Minutes from the Health and Social Care Integration Board
Tuesday 20 September 2016
North London Business Park, Boardroom
9.30 – 11.30

Present:

(AC) Andrea Clare, Head of Service, LBB (for item 6 – 0-25 Service)
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(CB) Chris Baxter, Medical Director and Consultant in Palliative Medicine, North London Hospice
(CW) Cathy Walker, Director of Operations, CLCH
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB (Chair)
(FJ) Fiona Jackson, Director of Integrated Care, Royal Free
(EW) Emma Walmsely, Volunteer Services Coordinator, Groundwork
(GA) Gerald Alexander, Chair, Local Pharmaceutical Committee
(JD) Jon Dickinson, Assistant Director, Adults and Communities, LBB
(JP) Julie Pal, Chief Executive, Community Barnet
(JS) Jonathan Stephen, Assistant Director of Community Services Barnet Enfield Haringey Mental Health Trust
(LG) Leigh Griffin, Director of Strategic Development, CCG
(MA) Muyi Adekoya, Acting Head of Service, LBB/CCG
(MK) Mathew Kendal, Director of Adults and Communities, LBB
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies:

(AS) Amit Shah, Pharmacy Lead, Barnet CCG
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(CMc) Collette McCarthy, Head of Children's Joint Commissioning, LBB/CCG
(DF) Debbie Frost, Chair, Barnet CCG
(FG) Fran Gertler, Head of Integrated Care, Royal Free
(JL) Jeff Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(MC) Mandy Claret, Project Manager, Barnet Community Education Providers Network (CEPN)
(PC) Pam Clinton, Chief Executive, North London Hospice

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair, DW welcomed the attendees to the meeting. Apologies were received as noted above.	
2.	**HSCI Board TOR** DW provided an introduction and brief history of the Board which met initially to develop the borough's Better Care Fund (BCF). The HSCI Board had agreed a memorandum of understanding and a concordat. Barnet is now in the third iteration of our BCF plan. DW went on to explain that the BCF is very much established in Barnet with new integrated care services being delivered. The Adults Joint Commissioning Unit has developed and managed the following services – care navigators, rapid response, the risk tool and BILT. Public Health and ZG have overseen the prevention and early intervention aspects of the BCF plan. In terms of service development updates, BILT, which was previously just operating in the west of the borough, has been developed into a borough wide service. The risk tool will be used in a new way to identify people at high risk and support them proactively. For prevention, we have commissioned a provider to deliver local Making Every Contact Count (MECC) training, developed and focused our Ageing Well programme and started to develop the principles around social prescribing linked with the CCG's Wellbeing Hub pilot. DW went on to describe the national policy context citing the A+E pressures and targets as well as targets to reduce delayed transfers of care. DW explained that the Sustainability and Transformation Plan (STP) for North Central London, in which Barnet is involved, is being developed and a senior level group has been developed to proactively address issues coming out of this process. DW stated that this Board is the opportunity to bring people back together at a Barnet level to look at what is needed following the regional and national developments. LG added that the STP will be submitted on the 21 October following a draft in June. The Case for Change has been well stated and includes an NHS 'do nothing' scenario of an £876m gap to 2021 (this does not include adults and children social care financial gap). Case for Change and STP updates can be found here - http://www.barnetccg.nhs.uk/about-us/sustainability-and-transformation-plan.htm Key aspects of the STP: • Productivity – such as sharing back office functions, improving workforce management (e.g. a nurse bank, HR processes) and medicine management • Consolidation – fewer settings, this needs to be explored further at an NCL level for strong clinical outcomes and financial benefits • Care closer to home – collaboration and integration to deliver more care in the community, this is not always cheaper but more accessible and cost effective • Better use of our estate (DW leading on this for NCL) • Service specific – cancer and mental health	

	Public meeting on the STP will be held on the 27 September in Barnet. CW thanked DW and LG for the update and went on to question the high level assumptions. CW stated the need for robust plans that demonstrate how we will reduce the gap. CB asked if end of life care is in the STP. DW stated that it is included in the Case for Change and in relation to A+E and delayed transfers of care. AH spoke about the prevention element of the STP and how this has been challenging to pin down. AH went on to state that to make a real difference, plans needed to move away from a short term, 5 year focus and look longer term. Barnet is a healthy borough but has specific challenges and these need to be reflected in the plans. LG stated that a national transformation fund will be made available to STP footprints dependant on the quality of the submission on the 21 October 2016. If NCL are able to access this it would mean that would be investment, up front, for the Care Closer to Home programme. The Board went on to comment on the Board's TOR and had the following feedback: • Primary care representation needs to be stronger including representation from the CCG Board as well as from the GP Federation • NCL leads should be invited as required • The Integration Concordat should be reflected in the aims • Childrens should also be represented in the TOR • Should include the key role this group will play in the development of the Care Closer to Home programme. AH asked about links with other Boards. ZG explained that the HSCI Board reports (with its minutes) to the Health and Wellbeing Board and will work closely with other project Boards. **TOR to be updated.**	**ZG**
3.	**Care Closer to Home** LG described the Care Closer to Home programme which aims to bring together community, social care and mental health and to fundamentally improve care and bring it closer to home. The programme will look at strengthening services in the community. From the CCG's perspective this is linked with the Primary Care Strategy developments and acknowledges that primary care does not operate in a vacuum and that wider transformation is needed. Primary care in this context is wider that GPs. The GP Federation is a vehicle for delivery but it is not enough and the Care Closer to Home programme will look at what more we can be doing for older people and older people with frailty. LG went on to explain that the CCG is developing a thought piece on the programme which will be reported to the Health and Wellbeing Board (HWBB) and that Dr Ahmer Farooqi is leading this work and should be a member of the HSCI	

	Board. JD acknowledged that this is a huge task and wanted to know how fragmentation was being avoided and how we are building on work that is already going on; some of this work in the community is already happening. CW echoed JD's joint to build on work that is already happening. DW mentioned that some mapping work has been done by the Council / Joint Commissioning Unit. MK stated that locally we should also take this as an opportunity to review what is not working. JP asked how the resident voice was being heard as part of the STP and developing work streams. DW agreed that there is significant work to do around engagement as plans become public. DW explained that there is one Healthwatch representative from Enfield on the NCL Board but we do need to think about what local engagement looks like; building on the involvement of JP and EW in the HSCI Board. The Board agreed to meet again before December and agreed to work as a virtual group in between meetings.	
4.	**Accountable Care** DW introduced the topic of Accountable Care. Early discussions have started to take place around a new model of care for NCL and the Board needs to think about what accountable care would look like for Barnet residents and how we can shape NCL thinking. Broadly, accountable care means one system, with one set of outcomes and one set of transactions – systems which are currently different with varying accountability structures. DW went on to explain that this links with the population health discussion and the original aims of the BCF to remove problems with payments and information sharing. LG stated that the CCG would be considering learning from other areas of the country (e.g. Yeovil in Somerset) and having initial discussions about what this means for Barnet at the CCG AGM on the 22 September. FJ asked, considering the range of models, was there a conclusion of a model across NCL? CW explained that there was no recommendation and that it is up to the local area to decide and explore. CW briefly described the single borough system developing in Camden. JP asked for the residents view to be included in the developments. **ZG to talk to JP and EW about resident engagement in accountable care.**	**ZG**
5.	**Population Health and the STP** AH introduced the topic of population health, referencing Barnet's Joint Health and	

	Wellbeing (JHWB) Strategy. AH mentioned the annual review and report of the JHWB Strategy going to the Health and Wellbeing Board on the 10 November, which continues to highlight prevention as a priority for the system. AH gave an overview of population health in Barnet, stating that overall the borough is healthy but there are some challenges and inequalities including population expansion. AH stated that is key to work with the CCG to embed prevention. AH went on to give an overview of the following priority prevention areas: • Alcohol: return on investment is strong for early intervention and prevention, brief intervention is effective; Barnet has established a local Making Event Contact Count training offer which has started to provide Council front line staff with skills and knowledge to maximise health promotion opportunities with residents. • Tobacco: inequalities are increasing and there is a need to focus on particular groups such as pregnant mothers and people with mental health conditions and the need to do more in acute and community settings. • Employment: lots of activity in Barnet including specific support for people with mental health conditions and learning disabilities and working with employers to improve recruitment and retain of employment practices. • Fast track into psychological support: good return on investment and good work across NCL in happening. • Physical activity: more needs to be done in Barnet; Public Health is working with the Sports and Physical Activity team as well as Regeneration. • Digital mental health support: coming online in October across London. • Sexual health: procurement activity is underway with a vision for electronic services across London. AH stated that investment in Barnet, focused on these areas would be beneficial. AH also stated that there are a lot of exciting opportunities and welcomes work with providers. AH would welcome mapping of what we are doing and how we can build on this and see where we are against new models and standards. AH asked DW how this links with the devolution pilots. DW stated that in December 2016 an agreement will be signed by the devolution pilot areas which will give them the devolution powers for one year in shadow from Spring 2017 with the rest of London following with full powers in place from April 2018. **AH and ZG to ensure that the JHWB Strategy reflects that Barnet will maximise the opportunities that come from the Haringey health devolution pilot** which is investigating the need for local authorities to be given new planning and licensing powers to create healthier communities. GA added that community pharmacy is a vital resource which is often forgotten in these discussions. The discussions about primary care and prevention need to include pharmacy. GA explained that pharmacy provides a highly skilled workforce and infrastructure which could contribute to the boroughs plans. GA went on to	**AH/ZG**

	describe the 78 pharmacies in Barnet which the Pharmaceutical Needs Assessment (produced in 2015) gives a good overview of the pharmacy offer in Barnet. The PNA can be found here - https://www.barnet.gov.uk/citizen-home/public-health/pharmaceutical-needs-assessment.html LG welcomed GA's comments and stated that pharmacy would be included in the Care Closer to Home developments. DW stated that primary care commissioning from NHS England to CCG's does not include dentistry, pharmacy or optometry. FJ added that there is work to do to increase resident perception of pharmacy and improve awareness and understanding of the offer as well as when it is appropriate to use different settings (e.g. pharmacy, A+E, GP). **JP and GA to meet to discuss Healthwatch's role in this.**	**JP/GA**
6.	**0 – 25 Programme** AC joined the meeting and presented the item. The aim of the programme works with children and young people aged 0-25 to avoid the cliff edge at aged 18 transitioning into Adult Services. The programme has achieved this through joined up working between Education to address the principles of Education Health and Care Plans (EHCP) and SEND legislation. The programme aims to improve forward planning with families to enable us to intervene earlier to avoid escalation into high cost unplanned provision. AC described the current joint working with health which includes: • A process for considering joint funding for complex cases-using continuing care application framework. • Commissioning of CAMHS (under review) • Pediatric occupational therapists placed within the service who work alongside health colleagues AC highlighted the following integration opportunities: • Development of an autism strategy e.g. adolescence resource centre • Targeted service for those on the autistic spectrum as highly expensive in teenage years • Lack of respite for those with behavioral problems as opposed to physical • Most complex children have no access to local resource and have to go out of Borough DW stated that we do not want people to be placed out of borough or have to have multi appointments where they are telling story a number of times; we are continuing to improve the offer. JP welcomed the presentation and stated that there as a clear role for the voluntary and community sector in supporting the development of the programme including providing services that can be purchased through Personal Health Budgets. **AC and JP to discuss.** JD added that after 18 the Autism Spectrum Disorder (ASD) pathway needs to be	**AC/JP**

	standardised. JD stated that he had raised this with the Joint Commissioner for Metal Health. JD felt that service from 0 – 18 are clearly defined but 18 plus are not clearly defined as part of the 0 – 25 programme. **JD and AC to discuss.** LG would like to look at extending the approach into health if there is evidence to support this as an approach. **LG and AC to discuss.** LG wanted to ensure that we are not transferring problems from 18 to 25 in terms of the cliff edge of services. AC is aware of this issue and the service is looking at processed so that planning start a lot earlier and that there is a good handover to adults. FJ noted the references to employment and further education and wanted to know the opportunities offered by providers as large employers. DW mentioned Project Search which targets young people at college between the ages of 16 – 25, to support them into employment. **AC to link with Caroline Glover.**	**JD/AC** **LG/AC** **AC**
7.	**AOB** None.	
Next meeting – TBC, November 2016		