



Attachment 1

DRAFT ACTION NOTES

Meeting: Democratic and Clinical Oversight Group

Date: Tuesday 4th October 2016

Attendees:	ClIr Darren Rodwell (chair)	DR	London Borough of Barking and Dagenham
	ClIr Maureen Worby	MW	London Borough of Barking and Dagenham
	ClIr Wendy Brice-Thompson	WBT	London Borough of Havering
	ClIr Mark Santos	MS	London Borough of Redbridge
	Steve Ryan	SR	BHR CCGs
	Vincent Perry	VP	NELFT
	Dr Waseem Mohi	WM	Barking and Dagenham CCG
	Dr Anil Mehta	AM	Redbridge CCG
Dr Gurdev Saini	GD	Havering CCG	

In attendance: Conor Burke, Cheryl Coppel, Anne Bristow, Andrew Blake-Herbert, John Brouder, Barry Jenkins

Apologies: Maureen Dalziel, ClIr Jas Athwal, Nadeem Moghal, Dr Atul Aggarwal, Dr Caroline Allum, Joe Fielder, Matthew Hopkins, Eric Sorensen, ClIr Roger Ramsey, Kash Pandya, Chris Naylor, Richard Coleman, Andy Donald

Agenda item	Summary
Welcome, introductions and	Introductions and apologies noted as above.

<p>apologies</p>	<p>CC outlined the current status of the ACO programme, highlighting progress made developing the SOC and a number of resulting proposals to move forward as follows:</p> <ol style="list-style-type: none"> 1) Establishment of an Integrated Care Partnership Board (ICP) and supporting governance structure. <p>The ICP would further strengthen partnership working establishing explicit joint commissioning arrangements and driving changes through a new delivery model in the form of localities.</p> <p>CC informed the group that Chief Officers had met on the 16th of September, to discuss the DCOG papers and had identified a preferred model for the ICP as set out in the attached papers. The governance paper also set out the opportunity to influence STP development and ensure that democratic leadership for BHR was embedded into STP process.</p> <ol style="list-style-type: none"> 2) Introduce and test new delivery mechanism through the development of the locality model, fast tracking a minimum of one locality in each borough 3) Agree a resource plan, to support delivery of the ACO objectives <p>CC noted that the group’s original ambition for full devolution had yet to be achieved and that the system should continue to work with the London Devolution team to explore opportunities.</p> <p>DR opened up the discussion to Councillors. MS stated disappointment that the original level of ambition related to devolution has not been delivered, however MS was clear that further progress must be made, given what has been achieved so far. MS stated that he was happy with the core principle outlined in the governance paper although noted two areas for improvement 1) Health and Wellbeing boards should be incorporated into the structure 2) the current membership does not include Public Health, DCS or Finance representatives. WBT noted concern that that progress had slowed since July and there was a need to push forward with this work. The case for devolution needed to be clearly made with a focus on how devolution benefits residents. MW highlighted the need to focus on what changes will be made at a local level. In addition there was a need to explore joint commissioning opportunities, and that this could start in a small area (e.g. LD), which could be developed in phased manner. MW stated a clear desire to ensure the partnership approach succeeds and continues to progress.</p> <p>DR opened the discussion to health representatives. JB gave a clear statement that NELFT supports the proposals and will continue to work closely with partners to ensure this is delivered. JB noted that significant action was required to offset growing deficits across BHR. CB stated that it was clear that the integrated locality model was the right way to progress, and was happy to hear Councillors supported the ambition to proceed further with plans. It was noted that a locality development session had been held on the 20th of September, involving all partner organisations and GP leads. This session had been successful, displaying a groundswell of opinion amongst GPs in support of developing locality teams to drive a new way of working, this was supported by a statement from Dr Jagen John. CB reiterated the sentiment that the system would need to have ambitious plans for change to deliver</p>
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the improved services required for the BHR population. GS highlighted concerns amongst some Havering GPs at the proposed pace and scale of change and that this would require a clear position regarding the overall governance framework and what this would mean for both GPs and the local population. With regard to the locality model; GS noted the need to collaborate closely with local partners and work in a different way, focussing on prevention.

DR noted that these concerns had been raised previously, and asked GP members how willing they would be to consolidate CCG powers into a new integrated body, and what assurance they would require. WM stated that CCG members were not at that stage, with CCG arrangements only in place for three years and that, at present, there was no appetite for significant change to commissioning arrangements. Chairs were willing to discuss new arrangements for jointly commissioning relevant secondary and community care services. WM stated the need for further clarity over the STP governance arrangements and how the BHR fed into these. AM cautioned that there was a risk of disengaging GPs if plans were not managed and communicated appropriately.

AB agreed with CB that there was a clear need for significant change and suggested that work on the locality models should continue, as locality development was not contingent on pooling commissioning arrangements. AB reflected that Boroughs were currently in different places in terms of locality development and the joint commissioning could arrangements could start on a small scale focused around a single area, to understand the implications while making progress. This would form the starting point of a journey towards joint commissioning, but require commitment from all parties. MW highlighted the potential impact that the STP could have on BHR if there was not a clear plan for engagement.

CC added that delivery of the £45M savings, detailed in the ACO SOC, were reliant on finding new ways to work across the system, and that this would need to sit within a framework, that was empowered to make commissioning decision across BHR. CC suggested that the ICP would be the forum for oversight and coordination across BHR.

ABH stated that it was clear that BHR needed to act transformatively in order to deliver improved services for BHR residents. The development of a locality model of care was key to this and needed to be progressed now. Joint commissioning arrangements could follow with a phased model of implementation. Clarity over the end point of the journey was required in order to drive engagement. CB raised the importance of having a unified BHR voice moving forward.

DR noted that London Councils has shown great interest in the progress of the BHR devolution pilot. He was keen to be able to demonstrate to London colleagues that the BHR plans supported health devolution. However, he continued to be concerned about the scale and pace and the extent to which they would achieve a shift to genuine joint decision making.

The group agreed the following:

- 1) The ICP would launch in November (taking on Board the points made in the DCOG meeting)
- 2) Development of fast track localities should proceed, in line with the roadmap.
- 3) Chief Executives should meet in October to agree the resource plan to support this next phase of work

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