and would be ready for the next financial planning group meeting.	**JM to sign paperwork** **MOD/ KJ to complete arrangements for spend of £700k**
6.	**<u>Next meeting</u>** 12th December, 11.30am-1.30pm, Board Room, NLBP MOD and IF will confirm if this date will work for them, so the group need to be mindful that the date of the meeting might change	**MOD/ IF to confirm availability**