Appendix A

Three boroughs (3B) Better Care Fund Plan for 2016/17

Updated Summary of Plan 16/17

Local Authorities	City of Westminster London Borough of Hammersmith and Fulham Royal Borough of Kensington and Chelsea
Clinical Commissioning Groups	Central London Clinical Commissioning Group Hammersmith & Fulham Clinical Commissioning Group West London Clinical Commissioning Group
	The Three Borough (3B) *Draft Addendum* 16/17 BCF Plan is being reviewed as part of the formal governance process by the 3B Health and Wellbeing Board Chairs and CCG Chairs and this process will be finalised by Friday 13th May 2016.
Date agreed at Health and Wellbeing Boards:	Original plan agreed 24.03.2014, 2nd revised plan agreed 19.09.2014

1. About this document

This summary narrative document for the 16/17 BCF Plan provides an addendum to the previously agreed 15/16 BCF Plan and summarises our proposed action to take forward the three borough (3B) BCF ambitions for the year ahead. The aims and principles of the original submission remain the same, however the plan is updated to reflect the changes in Health and Social Care since the plan was developed. Together Health and Social Care continue to work towards realising our ambition and moving towards full integration of our services that will enable the creation of local single pooled budgets to work more closely together around people, placing their well-being as the focus of health and care services. This draft narrative for the 3B BCF Plan has been requested by NHS England for assurance purposes and has been prepared alongside early work to create a NWL Sustainability and Transformation Plan (STP) across NW London. Although the STP is not due to be completed and discussed by organisations until June, in line with the government's expectation that health and care services are fully integrated by 2020 the STP will emphasise our approach to integration and collaboration across organisations. The evidence base to support the case for change and support the identification of our agreed BCF schemes was provided in the 15/16 BCF plan.

Integration across the health and social care system is a key priority in each borough's current Joint Health and Wellbeing Strategy (JHWS) and will be so in the creation of refreshed strategies being compiled during early 2016. Each of the JSNAs for the boroughs identifies strategic priorities for which the portfolio of projects in the Better Care Fund Programme is a crucial enabler. Overall there is commonality across health and care in terms of our local strategic priorities and together we are committed to ensuring transformational change that benefits our residents, particularly in out of hospital services. Our vision can be summarised by borough as:

- *Westminster; ensuring access to appropriate care at the right time and supporting people to remain independent for longer*
- *Hammersmith and Fulham; the development of integrated health and social care services which support prevention, early intervention and reduce hospital admissions*
- *Kensington and Chelsea; ensuring safe and timely discharge from hospital.*

2. Better Care Fund Delivery in 16/17

In the main we have agreed a rollover of the approved BCF programme from 15/16 into 16/17, including the agreed investment and the BCF Schemes and their scope. Our vision remains the same but we have updated the range of things we need to do in order to continue to deliver on our original ambition. Updated schemes have been appended to this narrative document (see appendix 1).

2.1 Links to Sustainability and Transformation Planning (STP)

A key part of our collaboration and integration across health and social care is demonstrated in the work we have been developing together to develop our Sustainability and Transformation Plan (STP). An STP base case was submitted to NHSE on 15 April, with a final plan due to be finalised by the end of June 2016. This will support a refresh of our current Better Care Fund (BCF) to ensure that the STP and BCF align and support the realisation of the aims and objectives of the BCF. This presents an opportunity for us to identify some of our BCF schemes that would be better delivered at scale such as Personal and Health Care Budgets (PHB) and Patient and Public Engagement (PPE).
The NHS Five Year Forward View (FYFV), published in October 2014, set out a shared vision for the

future of the NHS, which aligns to our strategic objectives in NW London. Planning Guidance released in December 2015 sets the requirement to develop a shared five-year plan. This should describe how areas will locally deliver the requirements of the Five Year Forward View. Boroughs in NW London will collaborate as 'place based systems' across health and local government, to address the ambition set out in the FYFV. For NW London we are committed to a five year plan that is based on the principle of subsidiarity, where things that can be decided and done locally, The NWL STP will describe plans at different levels of 'place'– across the whole system in North West London, from the local to the sub-regional, as appropriate.

The purpose of our STP is for NW London to:

- Describe clear plans to address the three aims of the Five Year Forward View of improving health and wellbeing, improving care and quality and achieving financial sustainability ;
- Set out a shared vision for health and care services;
- Confirm and align activity, finance, capital and workforce requirements across the region and over the next five years;
- Describe the implementation steps required to deliver the vision and plans at a local and NWL level;
- Be the primary route to accessing Sustainability and Transformation Funding from 2017/18

Once the Sustainability and Transformation Plan is finalised, the 3Bs will review the potential this brings for our BCF and how we further develop our ambition and delivered our stated outcomes.

2.2 Adult Social Care Transformation Programme

In adult social care, the transformation programme which was initiated in 2014 based on customer feedback and views, and which supports the delivery of the Better Care Fund plan, continues in three parts - as follows:

1. The customer journey project is now in full scale delivery - building on the priorities of the department and this plan, this is seeing us implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service (CIS), develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups

2. Commissioning intentions have been established for adult social care, working alongside health, and these are providing the basis for making a marked shift towards delivering outcomes based commissioning. We are moving away from traditional procurement and purchasing (based on units of cost and activity) to more of a focus on driving overall spend and budgets to deliver improving outcomes for users. There are four commissioning intentions (integrated information, advice and prevention, integrated intermediate care services, ongoing support in the community and buildings based support to ongoing care needs). These have all been developed against a baseline and, taken together with a wider review of the care market locally; they are forming ASC's contribution to the development of out of hospital services across the three boroughs.

3. Whole systems working - this area of work falls squarely within the remit of the Better Care Fund plan and is increasingly supporting adult social care and health partners focus on further opportunities to work together in the way services are commissioned, reviewed and delivered.

2.3 Whole Systems Integrated Care (WSiC)

NWL is one of 14 pioneer sites working to implement integrated care at scale and pace. Across the 8 boroughs, 31 partner organisations have agreed to work together in pursuit of a shared person-centred vision for integrated care. All CCG areas are developing their own approach to whole-

systems (with local authorities), however, the principles, which underpin these approaches, are shared.

As part of our BCF the Community Independence Service will work to integrate with and support WSIC Early Adopters and develop a seamless interface during the contract period. This will include responding to the different requirements of each CCG and local authority model and contributing to service developments as the WSiC programme is embedded across the area.
The three clinical commissioning groups are at differing stages of developing and mobilising primary care models for Whole Systems Integrated Care. The principle of each model is the same in which primary care teams will proactively work with patients (who will mostly be over 65 and have one or more long term condition) with the aim of promoting intensive care planning, self-management of conditions and maintenance of long term independence. The aim is for better coordinated, proactive and accessible care.

The WSIC programme aims to bring together planned and unplanned care, including the functions of the CIS, into an overall pathway of care, which enables healthy ageing, improved quality of life and maintains independence. WSIC principles endorse primary care leading intensive case management and care planning as the heart of this integration, organised at both practice and hub/village/locality level.

3. Our vision for health and social care locally

The BCF remains one of the key transformational programmes that aim to improve experience of, and outcomes from, health and social care provision for the populations we serve. As part of our BCF Vision; we have identified some of the key transformation programmes that will support the delivery of the BCF and integrated care. We continue to develop strong alignment in the visions of these programmes which will;

- encourage working as a single team across adult social care, public health, housing, mental health, primary care, community care, hospital care and other allied services
- Are dedicated to improving the health and wellbeing of the 600,000 people who live in Hammersmith & Fulham, Kensington & Chelsea and the City of Westminster.

3.1 Three boroughs (3Bs)

The previously agreed vision across the three borough (3B) is founded on population needs assessment and patient, service user and carer feedback, which has developed over the long-term through a broad spectrum of engagement and consultation.

This approach supports the highest risk proportion of the population who consume the majority of resources, this is a particular focus, and the consequences of these changes in need and environment are already evident. Critical services have been centralised where necessary to deliver higher quality care, (including Major Trauma and Stroke services) and improvements are being made to the way services are delivered in the community so care is delivered as close as possible to where individuals live and is integrated with local hospitals. Drawing on insights from the three JSNAs, we are using the BCF as an opportunity to accelerate the integration of patient-centred delivery across health and social care. Our schemes support a co-commissioning approach that encourages co-ordinated operational management across different service providers to best meet the needs of patients and service users.

We recognise that more must be done to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; to support individuals with long term conditions; and to enable older people to live more independently. Our shared vision for whole systems integrated care is that we want to improve the quality of care for individuals, carers and families, empowering and

supporting people to maintain independence and to lead full lives as active participants in their community. It is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys, we know that people want choice and control and for their care to be planned with people working together to help them reach their goals of living longer, staying and living well. They want care delivered by people and organisations that show dignity, compassion and respect at all times.

In order to achieve this approach we are committed to ensuring that;

- **People will be empowered to direct their care and support**, and to receive the care they need in their homes or local community
- **GPs will be at the centre** of organising and coordinating people's care
- **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **Co-ordinate around individuals**, targeted to their specific needs
- **Improve outcomes**, reducing premature mortality and reducing morbidity
- **Improve experience of care**, with the right services available in the right place at the right time
- **Maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing
- **Through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

As part of the agreed 15/16 BCF plan we provided detailed information in the form of 'personas' to highlight the engagement and value we have placed upon our patients, service users and carers to ensure that changes to our services and the desired outcomes are co designed. This work continues as we move into the second year of the plan.

3.2 Primary care transformation

The three boroughs (3Bs) CCGs have been jointly co-commissioning primary care with NHS England since April 2015. This approach is one of three different models of co-commissioning available to CCGs and was selected following close engagement with GPs across the three boroughs, as well as with other clinicians, lay members, and other relevant stakeholders. It means that NHS England remains the accountable commissioner for primary care but shares decision-making with the CCGs. This is done through a NHSE/CCG joint committee in each CCG, on top of the close day-to-day working between the NHSE and CCG primary care teams. The joint committees have Health and Wellbeing Boards and Healthwatch representation.

A core task of the co-commissioning joint committees is to design and implement new local models of primary care that meet the specific needs of communities within each CCG, whilst building on local progress with whole-systems integrated care and BCF. This work is now under way in all three boroughs and will deliver local primary care that is accessible, co-ordinated, and proactive.

Having GP practices work together is vital to this, as it is to delivering safe co-ordinated and

proactive care with maximum efficiency. This is why the three CCGs are continuing to support their local GP federations to develop into robust providers of a wider range of primary care services. This is also a critical aspect of the development of Accountable Care Partnerships, which to deliver maximum benefits require general practice voice to play a strong and coherent role.

4. Progress made in 15/16 about the differences to patient and service user outcomes?

Our approved 15/16 BCF Plan identified a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing. These include:

- Mental health problems (diagnosed and undiagnosed)
- Unsuitable housing leading to and exacerbation of conditions/capacity
- The need for reablement now or in the near future
- Mobility and transport issues
- Significant life impacting event e.g. bereavement
- Frequent and unplanned use of multiple services
- Social isolation
- Multiple long term conditions.

Our vision to achieve by 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.

5. Our programme delivery through the BCF in 15/16

As outlined in the 15/16 BCF Plan, we have a broad range of transformational changes across acute and primary care and adult social care – as well as overarching developments towards a whole system approach that have been in place in the three boroughs (3B) over the past few years, the BCF schemes further enhance this strategic change as they are a balanced mix of on the ground operational changes to key services; further understanding of patient and service user needs; more effective joint commissioning; and development of key enablers including systems infrastructure, therefore the BCF schemes continues to support our ambition in 2016/17.

Within the 3Bs, the customer journey project has moved to full scale delivery - building on the priorities of the department and this plan, this is supporting us to implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service, develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups.

Our innovative schemes (See Appendix 1, BCF Schemes 16/17) are driving consideration of new approaches to operational governance, such as the contracting approach we are taking to the Community Independence Service (CIS) reprocurement – that support rather than hinder integration. Over the next 3 years, community healthcare, primary care, hospital and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home. We will design and implement new ways of ensuring clarity of delivery responsibility across commissioners and providers – ensuring that there are feedback loops, so that we continue to understand patient and service user perspectives and share learning across the delivery chain

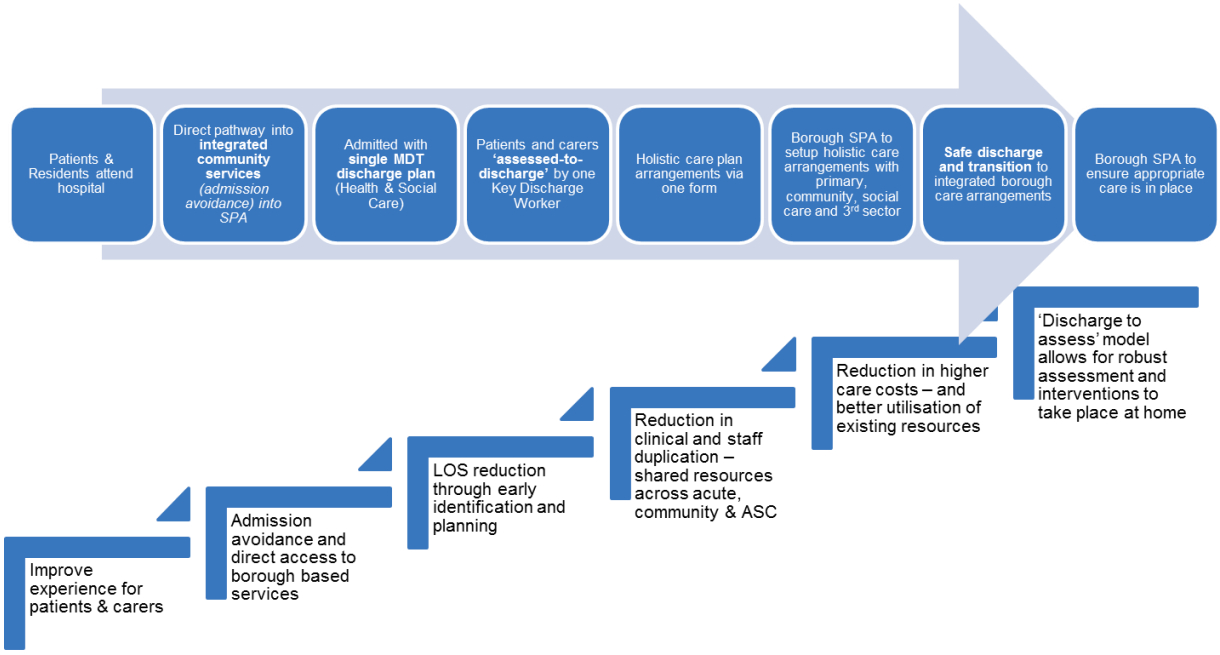
5.1 Development and implementation of 7 day working across Health and Social Care

North West London was awarded "Early Adopter" status by the NHS England/NHSIQ Seven Day Services Improvement Programme in November 2013. In October 2015 we then accepted the opportunity as a sector, to be a national First Wave Delivery Site for the refreshed 7 day services programme (as launched by the PM at the conservative party conference).

The NHS England Seven Day Services Programme centres on delivery of a set of 10 Clinical Standards for Acute Care. Standard 9 sets out the requirement for a 7 day discharge pathway:

Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3Bs, but also across the wider North West London footprint. The following outlines the vision:



Delivery to date has included the development of one agreed health and social care needs based assessment form which will be used across the three boroughs (3B) and the wider North West London sector, to manage referrals from hospitals into community and social services from 1st May 2016.

5.2 Community Independence Service (CIS)

In 15/16 we undertook a transitional year for the Community Independence Service (CIS). This included working to align the service across the 3Bs to deliver, Rapid Response, In-reach, Rehabilitation and Reablement services. Year one was supported by the appointment of a Lead Health Provider working in partnership with Adult Social Care and our Community Services provider to implement the model of care. In 16/17 the CIS service is being reprocured and the new provider should be in place by 1st July 2016. In establishing a new service across Health and Social Care, anticipated

year one benefits were not achieved, this was due to the speed of roll out and the challenges of recruiting the required workforce. In 16/17 we have further enhanced our CIS model and anticipate our ambition for the release of the planned benefits.

5.3 Neuro-rehabilitation

The Neuro-rehabilitation service was reporocured in 15/16 and went live on 1st April 2016 this commission has resulted in an annual efficiency savings for the three boroughs (CCG, Health efficiency) through reduction in DTOCs for neuro-rehab patients and an improved patient pathway.

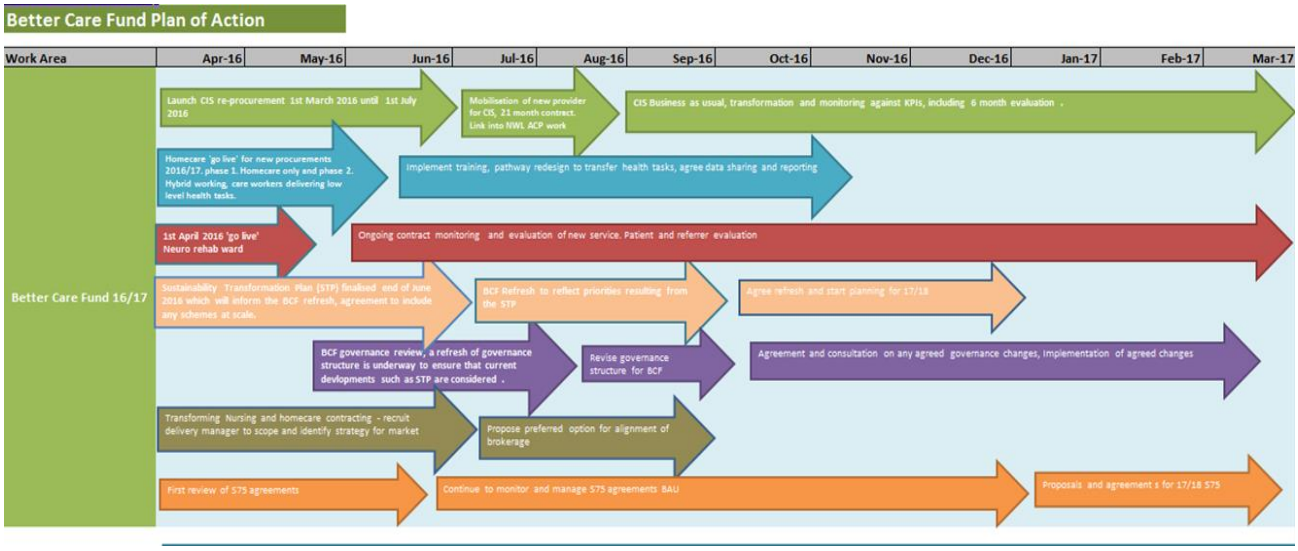
6. Summary of 16/17 planned BCF schemes

The agreed schemes for the15/16 will continue in 16/17 in line with the rollover and continuation of our BCF plan, this includes the same schemes and the overall an agreed investment, £159.3m. We have also identified that there is an additional Health cost pressure of up to £3m, this will be risk managed and reviewed through governance processes in year. We will work together to ensure that mitigating actions are taken in year to manage these cost pressures and these costs may have to be offset against the wider S75 agreements.

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
	A4	Integrated Hospital Discharge and 7 Day Working
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health and Care Budgets
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

6.1 Summary of Plan of Action 16/17

The summary plan below shows a high level timeline of the main milestones to be delivered over the course of the 16/17 BCF plan. Achievement against this schedule will be closely monitored as part of the BCF Programme Implementation and Monitoring. For full details see (Appendix 2).



7. How our BCF meets National Conditions for 2016-17

As part of our 16/17 BCF plan we will continue to monitor, develop and meet the requirements of the National Conditions as outlined in the 15/16 BCF Plan. The BCF is now in its second year, the BCF includes national conditions and locally set requirements, this approach continues in to 16/17 with the following national conditions as outlined. Details of the metrics that underpin these are provided within the 16/17 BCF template outlining the agreed ambition, confirming that we have met the 8 required National Conditions and confirmation of the agreed funding levels for 16/17 that is, roll over of the 15/16 BCF investment at £159.3m.

The 16/17 conditions include;

1. **Plans to be jointly agreed**

   The agreed BCF plan for 15/16 was jointly agreed and as outlined includes robust governance and reporting mechanism. In 16/17 this updated narrative and the required template has been agreed across the 3Bs. This includes the detail of the schemes that underpin our BCF, the summary narrative and the investment required to deliver the ambition of our 16/17 BCF plan.

2. **Maintain provision of social care services (not spending)**

   As outlined in the agreed 15/16 BCF plan we will continue to maintain provision of social care services at the same level and all BCF schemes have been carried over (In total we are investing overall £159.3m for our BCF, this is in line with the agreed investment in 15/16. A key component of the 3B BCF plan is the additional investment in social care through the Community Independence Service, which will enhance rehabilitation and reablement services, leading to a reduction in hospital readmissions and residential/nursing home admissions.

3. **Agreement for delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate**

   Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3B, but also across the wider North West London footprint, with NWL acting as an early implementer. The Community Independence Service (CIS), also supports this

National Condition with a model that includes Rapid Response, In-reach, Rehabilitation and Reablement.

4. Better data sharing between health and social care, based on the NHS number

In summary during 15/16 our services implemented the NHS number as the single identifier for our patients, having delivered this ambition we now are developing a single integrated IT platform initially as part of the Community Independence Service (CIS). Furthermore, this project will integrate ASC and GP IT systems. The project rational is based on the assumption that sharing of medical and social records across different settings of care reduces risk, reduces duplication and improves outcomes and speed in both assessment and care of the individual, as well as enhancing the client's experience.

5. Ensure a joint approach to assessments and care planning to ensure that, where funding is used for integrated packages of care, there will be an accountable professional

To build upon the approved 15/16 BCF plan, across the 3B an integrated care programme has been implemented that includes assessment and provision of integrated packages of care. This includes care planning, case management and the provision of an accountable professional. Our integrated care pathway and delivery puts GPs at the centre of care (e.g. WSiC) and the CIS with GPs taking the lead in coordinating care as the agreed lead professional.

6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Across NWL and the 3Bs transformation plans have been developed and consulted upon with the Local Authority, hospitals, community and mental health services and other local stakeholders. As part of the Sustainability and Transformation Planning (STP) we have representation from all organisations. As part of the agreed 15/16 BCF and the 16/17 BCF plan our operating plan agreements have been or are being negotiated with regards to the impact of reductions in activity. Reductions in activity are within CCG QIPP plans that will be reported via our NHSE Operating Plan.

7. Agreement to invest in NHS commissioned out-of-hospital services

In NWL and the 3Bs we continue to develop and invest in our out of hospital services at levels above the mandate. This supports our Out of Hospital strategy to deliver care to our patients closer to home and in the right setting to ensure that we reduce dependency on our hospitals and acute settings.

8. Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve

We are committed to continuously developing our response to delayed transfers of care. This includes an understanding of our local issues relating to DTOC, a local action plan (see appendix 3, DToC draft local action plan),clear ambition and a trajectory to reduce DToC has been developed to clearly outline what we need to undertake as part of the BCF in 16/17 to address DTOC.

Delayed Transfer of Care (DToC)

As part of our BCF schemes in project A's we recognise the interdependency that supports our ambition for reducing DToC and the principle of quality care is delivered in the right place. Looking to 16/17 both nationally and locally in 3B we recognise the importance of further reduction in DToCs and therefore our BCF plan will continue to priorities delivery against this ambition. The CCGs, Local Authorities and provider partners recognise that any stay in hospital can be a stressful and uncertain time for patients and their families and carers and their experience of being discharged from hospital is often not positive. The BMA in its report on *Hospital Discharge: the patient, carer and doctor perspective (January 2014)* highlighted many of the poor experiences reported on by patients and their families.

It is widely agreed that effective discharge planning and management plays a vital part in ensuring capacity is available for patients needing to access acute care beds, and supporting a resilient

system. In addition the Care Act reinforces the need for the system and people to work together to ensure timely discharge and transfer of people as soon as they are medically optimised and safe to transfer.

Addressing the complexities of hospital discharge processes requires a system response from commissioners and providers. Our aim is to ensure that people in hospital have a timely discharge, and are able to receive the ongoing care they need at home or in the community that enables them to meet their health and wellbeing outcomes. We wish to reduce the current fragmentation of the discharge processes so that people have a positive experience of their discharge from hospital in which they and their family/carers are clear of the process, the multi-disciplinary team involved in their discharge, and are fully involved in the decisions affecting their ongoing care. We believe this is a critical requirement in terms of providing continuity of care once back home or in the community, and to prevent further unnecessary admissions to hospital. This has led to our collective work on Enabling Positive Discharges which started in October 2015 and has generated a willingness to develop common approaches and processes and a system wide DTOC action plan and programme.

The CCGs, Local Authorities, acute providers and community health providers across Tri-borough have therefore formed the Tri-Borough Integrated Hospital Discharge Steering Group to align all the projects concerning hospital discharge into a single programme structure.

The Steering Group will report into the BCF Implementation Board as well as the Tri-borough System Resilience Group who will be identifying positive hospital discharge as one of its 2016/17 priorities. The Steering Group is currently developing an overarching action plan reflecting all the individual projects against key themes and which will enable prioritisation. It will also identify benefits to be achieved through these actions and measurement of these benefits. A summary report will be developed to present a monthly update across the programme and outcomes/benefits being delivered

We have identified a number of priority areas within our DTOC work programme so far which enable improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Development of integrated hospital discharge teams and pathways within a number of hospital wards to provide a common discharge approach across the 3 borough (project A2)
- Increased provision of interim beds to enable step down from hospital and to allow for full assessments of people's needs to be undertaken in the community
- Alignment of organisational Choice policies supported by information for patients, families and carers on the local options available for community or home based care upon discharge

Our DTOC work programme therefore has a number of interdependencies with other strategic initiatives including:

- Re-procurement of our Community Independence Service which includes In Reach to facilitate early discharge from hospital
- Review of our provision of Intermediate Care beds to ensure we can meet local needs for step down and step up provision in the community

Disabled Facilities Grant (DFGs)

Housing departments in 2 boroughs administer the DFGs and ASC in one. The plans are developed by Housing and ASC and the agreed funding will be allocated to the Housing depts. However, as Social Care capital and DFG capital funding has been combined from 2016/17, the DFG will be influenced by the Housing plan, spending patterns and commitment and ASC need for capital.

8. BCF Programme arrangements including governance and financial arrangements

Across the three boroughs (3B), we have invested significantly in building strong governance arrangements to support the Better Care Fund. As outlined previously, the governance arrangements described below are designed to ensure all 6 sovereign entities are central to decision making without creating unnecessary delays or blockages.

A BCF Board provides a forum for Cabinet members and CCG Chairs (described in Section 4c below). The BCF Board makes recommendations to HWB members, particularly in relation to the large scale integrated initiatives that require a joint approach. The HWBs meet on a quarterly basis.

The Health and Wellbeing Board in each of the boroughs has continued to develop and mature. We have a joint monthly meeting between the executive teams in CCGs and Local Authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each Local Authority and CCG.
We continue to have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services, which are already overseen by the Joint Executive Team (JET). This will enable us to review pooled budget requirements for the new financial year 16/17. We will continue arrangements for hosting with the LA, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that Local Authority or CCG.

As aforementioned, the Sustainability and Transformation Plan (STP) is currently being developed, the plan is due for completion by the end of June 2016 and following this we will look to refresh the Better Care Fund and also amend the current governance arrangements as required.

9. Risk management and contingency planning

In line with our 15/16 BCF Risks and Contingency we have refreshed our risk plan, (a detailed BCF Risk Log is provided in Appendix 5) we continue to manage these in line with ensuring that all risks are identified and plans are in place to help mitigate these to support delivery against our BCF Plan 16/17. In summary our BCF plan will continue to be developed with providers and is based on the principles of achieving a reduction of acute admissions.

The same core principles of risk sharing have been agreed within the BCF programme:

- Organisations take responsibility for the services they sign-up to deliver (against agreed specification of service quality, type and volume)
- Organisations take responsibility for the benefits that are expected to be realised in their organisation
- Effective monitoring arrangements to identify where there are variances and to reconcile back to the original budget (similar to s.75 arrangement)
- Commitment to a shared approach to resolving variances and amending service model and share of costs if required.

The BCF is based on an agreement to share the financial risks and rewards of new out-of-hospital services between CCGs and Local Authorities. The agreement is based on estimates of activity,

costs and benefits of those services and the previous year's activity has supported us to develop plans that reflect actual activity. There is of course the risk that, if the planned net benefits are not delivered, there will have to be a call on existing resources in the CCGs and Local Authorities. The CCGs have identified contingency funds should the expected benefits not be realised, this demonstrates the strong commitment we have to develop our integrated working under the BCF.

10. Summary of BCF engagement

The agreed 15/16 BCF plan outlined our engagement process in relation to developing our BCF. We continue to work together to support patient, service user and public engagement, develop our service provider engagement and identify the implications for acute providers.

The process of engagement across these stakeholders is iterative and responsive to the live BCF schemes that we continue to develop and implement as highlighted in the schedule. Our BCF progress continues to report to our Health and Well-Being Boards, including this16/17 BCF implementation plan and link to our Strategic Partnership Group (SPG). The development of the Integration and Collaboration Working Group reports to the JET and steers the NWL STP to ensure place based commissioning and transformation for the three boroughs, this new forum is being used to engage all providers in the ambitions of the BCF and scheme progress within the overarching context of the STP.

This year's BCF is a continuation of the agreed 15/16 plan. As this is year 2 of the BCF, the consequential impact to providers is being negotiated via our current QIPP plans as part of the contract negotiations. The activity reduction linked to the CIS, 7 day services and neuro-rehab are part of the 16/17 contract negotiations that reflect the ambition of the BCF and the reduction of activity in these areas.