London Borough of Hammersmith & Fulham

Cabinet

Agenda

MONDAY
3 NOVEMBER 2014
7.00 pm

COURTYARD ROOM
HAMMERSMITH
TOWN HALL
KING STREET
LONDON W6 9JU

Membership

Councillor Stephen Cowan, Leader of the Council
Councillor Michael Cartwright, Deputy Leader
Councillor Sue Macmillan, Cabinet Member for Children and Education
Councillor Andrew Jones, Cabinet Member for Economic Development and Regeneration
Councillor Max Schmid, Cabinet Member for Finance
Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care
Councillor Lisa Homan, Cabinet Member for Housing
Councillor Sue Fennimore, Cabinet Member for Social Inclusion
Councillor Wesley Harcourt, Cabinet Member for Environment, Transport & Residents Services

Date Issued
23 October 2014

If you require further information relating to this agenda please contact: David Viles, Committee Co-ordinator, Governance and Scrutiny, tel: 020 8753 2063 or email: David.Viles@lbhf.gov.uk

Reports on the open Cabinet agenda are available on the Council's website: http://www.lbhf.gov.uk/Directory/Council_and_Democracy

PUBLIC NOTICE

The Cabinet hereby gives notice of its intention to hold part of this meeting in private to consider items (14 to 16) which are exempt under paragraph 3 of Schedule 12A to the Local Government Act 1972, in that they relate to the financial or business affairs of any particular person, including the authority holding the information.

The Cabinet has received no representations as to why the relevant part of the meeting should not be held in private.

Members of the Public are welcome to attend.
A loop system for hearing impairment is provided, together with disabled access to the building

DEPUTATIONS

Members of the public may submit a request for a deputation to the Cabinet on non-exempt item numbers **4-11** on this agenda using the Council's Deputation Request Form. The completed Form, to be sent to David Viles at the above address, must be signed by at least ten registered electors of the Borough and will be subject to the Council's procedures on the receipt of deputations. **Deadline for receipt of deputation requests: Wednesday 29 October 2014.**

COUNCILLORS' CALL-IN TO SCRUTINY COMMITTEES

A decision list regarding items on this agenda will be published by **Wednesday 5 November 2014.** Items on the agenda may be called in to the relevant Accountability Committee.

The deadline for receipt of call-in requests is: **Monday 10 November 2014 at 3.00pm.** Decisions not called in by this date will then be deemed approved and may be implemented.

A confirmed decision list will be published after 3:00pm on **Monday 10 November 2014.**

London Borough of Hammersmith & Fulham

Cabinet
Agenda

3 November 2014

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If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

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14.	**EXEMPT MINUTES OF THE CABINET MEETING HELD ON 6 OCTOBER 2014 (E)**	
15.	**SURRENDER AND RE-GRANT OF LEASES AT 16 ST STEPHENS AVENUE (E)**	
16.	**TRI- BOROUGH MANAGED SERVICES - FINANCE AND HUMAN RESOURCES (TRANSACTIONAL SERVICES) - EXEMPT ASPECTS (E)**	

The Cabinet is invited to resolve, under Section 100A (4) of the Local Government Act 1972, that the public and press be excluded from the meeting during the consideration of the following items of business, on the grounds that they contain the likely disclosure of exempt information, as defined in paragraph 3 of Schedule 12A of the said Act, and that the public interest in maintaining the exemption currently outweighs the public interest in disclosing the information.

London Borough of Hammersmith & Fulham

Cabinet

Minutes

Monday 6 October 2014

PRESENT

Councillor Stephen Cowan, Leader of the Council
Councillor Michael Cartwright, Deputy Leader
Councillor Sue Macmillan, Cabinet Member for Children and Education
Councillor Andrew Jones, Cabinet Member for Economic Development and Regeneration
Councillor Max Schmid, Cabinet Member for Finance
Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care
Councillor Lisa Homan, Cabinet Member for Housing
Councillor Sue Fennimore, Cabinet Member for Social Inclusion
Councillor Wesley Harcourt, Cabinet Member for Environment, Transport & Residents Services

1. MINUTES OF THE CABINET MEETING HELD ON 1 SEPTEMBER 2014

RESOLVED:

That the minutes of the meeting of the Cabinet held on 1 September 2014 be confirmed and signed as an accurate record of the proceedings, and that the outstanding actions be noted.

2. APOLOGIES FOR ABSENCE

There were no apologies for absence received.

3. DECLARATION OF INTERESTS

Other significant interests were declared by the following Members:-

Item 8 - Interim Proposal to extend current 16 Hammersmith and Fulham Children's Centre contracts for up to one year

Councillor Wesley Harcourt as Chairman of Old Oak Housing Association.

Councillor Vivienne Lukey as a Governor of Bayonne Nursery School.

Item 9 - Extension of Youth Service contracts up to 31 March 2016

Councillors Sue Fennimore and Wesley Harcourt as Governors at Phoenix High School.

Item 11 - Use of 2014-15 Public Health Underspend In LBHF

Councillors Sue Fennimore and Wesley Harcourt as Governors at Phoenix High School.

Item 19 - Lyric Theatre

Councillor Sue Fennimore as a Director of Lyric Theatre.

4. APPOINTMENT OF CONTRACT TO DELIVER CCTV MAINTENANCE AND NEW INSTALLATIONS FOR LBHF AND RBKC

RESOLVED:

1.1. That the contract for CCTV maintenance and new CCTV installations in the London Borough of Hammersmith & Fulham (LBHF) and the Royal Borough of Kensington & Chelsea (RBKC) be awarded to Chroma Vision who submitted the most economically advantageous tender in terms of the specified price/quality evaluation model, for a period of 5 years from 1 January 2015 to 31 December 2019, with an option to extend for a period of up to three further years to 31 December 2022; the annual contract sum will be £98,400 (£79,700 LBHF and £18,700 RBKC).

1.2. That the Deputy Leader, in consultation with the Executive Director of Environment Leisure and Residents Services, extends the contract in line with the provisions contained within the contract documentation, if the extension is considered appropriate at the time.

1.3. That the RBKC Cabinet Member for Community Safety, IT and Corporate Services note recommendation 1.2 above. LBHF will seek RBKC approval before any extension of the contract takes place to ensure that both council's wish to extend their provision. Should LBHF wish to extend the contract but RBKC do not agree to this LBHF will seek to vary the specification when exercising the option to extend so that RBKC elements are not included in the extension.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

5. CORPORATE REVENUE MONITOR 2014/15 - MONTH 3

RESOLVED:

1.1. That the forecast underspend of £2.153m for the General Fund and the underspend of £0.086m forecast for the HRA, be noted.

1.2. That approval be given to the virement requests totalling £0.902m General Fund and £0.106m Housing Revenue Account as detailed in Appendix 11.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

6. CAPITAL MONITOR AND BUDGET VARIATIONS 2014/15 (FIRST QUARTER)

RESOLVED:

1.1. That the proposed technical budget variations to the capital programme totalling £24.3m (summarised in Table 1 and detailed in Appendix 2), be approved.

1.2. That approval be given to the Council's policy to manage its VAT Partial Exemption position (para 8.2) for 2014/15 and 2015/16.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

7. CHILDREN AND FAMILIES ACT : IMPLEMENTATION PLAN

Officers reported that the Children and Families Act required Education, Health and Social Care services to work more closely together and undertake a combined assessment process for young people with complex needs. This assessment process would result in the production of a combined Education, Health and Care plan replacing the current 'Statements' of special educational need.

Councillor Macmillan noted that in line with the Administration's policy to engage with residents, the department will work closely with a wide group of residents through the Children and Education Policy and Accountability Committee on its implementation. The PAC will review the initial guidelines and their impact at its meeting in January 2015 and make recommendations as required.

RESOLVED:

That approval be given to the initial eligibility guidelines for formal implementation for the academic year 2014/15 as set out in the report.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

8. INTERIM PROPOSAL TO EXTEND CURRENT 16 HAMMERSMITH AND FULHAM CHILDREN'S CENTRE CONTRACTS FOR UP TO ONE YEAR

The Leader noted that keeping Children's Centres open was a main manifesto commitment. He thanked officers for all their hard work in finding the funding to achieve this.

RESOLVED:

1.1. That the application of the Council's Standing Orders (CSO) be waived so that a new contract can be awarded to the existing service providers in the absence of competition.

1.2. That the current service providers continue to provide the service beyond the current expiry date of the contracts for up to one year i.e. contracts are

extended from 1 April 2015 – 30 September 2015, with provision for further extension to 31 March 2016 if required, be agreed.

1.3. That the service provision is on the same terms and conditions as the current contracts, including the option for the Council to terminate the service on a minimum of three months' notice, be noted.

1.4. That the level of funding for the duration of the extension remains the same as current contracts paid on a quarterly basis, as set out in Appendix 1 which details the total contract value for year, be noted.

1.5. That authority to approve any further actions necessary to ensure that the Council meets its statutory duties for the provision of children's centres and to give practical effect to the interim measures that are proposed, be delegated to the Cabinet Member for Children and Education, be approved.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

Other signficant interests were declared by Councillor Wesley Harcourt as Chairman of Old Oak Housing Association and Councillor Vivienne Lukey as a Governor of Bayonne Nursery School.

9. EXTENSION OF YOUTH SERVICE CONTRACTS UP TO 31 MARCH 2016

RESOLVED:

1.1 That approval be given to enact the extension option so as to extend the contracts for a period of up to 12 months, with effect from the 1st April 2015, as per contract clause 1.1 (duration) outlined below:

The Agreement shall take effect on the Commencement Date and shall continue for a period of two years (the "Initial Term"), unless terminated earlier.

Subject to satisfactory performance by the Organisation, the Council may wish to extend the Agreement for a further period of up to 12 (twelve) calendar months. The Council may approach the Organisation if it wishes to do so before the end of the Initial Term. The clauses in the Agreement will apply throughout any such extended period unless otherwise stated to the contrary.

1.2 That the level of funding for the duration of the extension remains the same as current contracts paid on a quarterly basis, be approved.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

Councillors Sue Fennimore and Wesley Harcourt declared an interest as Governors at Phoenix High School.

10. CONTRACT AWARD : HEALTH TRAINER SERVICE

RESOLVED:

1.1 For Westminster City Council

Approval to award a framework agreement for three years, with the option to extend for one further year, to the recommended provider was approved at Tri Borough CAB on 4th August 2014.

To call off of the framework agreement and enter into a contract for three years from 1st January 2015, with the option to extend for one further year (subject to performance), with the recommended provider at a three year contract cost of £1,884,750.

1.2 For the Royal Borough of Kensington and Chelsea

To call off of the framework agreement and enter into a contract for three years from 1st January 2015, with the option to extend for one further year (subject to performance), with the recommended provider at a three year contract cost of £1,238,550.

2.3 For the London Borough of Hammersmith and Fulham

That approval be given to call off of the framework agreement and enter into a contract for three years from 1st January 2015, with the option to extend for one further year (subject to performance), with the provider recommended in the exempt report at a three year contract cost of £2,261,700.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

11. USE OF 2014-15 PUBLIC HEALTH UNDERSPEND IN LBHF

Cabinet was informed that the Public Health grant was ring fenced by the Government for use in areas directly related to the achievement of public health outcomes. Fourteen proposals were being recommended for support during each of the four years starting from 2014-15.

RESOLVED:

1.1. That approval be given to the funding of the fourteen proposals set out in the report, totalling £5,395,753, from the Public Health ring-fenced grant for 2014/15 to 2016/17 and the ring-fenced surplus brought forward from 2013/14.

1.2. That the commitment from Public Health to invest £368,000 per annum into Children's Centres in order to achieve public health outcomes from 2015-16 onwards, to be funded by efficiencies in contracted and planned expenditure, be approved.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

Councillors Sue Fennimore and Wesley Harcourt declared an Other Significant interest in this item as Governors at Phoenix High School.

12. TFL FUNDED ANNUAL INTEGRATED TRANSPORT INVESTMENT PROGRAMME 2015/16

In welcoming this report, Councillor Harcourt noted that the borough wide 20mph speed limit feasibility design and consultation, and the introduction of pedestrian countdown at traffic lights to improve pedestrian crossings were among the projects to be approved. Officers informed the meeting that there was no funding in the budget for the flyover. Dialogue with the Mayor was on going for a clear commitment to the project.

RESOLVED:

1.1 That approval be given to carry out feasibility design and consultation on projects C1 to C3, E1 to E4 and L1 to L3 (identified in the body of the report) at a total cost of £91,500 (approximately 15% of the total capital project cost, and all charged to the capital project) as set out in paragraph 5.2 (forms part of the £1,711,000).

1.2 That authority be delegated to the Cabinet Member for Environment, Transport and Residents Services, in consultation with the Executive Director of Transport and Technical Services, to approve the implementation of projects C1 to C3, E1 to E3 and L1 to L3 (identified in the body of the report) totalling £518,500 (forms part of the £1,711,000), subject to favourable outcome of public engagement and consultation.

1.3 That authority be given to carry out feasibility design and consultation on a borough wide 20mph speed limit at a total cost of £200,000 as set out in paragraph 5.2 (forms part of the £1,711,000).

1.4 That authority be given to utilise £200,000 to contribute to the £2m plus Shepherd's Bush Town Centre West major project that is approved by Cabinet and construction currently underway as set out in paragraph 5.3 (forms part of the £1,711,000).

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

13. BRADMORE CONSERVATION AREA - EXTENSION

RESOLVED:

1.1 That approval be given to the designation of an extension to the Bradmore Conservation Area as set out in the plan in Appendix 1 to include the following properties: Nos. 2-26 (even) & Nos. 1-21 (odd) Brackenbury Gardens; Nos. 1, 1A, Brickfields House 1B & 3–15 (odd) Brackenbury Road; Nos. 1–9 Providence Villas, Brackenbury Road; Nos. 155-163 (odd) Goldhawk Road; Nos. 18-22 (consec.) Sycamore Gardens; Nos. 26-48 (even) Glenthorne Road; Overstone House & Nos. 2-92 (even) & Nos. 1-71 (odd) Overstone Road; Nos. 2-26 (even) & Nos.

30-76 (even) & Nos. 1-63 (odd) Southerton Road; Nos. 2-16 (even) Iffley Road and Nos. 1-17 (consec.) Kilmarsh Road.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

14. KEY DECISIONS LIST

The Key Decision List was noted.

15. EXCLUSION OF PRESS AND PUBLIC

RESOLVED:

That under Section 100A (4) of the Local Government Act 1972, the public and press be excluded from the meeting during consideration of the remaining items of business on the grounds that they contain information relating to the financial or business affairs of a person (including the authority) as defined in paragraph 3 of Schedule 12A of the Act, and that the public interest in maintaining the exemption currently outweighs the public interest in disclosing the information.

[The following is a public summary of the exempt information under S.100C (2) of the Local Government Act 1972. Exempt minutes exist as a separate document.]

16. APPOINTMENT OF CONTRACT TO DELIVER CCTV MAINTENANCE AND NEW INSTALLATIONS FOR LBHF AND RBKC : EXEMPT ASPECTS (E)

RESOLVED:

That the report be noted.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

17. EXTENSION OF YOUTH SERVICES CONTRACTS UP TO 31 MARCH 2016 - EXEMPT ASPECTS (E)

RESOLVED:

That the report be noted.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

18. CONTRACT AWARD : HEALTH TRAINER SERVICE - EXEMPT ASPECTS (E)

RESOLVED:

That the recommendations in the exempt report be agreed.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

19. LYRIC THEATRE (E)

RESOLVED:

That the recommendations in the exempt report be agreed.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

Councillors Sue Fennimore declared an Other Significant Interest in this item.

20. ADULT LEARNING & SKILLS - PROVISION OF SPECIALIST INFORMATION TECHNOLOGY (IT) SERVICES - MANAGEMENT INFORMATION SERVICES (MIS) (E)

RESOLVED:

That the recommendations in the exempt report be agreed.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

21. RECOMMENDATION FOR DELEGATED AUTHORITY FOR PREVENT DELIVERY IN H&F (E)

RESOLVED:

That the recommendations in the exempt report be agreed.

Reason for decision:
As set out in the report.

Alternative options considered and rejected:
As outlined in the report.

Record of any conflict of interest:
None.

Note of dispensation in respect of any declared conflict of interest:
None.

Meeting started: 7.00 pm
Meeting ended: 7.30 pm

Chairman .....

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
CORPORATE REVENUE MONITOR 2014/15 - MONTH 5	
Report of the Cabinet Member for Finance – Councillor Max Schmid	
Open Report	
Classification - For Decision **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Jane West – Executive Director of Finance and Corporate Governance	
Report Author: Gary Ironmonger – Finance Manager Revenue Monitoring	**Contact Details: Gary Ironmonger** Tel: 020 8753 2109 E-mail: gary.ironmonger@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The General Fund outturn forecast is a favourable variance of £5.571m with budget risks of £5.369m. This is before taking account of contingencies.

1.2. The saving proposals put forward in the Interim Budget Report to Council in July are incorporated within this Report. The forecast underspend is £1.573m more than that set out in the July Council Report.

1.3. The HRA is forecast to underspend by £0.423m with HRA general reserves of £10.947m at year end. The HRA budget risks are £0.600m.

1.4. General Fund virement requests of £0.487m are recommended for approval. There are no virement request for the HRA at Month 5.

1.5. Approval is sought to write off £0.047m of uncollectable debt relating to the Sullivan and Townmead business incubator units.

2. RECOMMENDATIONS

2.1. To note the General Fund and HRA month 5 revenue outturn forecast.

2.2. To approve the virement requests totalling £0.487m for the General Fund as detailed in Appendix 11.

2.3. To approve that £0.047m of uncollectable debt relating to commercial tenants at the Sullivan and Townmead business incubator units is written off.

3. REASONS FOR DECISION

3.1. The decision is required to comply with the financial regulations.

4. CORPORATE REVENUE MONITOR (CRM) 2014/15 MONTH 5 GENERAL FUND

Table 1: General Fund Projected Outturn – Period 5

Department	Revised Budget At Month 5 £000s	Forecast Year End Variance At Month 5 £000s	Forecast Year End Variance At Month 3 £000s
Adult Social Care	64,955	(540)	283
Centrally Managed Budgets	27,769	(2,480)	(260)
Children's Services	48,358	527	836
Unaccompanied Asylum Seeking Children	1,013	115	0
Environment, Leisure & Residents' Services	31,461	203	51
Finance and Corporate Services	16,995	(187)	95
Housing & Regeneration	8,048	(566)	(887)
Library Services (Tri- Borough)	3,221	(30)	0
Public Health Services	346	(346)	(346)
Transport & Technical Services	15,772	45	121
Controlled Parking Account	(20,298)	(2,312)	(2,269)
Net Operating Expenditure*	**197,640**	**(5,571)**	**(2,376)**
Interim Budget Savings		**3,998**	
Revised Variance after Interim Savings		**(1,573)**	
Key Risks		**5,369**	**6,153**

***note**: figures in brackets represent underspends

4.1. Detailed variance and risk analysis by department can be found in Appendices 1 to 9.

CORPORATE REVENUE MONITOR 2014/15 HOUSING REVENUE ACCOUNT

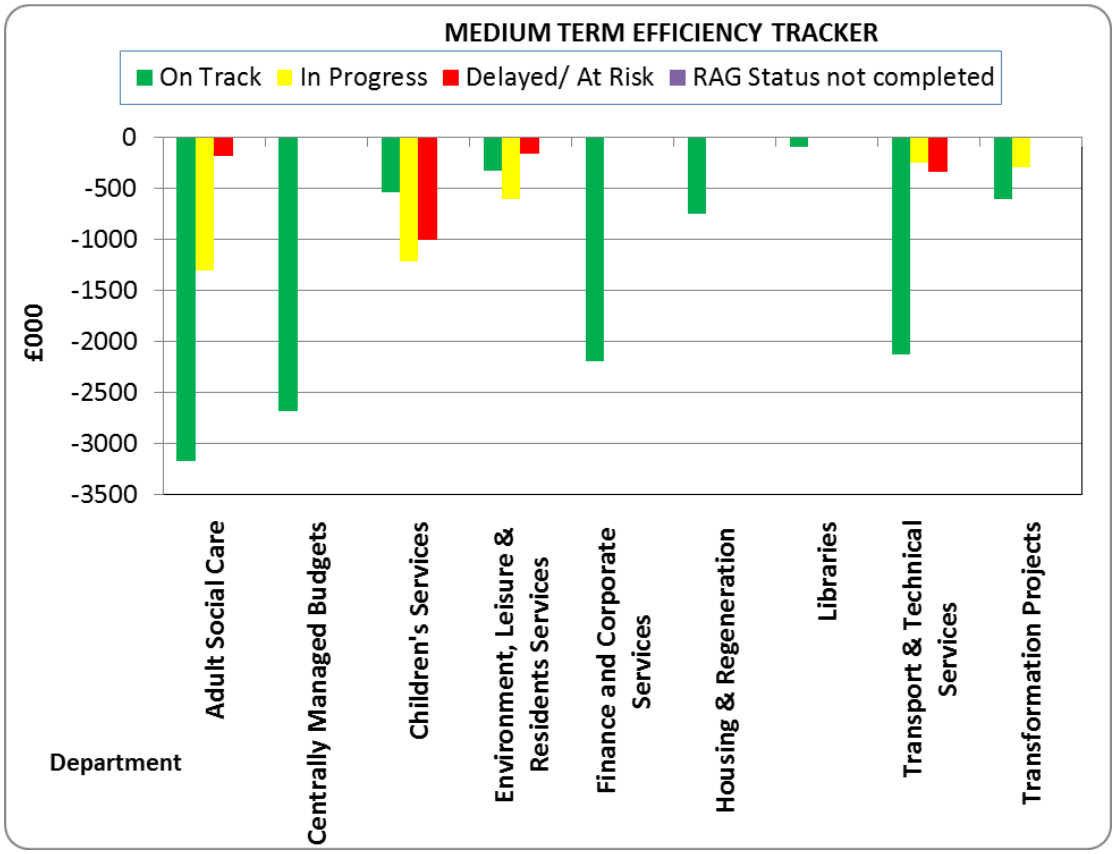
Table 2: Housing Revenue Account Projected Outturn - Period 5

Housing Revenue Account	£000s
Balance as at 31 March 2014	**(7,494)**
Add: Budgeted Contribution to Balances	(3,030)
Add: Forecast Underspend	(423)
Projected Balance as at 31st March 2015	**(10,947)**
Key Risks	**600**

4.2. Detailed variance and risk analysis can be found in Appendix 10.

5. MEDIUM TERM FINANCIAL STRATEGY EFFICIENCY TRACKER SUMMARY

5.1. The 2014/15 budget included efficiency proposals of £17.905m. Progress against these is summarised below and detailed in Appendices 1 to 9.



6. VIREMENTS & WRITE OFF REQUESTS

6.1. Cabinet is required to approve all budget virements that exceed £0.1m.

6.2. Virements totalling £0.487m are requested for the General Fund budgets There are no virement request for the HRA at Month 5.(Appendix 11).

6.3. Approval is sought to write off £0.047m of debt relating to the business incubator units at Townmead and Sullivan Way.

7. CONSULTATION

7.1. N/A.

8. EQUALITY IMPLICATIONS

8.1. It is not considered that the adjustments to budgets will have an impact on one or more protected group so an EIA is not required.

9. LEGAL IMPLICATIONS

9.1. There are no legal implications for this report.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. The General Fund outturn forecast at Month 5 is for a favourable variance of £5.571m. This is £1.573m more than the savings proposals identified in the Council's interim budget review.

10.2. Any redirection of resources resulting from the interim budget review should take account of the overall impact on departmental variances. On current projections Adult Social Care need to retain at least some of these savings to cover overspends in other areas. Children's Services are projecting an overspend that would be exacerbated if these savings were redirected to other projects. Other areas are currently forecasting to come in close to or under budget if resources are redirected following the interim budget review.

10.3. The HRA outturn forecast at Month 5 is an underspend of £0.423m.

10.4. Implications verified/completed by: James Arthur/Gary Ironmonger

11. RISK MANAGEMENT

11.1. Details of actions to manage financial risks are contained within departmental Appendices (1-10).

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. N/A

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	CRM 5	Gary Ironmonger - Tel: 020 8753 2109	FCS

List of Appendices

Appendix 1	Adult Social Care Revenue Monitor
Appendix 2	Centrally Managed Budgets
Appendix 3	Children's Services Revenue Monitor
Appendix 3a	Unaccompanied Asylum Seeking Children Revenue Monitor
Appendix 4	Environmental Leisure and Residents Services Revenue Monitor
Appendix 5	Finance and Corporate Services Revenue Monitor
Appendix 6	Housing and Regeneration Department Revenue Monitor
Appendix 7	Library Services (Tri-Borough) Monitor
Appendix 8	Public Health Services Monitor
Appendix 9	Transport and Technical Services Monitor
Appendix 9a	Controlled Parking Account Revenue Monitor
Appendix 10	Housing Revenue Account Monitor
Appendix 11	Virements Requests

APPENDIX 1: ADULT SOCIAL CARE

BUDGET REVENUE MONITORING REPORT – PERIOD 5

APPENDIX 1: ADULT SOCIAL CARE

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Operations	38,156	358	349
Provided Service and Mental Health Partnership	9,088	(152)	(105)
Commissioning	8,267	(597)	39
Procurement and Business Intelligence	1,037	(80)	0
Finance	7,910	(7)	0
Directorate	497	32	0
Additional Public Health external funding has been identified that offsets for employment of PD/ LD costs		(94)	
Total	**64,955**	**(540)**	**283**
Interim Budget Savings Reported as @ Full Council 23rd July 2014		809	
Updated Variance @ Month 5		**269**	

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Operations	358	There are pressures on the Home Care Packages and Direct Payments budgets as people are supported at home, in line with Tri-Borough ASC strategy. There is a net projected overspend of £498,000 in this budget. Discussions continue with the Clinical Commissioning Group to secure permanent funding for the increasing demand of meeting Care at Home. Within the Older People (OP) and Physical Disabilities (PD) Placement budget we are projecting a net underspend of (£438,000)

Departmental Division	Variance £000s	Explanation & Action Plans
		Included in this projection is (£157,000) as a contribution from NHS funding for Social Care in these areas.. This is welcomed given the pressures in the Home Care market. One of the main changes since last month is the proposal to vire from the placement budget £287,000 to temporarily offset the MTFS savings on the customer journey work stream. When the savings plans were drafted we had hoped that the outcome of the customer journey work would have begun to be achieved, but we won't see this until 2015/16. Within the Learning Disability (LD) Service, there is a net projected overspend of £332,000.The main reasons for the overspend relate to two transitions customers being factored in (one previously expected to be Continuing Care and one new customer) and a further two Social Care customer now staying for the full year. Since last month projection, there is one client who has transferred from Social to Continuing Care, resulting in the LD Placement projected overspend of £239,000. In the LD Direct Payment budget there is a net projected overspend of £93,000 due to an increase of four customers. An Action Plan is in place to address this and the outcomes will be reported in subsequent reports, and a risk has been factored in for clients who are no longer meet continuing health care. The new Transport contract is not now expected to deliver savings in 2014/15. A briefing to the Cabinet Member is being discussed on the redesign and variation of the service.
Provided Service and Mental Health	(152)	Within the Provided Service Division the main reason is a projected underspend of (£100,000) with a lower number of no recourse to Public Funds clients and (£52,000) within Mental Health on direct payments and day care services..
Commissioning	(597)	Within the Commissioning Division projection is (£552,000) of Supporting People cost to be funded from Public Health. In addition there is

Departmental Division	Variance £000s	Explanation & Action Plans
		a projected underspend of (£121,000) from Supporting People procurement savings on new contracts from the West London Framework agreement and variations on existing contracts. This is partly offset by pressure on the legal budget of £30,000 and the Tri-Borough Commissioning recharges there is projected overspend of £29,000.
Procurement and Business Intelligence	(80)	There is reduction in general training budget and Social workers training expenditure.
Finance	(7)	Marginal underspend projected in Client Affairs team.
Directorate	32	Marginal overspend on supplies and services and advertising cost.
Total	**(540)**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Learning Disability review of Continuing Care client	0	250
Home Care Contract rate negotiation	50	350
Total	**50**	**600**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Adult Social Care	(4,664)	(3,589)	(1,075)	0

5. Comments from the Executive Director

Adult Social Care (ASC) is projecting a net underspend of (£540,000) as at the end of period five. This is an improvement in the projection of £1,241,000 compared to the period four projected overspend of £701,000 reported to Business Board.

There are two main reasons for the change in projections are departmental management action and early achievement of savings.

The departmental changes in the projection relates to a proposed virement from the placement budget to offset the MTFS customer journey savings target of £287,000 in 2014/15. The other changes in the projections since last month relates to lower OP & PD placement costs following a review of high cost clients, management action taken within LD placement budget and a reduction in general training costs.

As part of the incoming Council Administration to review the 2014/15 General Fund revenue budget, ASC has identified three savings ideas that can be achieved early in this financial year. As detailed in table below, three savings totally (£809,000) are included in the projected outturn position of (£540,000) underspend. In addition there is (£94,000) factored into the projection from Public Health external funding to offsets costs for employment of PD/LD clients.

The current Home Care (HC) contracts expire on 30th September 2014. Individual spot contract will be procured for HC customers for the period 1st October 2014 to 31st March 2015, until the new HC contracts are procured. Procurement are currently renegotiating the spot rates with providers. It is anticipated that rates could rise by approximately 10% which equates to £300k. Additionally the West London Alliance HC volume discounts may no longer be paid by providers, which will add a further to £50k to the risk.

The department is expected to deliver savings of £4,664,000 in this financial year and at this stage of the year 77% are on track to be delivered. The remaining savings are classified as amber as discussions are on-going with the service providers and at this stage are expected to be delivered.

Council Interim Budget Savings 2014-15	Savings £000's	On Target	Notes
Adult Social Care			
Improve outcomes and reduce dependency amongst residents through better joint services with the NHS.	(157)	Yes	
Review of no recourse to public funds savings.	(100)	Yes	
Additional Public Health external funding has been identified that offsets Support People costs by £552k	(552)	Yes	
Adult Social Care Total	**(809)**		
Additional Public Health external funding has been identified that offsets for employment of PD/LD costs by £94k	**(94)**	Yes	

APPENDIX 2: CENTRALLY MANAGED BUDGETS

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Corporate & Democratic Core	5,839	(80)	(60)
Housing and Council Tax Benefits	(90)	0	0
Levies	1,570	0	0
Net Cost of Borrowing	2,322	(200)	0
Other Corporate Items (Includes Contingencies, Insurance, Land Charges)	8,133	(200)	(200)
Pensions & Redundancy	9,995	0	0
Other (Council Tax Support, Contribution to Balances, provisions)	0	(2,000)	**0**
Total	**27,769**	**(2,480)**	**(260)**
Interim Budget Savings Reported as @ Full Council 23rd July 2014		2,480	
Updated Variance @ Month 5		**0**	

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Corporate & Democratic Core	(80)	This underspend is due to reduced Audit fees.
Net Cost of Borrowing	(200)	Underspend based on expected change to debt profile over remainder of the year.
Other Corporate Items	(200)	Due to the buoyant housing market Land Charges income is forecast to be £200k better than budget.
Other	(2,000)	Potential redirection of resources in line with Interim Council budget for Contribution to balances and provision and Council Tax Support)
Total	**(2,480)**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Increase in Tri Borough accommodation costs due to staff relocation to RBKC.	0	250
There is a risk that the Net Cost of Borrowing may be under or over budget depending on the changes to the capital programme implemented in 2014/15	(500)	500
Total	**(500)**	**250**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Centrally Managed Budgets	**(2,686)**	**(2,686)**	**0**	**0**

5. Comments from the Director

After accounting for the Interim Budget savings identified below Centrally Managed budgets (excluding contingencies) are forecast to have nil variance.

Council Interim Budget Savings 2014-15	Savings £000's	On Target	Notes
CMB			
Budgeted contribution to balances	(900)	Yes	This is on target to be delivered.
Inflation provision	(400)	Yes	The inflation contingency is currently expected to be £400k under budget.
Redundancy provision	(200)	Yes	Redundancy spend is expected to be £200k under budget.
External Audit savings of £80,000 have been identified	(80)	Yes	Based on current fees external audit expenditure is expected to be £80k under budget.
Debt restructuring opportunities that will enable budget savings of £200,000.	(200)	Yes	Proposals for the restructuring of debt to meet this saving are under review.
Council Tax Support	(500)	Yes	As unemployment falls a caseload reduction is expected to deliver this saving.
Land Charges	(200)	Yes	Land charge income is currently forecast to be £200k better than budgeted.
CMB Total	**(2,480)**		

APPENDIX 3: CHILDREN'S SERVICES

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Tri Borough Education Service	4,385	(306)	(328)
Family Services	32,540	725	822
Children's Commissioning	5,641	308	342
Finance & Resources	5,787	0	0
Dedicated School Grant & Schools Funding	5	(200)	0
Total	**48,358**	**527**	**836**
Interim Budget Savings Reported as @ Full Council 23rd July 2014		439	
Updated Variance @ Month 5		**966**	

2. Variance Analysis with Action Plans to Address Forecast Overspends/(underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Tri Borough Education Service	(306)	The major variance is the delivery of savings through the tri borough transport contract. There has been a reduction in the forecast underspend since period 3 due to increased demand.
Family Services	725	Significant placement pressures remain with regards to Southwark Judgement cases £250k, No Resource to Public Funds £300k, and Secure Remand £200k Support to looked after children via s23 £170k
Children's Commissioning	308	The schools meal contract is likely to be extended to align with Tri-borough, and so funding the Adult School Meals shortfall of £146k by Dedicated Schools Grant is still uncertain. Pressures remain relating to transport commissioning and risk regarding in year MTFS.
DSG	(200)	Appropriate expenditure will be identified to maximise use of DSG effectively
Total	**527**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Secure Remand	100	250
No Recourse To Public Funds	200	350
Southwark Judgement Support	150	250
Kinship Fees related to the Tower Hamlets Judgement	0	450
Cost of supported accommodation rent rising above Housing Benefit	100	350
Rising cost of support to care leavers in education over 21	150	250
There is a potential saving from the new Tri-Borough Transport contract. However, this may not be realised due to legacy costs from the in-house contract,fluctuating contract costs and significant concerns over the performance of the contract raised in the July meeting of the Policy and Accountability Committee.	0	267
Total	**700**	**2,167**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Children's Services	(2,780)	(544)	(1,225)	(1,011)

5. Comments from the Executive Director

The Children's Services Department is projecting an overspend of £925,000 at this early stage of the financial year. The department's 13/14 outturn was a balanced position with no further balances established to assist with pressures and risks in this financial year.

The department has identified and is working to deliver £2.780m of savings in this financial year.

Significant pressures remain in this financial year and are ongoing issues created by changes in legislation and court rulings affecting the delivery of services to children and young people in need.

Cases presenting under the Southwark Judgement continue to cause a pressure and we are expecting additional expenditure of approximated £250k this year.

Changes to the youth offending remand funding has previously been identified as a risk and is on-going, last year the dept. saw 23 young people remanded. Since April 14 five young people have been in remand with one case likely to be on remand a minimum of 6 months. The effect of these young people being deemed looked after whilst on remand is now leading to an increase in post 18 young people presenting who are eligible for leaving care support and accommodation.

The department have experienced increasing numbers of young people presenting who have no recourse to public funds. In last financial year 95 cases were in need of support costing a total £213k. We continue to experience high levels of cases presenting for support and expect at this stage that the expenditure will be at a similar level. Further evidence based analysis will be undertaken with the aim of driving down demand and therefore costs associated with this group.

The risk arising from the recent Tower Hamlets court case challenging an authority's right not to pay kinship carers the same fees as registered foster carers remains. Tower Hamlets lost the case and we are therefore currently looking at the qualifying criteria which carers will have to meet in order to receive the carer fee element in line with main stream foster cares. The current foster carer weekly fee is £237. The potential risk on a full year basis if all kinship carers qualified for a fee payment would be £450k .

The department are seeing a rise in the number of young people in further education and university placements post 21. This is leading to a rise in costs and can be significant at these young people are not eligible for housing benefit whilst in education.

The cost of supported accommodation rents is increasing and the levels of housing benefit is not covering the full cost. This additional costs falls to the department and is another ongoing pressure.

It should be noted that a significant level of planned savings are predicated on reducing number of looked after children and care leavers. The department are continuing with the activity to reduce the number and placement profile of but it must be highlighted that volumes are subject to change and the current reductions are not as expected. There are also a number of very high cost specialist placement requirements which will be ongoing.

Council Interim Budget Savings CRM5 Update

Council Interim Budget Savings 2014-15	Savings £000's	On Target	Notes
Children's Services			
The Tri-borough Children's Services has been successful in achieving a 'payment by results' bonus of £200,000 from its Troubled Families	(200)		**To Update -** CHS currently hold the PBR received on the balance sheet. The in year saving of £200k will be

Council Interim Budget Savings 2014-15	Savings £000's	On Target	Notes
programme in H&F			met from the reserve
Further savings have been found arising from the corporate allocation of Dedicated Schools Grant that can reduce net spend in 2014/15 by £200,000	(200)		Appropriate expenditure will be identified to maximise the use of DSG effectively.
Other external funding has also been identified that offsets costs of £39,000	(39)		**To Update -** Progress to be confirmed in next CRM
Children's Services Total	**(439)**		

APPENDIX 3a: UNACCOMPANIED ASYLUM SEEKING CHILDREN

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Unaccompanied Asylum Seeking Children	1,013	115	0
Total	**1,013**	**115**	**0**

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
UASC	115	Grant for Asylum Seeking Children & UASC leaving care has not increased in the last 2 years & accommodation costs and support costs have risen beyond inflation.
Total	**115**	

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Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Accommodation Cost not covered by grant allocation	100	200
Total	**100**	**200**

4. Comments from the Executive Director

The grant for asylum seeking children and UASC leaving care has not increased for the last 2 year however accommodation and support costs have risen beyond inflation. There is therefore a risk that an overspend will arise if accommodation costs cannot be reduced.

APPENDIX 4: ENVIRONMENT, LEISURE & RESIDENTS SERVICES

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Cleaner, Greener & Cultural Services	21,289	(381)	(512)
Safer Neighbourhoods	9,234	522	630
Customer & Business Development	1,012	(55)	(146)
Director & Resources	(74)	117	79
Total	**31,461**	**203**	**51**

2. Variance Analysis with Action Plans to Address Forecast Overspends

Division	Variance £000s	Explanation & Action Plans
CCGS – Waste disposal	(400)	The boroughs strongly negotiated a much better unit cost of recyclate this year which has reduced costs by circa £500k. This is partly offset by the increasing waste tonnages overall. A London-wide trend is showing that more expensive general waste tonnages are increasing whilst cheaper recycling tonnages are decreasing. This is compounded by reduced income from the sale of recyclate as market commodity prices are decreasing. In July general waste tonnages were 0.8% higher than last year but this financial year has seen increases as high as 11% when compared to the previous year – demonstrating the volatility of waste disposal. If these trends continue, annual costs will increase by £270k. A waste innovation group, set up to progress initiatives to reduce waste tonnages and increase recycling in the medium term, will report its findings in the Autumn. A more detailed analysis of the Waste Authority costs was submitted to PAC in September.
CGCS – Street Scene Enforcement	38	The council always prosecutes those who do not pay Fixed Penalty Notices (FPNs) which has added a £19k pressure on the legal budgets this year. FPN income has also reduced year on year (£22k year to date compared to £34k for the same period last year). This is mostly due to increased littering compliance in the borough's transport hubs, which has a positive impact on the overall street scene but at the same time gives rise to a £16k income pressure. The aim of FPNs is to achieve compliance in an area of enforcement and so the service is assessing how to manage these pressures going forward. Options will be presented to the lead cabinet member in September.

Division	Variance £000s	Explanation & Action Plans
SND - Coroners and Mortuary	89	A continued reduction in corporate overheads means less recharge income from partner boroughs. Growth has been proposed to fund this pressure from 2015/16.
SND - Transport	316	As previously reported, reductions in the council's vehicle fleet over a number of years has resulted in a significant recharge income pressure. Given that this pressure can no longer be sustained by the department, an action plan to secure alternative new business and close all but £100k of the budget gap was prepared before the start of the year. The remaining £100k is included as growth in 2015/16. Despite best efforts to secure new business, negotiations with the only potential high value customer have recently fallen through. The loss of this anchor income, and given that a comprehensive review of the market concluded that alternative income generating business potential is limited, it is no longer financially viable to provide an in-house vehicle repair workshop. Given that this service has historically been budgeted to generate a net surplus, a request for growth will need to be made from 2015/16 to write out the workshop budgets.
Customer & Business Develop-ment	51	There is a forecast shortfall in the non-guaranteed income element of the new CCTV ducting contract. The contractor is trying to progress fibre installation at five LBHF housing sites through discussions with the Housing and Regeneration department. Depending on take up, this has the potential to close the budget pressure this year.
Director &Res. – People portfolio savings	117	Only £7k of the £124k people portfolio savings target is forecast to be achieved, which is less than the £57k achieved last year due to ex graduate attachments reaching the end of their attachment and being appointed into permanent roles. A corporate review of targets is underway, following which it is expected that any shortfall will be met corporately.
Other	**(8)**	Other smaller underspends
Total	**203**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000	**£000**
Risk of increased waste disposal and contamination tonnages	(500)	0
Risk that Transport income shortfall cannot be absorbed	0	100
Total	**(500)**	**100**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
ELRS Department	(1,110)	(327)	(613)	(165)

Red risks - plans to rationalise the number of bring back recycling units is currently on hold whilst the impact on recycling rates and the street scene is assessed (£25k target). There is a forecast pressure on the ducting contract (£140k target against which income of £89k is predicted).

5. Comments from the Executive Director

The department is forecasting a £203k overspend due to uncontrollable pressures from outside of the department - £117k people portfolio savings and £89k Coroners and Mortuary. Whilst the department will look to offset these pressures as far as possible this year from waste disposal underspends, volatile waste tonnages suggest corporate funding is likely to be requested in year. The Coroner and Mortuary pressure is a one off pressure for 2014/15 as corporate growth has been requested to permanently close the budget gap from 2015/16. The shortfall against the People Portfolio savings target is an ongoing pressure. The department is committed to maximising savings through the use of graduate attachments, but following a significant programme of restructure flowing from the bi-borough service reviews, there are very few vacancies and so limited opportunity to engage graduates or achieve a 10% saving on vacant PO posts. It is expected that any shortfall against this transformational target will be met corporately, as agreed when the savings were allocated to departments.

APPENDIX 5: FINANCE AND CORPORATE SERVICES

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
H&F Direct	19,172	33	215
Innovation & Change Management	(188)	(100)	(35)
Legal Democratic Services	(1,296)	(30)	0
Third Sector, Strategy & Communications	1,133	(30)	0
Finance & Audit	409	0	(85)
Procurement & IT Strategy	2,455	140	0
Executive Services	(466)	(70)	0
Human Resources	691	(130)	(150)
Other	0	0	150
Total	**16,995**	**(187)**	**95**
Less - Interim Budget Savings Reported @ Full Council 23rd July 2014		206	
Updated Variance @ Month 5		**19**	

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
H&F Direct	33	Reduction in overspend is due to agreement for a one of drawdown from the Housing Benefit Reserve, as agreed in the CRM 4 report
Innovation & Change Management	(100)	Underspend is due to both vacancies and increased recharge of staff costs to corporate projects
Procurement & IT Strategy	140	Overspend is due to shortfall against the HFBP contract
Executive Services	(70)	Increased underspend due to further vacancies in the division
Other	(190)	
Total	**(187)**	

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Table 3: Key Risks

None to report.

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Finance & Corporate Services	(2,192)	(2,192)	0	0

5. Comments from the Director

Council Interim Budget Savings 2014-15	Savings £000's	On Target	Notes
Finance and Corporate Services			
General Fund savings from reduction in Communications activity.	(156)	Yes	
Human Resources Team have identified an on-going saving starting in 2014/15 of £50,000 from the reduction of a post	(50)	Yes	
Finance and Corporate Services Total	**(206)**		

Following the Interim Budget report, FCS is now broadly on budget. It has a small overspend which will be managed down to zero over the coming months.

A shortfall against the HFBP contract is being off-set by underspends in a number of divisions as a result of vacancies and recharges to corporate programmes.

Drawdown of £200k funding from the Housing Benefit reserve is requested to fund work carried out to improve Housing Benefit subsidy performance. This work in reducing Local Authority error assists LBHF in maximising Housing Benefit subsidy received from Government.

APPENDIX 6: HOUSING & REGENERATION DEPARTMENT

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Housing Options, Skills & Economic Development	8,107	(589)	(887)
Housing Strategy & Regeneration	4	0	0
Housing Services	40	0	0
Finance & Resources	(103)	23	0
Total	**8,048**	**(566)**	**(887)**
Interim Budget Savings Reported as @ Full Council 23rd July 2014		34	
Updated Variance @ Month 5		**(532)**	

2. Variance Analysis with Action Plans to Address Forecast Overspends/(underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Housing Options, Skills & Economic Development	(589)	This relates mainly to a forecast reduction in the net costs of Bed and Breakfast (B&B) accommodation of (£483k) due to a reduction in average client numbers from a budgeted figure of 275 to a forecast of 118. Additionally, the net costs of Private Sector Leasing (PSL) accommodation are expected to reduce by (£565k) due to a fall in the average number of units from a budgeted figure of 853 to a forecast of 646 and a reduction in the increase to the bad debt provision required due to an improvement in the collection rate (from a budgeted figure of 89.0% to a forecast of 95.0%). This is offset by a shortfall in income and increased costs on the business incubator units at Sullivan, Townmead and the BBC units of £255k. Additionally, it is proposed to utilise £223k of the temporary accommodation underspend to fund the first five months of a package of incentive payments to landlords associated with the Council's temporary accommodation portfolio which was originally budgeted to come from corporate contingencies. Note that forecast incentive payments payable over the remaining seven months of the year of £257k will be funded from internal departmental reserves. Other

Departmental Division	Variance £000s	Explanation & Action Plans
		minor variances of (£19k) are also predicted.
Housing Strategy & Regeneration	0	
Housing Services	0	
Finance & Resources	23	
Total	**(566)**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Economic Development Employment & Training Initiatives – a number of employment, training and business development schemes are due to be funded from Section 106 monies provided by Earls Court development partners in this financial year, elements of these schemes would normally be resourced using staff already in post and money was allocated to fund these posts as part of the budget. However, as a result of the current review of the Council's Earls Court regeneration project plan, the delivery and funding of these schemes in this year are at risk.	0	56
Total	**0**	**56**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Housing & Regeneration	(750)	(750)	0	0

5. Comments from the Executive Director

The Housing and Regeneration department currently expects the overall outturn for the year 2014/15 to produce a favourable variance of (£566k), an adverse movement of £33k from the CRM 4 position of (£599k) reported to Business Board. The main reasons for this are set out in Table 2 above. It is anticipated that any underspend at year-end will be set aside in an earmarked

reserve to address future risks around temporary accommodation and homelessness.

The main reason for the movement is due to the need to make higher than expected provision for bad debts at the Townmead & Sullivan workshops resulting in a movement of £53k. Other minor movements of (£20k) are forecast.

Officers are currently investigating options to mitigate against the overspend of £255k on the business incubator units at Sullivan and Townmead and the BBC units, and this will be reported via the CRM in due course.

Approval is requested to write off £47k of debt relating to commercial tenants at the Sullivan and Townmead business incubator units. These debts have now been deemed irrecoverable following a review by the Council's enhanced revenue collection partner, Agilisys. As this debt is already fully provided for, there will be no adverse impact on the above departmental variance.

Council Interim Budget Savings 2014/15

On 23rd of July 2014 Cabinet approved the following additional savings targets which officers are working to achieve. This is included in the forecast variance reported above.

	Savings £000s	**On Target**	**Notes**
Housing & Regeneration			
HRD officers have identified £34,000 of savings originally proposed for 2015/16 that they have been asked to bring forward	(34)	(34)	
HRD Total	**(34)**		

APPENDIX 7: LIBRARY SERVICES (Tri-Borough)

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Tri-borough Libraries & Archives Service	3,221	(30)	0
Total	**3,221**	**(30)**	**0**
Interim Budget Savings Reported as @ Full Council 23rd July 2014		30	
Updated Variance @ Month 5		**0**	

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

None to report. Previously reported underspends are now shown below within the Interim Budget savings update

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Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Income from customer fees and charges	10	50
Westfield premises and utility costs	10	30
Total	**20**	**80**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Tri-borough Libraries & Archives	(100)	(100)	0	0

5. Comments from the Director

At this stage in the year no significant financial issues causing an unmitigated pressure are foreseen. However areas of risk include income from fees and charges due to income generated from increasingly obsolete formats (DVDs, CDs). Room and space hire opportunities are being reviewed as a means to mitigate these pressures over the longer term. Rising utility costs across all premises may cause pressures.

Both the original budget savings target for 2014/15 (£100k) and the interim savings target (£30k) have been achieved. The table below summarises the position on the interim budget savings:

Council Interim Budget Savings 2014-15	**Savings £000's**	**On Target**	**Notes**
Tri-Borough Libraries			
The Tri-borough Library Service has identified that due to the increase in demand for eBooks it can release £30,000 from its book stock budget	(30)	Yes	Book fund commitment has been released so this interim saving has been achieved.
Tri-Borough Libraries Total	**(30)**		

APPENDIX 8: PUBLIC HEALTH SERVICES

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Sexual Health	6,978	(75)	(82)
Substance Misuse	5,464	(1)	0
Behaviour Change	2,110	(187)	0
Intelligence and Social Determinants	40	1	1
Families and Children Services	2,608	(195)	(192)
Public Health Investment Fund	0	1,902	0
Future Public Health Investment Funding	0	780	0
Substance Misuse – Grant, Salaries and Overheads	(5,470)	0	0
Public Health – Grant, Salaries and Overheads	(11,384)	(2,571)	(73)
Total	**346**	**(346)**	**(346)**

2. Variance Analysis with Action Plans to Address Forecast Overspends/ (Underspend)

Departmental Division	Variance £000s	Explanation & Action Plans
Sexual Health	(75)	Forecast adjusted to reflect final CLCH contract values & revised forecast for condom distribution and HIV prevention.
Substance Misuse	(1)	Net of under provision of 13/14 residential placements and “Education, Training and Employment (ETE) Lead” budget correction.
Behaviour Change	(187)	Change in forecast due to; • £86K over provision for 2013/14 Health Checks • £37K estimated under-spend in 2014/15 on Health Checks • £24K estimated under-spend in2014/15 for Smoking Cessation • £40K under-spend in 14/15 Health on Trainers
Intelligence and Social Determinants	1	One-off contribution to Airtext, not in the original budget.
Families and Children Services	(195)	The re-commissioning of the obesity prevention service, as part of the childhood obesity programme, has been rescheduled to April 2015, saving this year’s budget £183K. The remaining £12K is the expected under-spend for dental health.

Departmental Division	Variance £000s	Explanation & Action Plans
Public Health Investment Fund (PHIF)	1,902	Earmarked funds for Public Health investment in other Council Departments.
Future Public Health Investment funding	780	Unallocated budget and identified savings ear-marked for future Public Health Investment Fund spend.
Public Health – Grant, Salaries and Overheads	(2,571)	This represents the net movement of the above identified variances and the planned reduction of General Fund contribution from £346K to zero.
Total:	**(346)**	

Table 3: Key Risks

Risk Description:	Lower Limit	Upper Limit
	£000s	£000s
PCT Legacy invoices – low risk. Dispute over ownership of liability (and corresponding NHS funding)	0	244
Total	**0**	**244**

Table 4: MTFS Progress (with explanations of schemes at red status)

None to report.

5. Comments from the Director

It is currently expected that the budgeted contribution from the general fund (£346K) will not be required to be drawn down, as there is sufficient Public Health Grant and under-spend to meet all existing and expected commitments.

Included within the Public Health budget are unallocated funds of £2.2M (after the planned reduction in General Fund contribution). Of this, £1.9M has been earmarked for Public Health Investment Fund projects (subject to Cabinet approval). The remaining unallocated amount will be £780K (including savings identified above), and will be ear-marked to fund PHIF projects in future years.

APPENDIX 9: TRANSPORT AND TECHNICAL SERVICES

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Building & Property Management (BPM)	(1,657)	(342)	(234)
Transport & Highways	11,807	236	227
Planning	2,846	(150)	(96)
Environmental Health	3,332	(1)	(56)
Support Services	(556)	302	280
Total	**15,772**	**45**	**121**

2. Variance Analysis (include Action Plans to Address Forecast Overspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Advertising Hoardings	(302)	The favourable variance is due to the over achievement of advertising income against budget. The forecast takes into account the estimated income reduction due to the closures of the Hammersmith Flyover over the summer.
Valuation Services	65	The property disposal section is at risk of overspending by £130k due to property disposals costs exceeding the permitted charge against estimated capital receipts. This is offset by a forecast (£65k) underspend in Valuation Services staffing.
Facilities Management	50	The main pressure is the forecast overspend in the TFM contract. The adverse variance includes £150k which relates to 2013/14. The TFM contract has also increased in value due to the final costs of staff transferred to Amey, the final costs of pensions and costs of the space planning function. Refunds for underperformance are expected from Amey but will not be included in the forecast until confirmed. There are underspends in the EC Harris contract and carbon reduction.
Civic Accommodation	(125)	The favourable variance is mainly due to a combination of additional rental income and underspends in utilities.
Sections within Building & Property Management	(30)	Building Control is favourable by (£40k) income from large building schemes. This is offset by an unfavourable variance of £10k within other sections in Building & property Management.
Total - BPM	(342)	
Transport and Highways	236	The unfavourable variance represents the non-achievement of a MTFS income target of £250k for advertising on pavements. This has been addressed

		in the MTFS proposals for 15/16.
Planning	(150)	The forecast underspend is due to high levels of routine planning applications expected as the wider economy recovers and applicants seek to beat the CIL deadline.
Environmental Health	(1)	
Support Services	302	This reflects the under-achievement of the MTFS People Portfolio savings target. TTS has not found it possible to employ the numbers of graduate attachments necessary to achieve the savings target. This has been addressed in the MTFS proposals for 15/16.
Total:	**45**	**Unfavourable**

Table 3: Key Risks

Risk Description	**Lower Limit**	**Upper Limit**
	£000s	**£000s**
There is a risk of a planning income shortfall of £220k related to project activity.. .	0	220
If the Licensing Fee increases included as an MTFS saving are not approved after national consultation initiated by the Home Office.	0	40
If there is a change in the sharing of the TFM costs (LBHF is bearing 30% of the total) there will be an additional pressure. The worst-case scenario represents a 2% increase in the overall cost share.	0	300
If the costs already incurred to dispose of HRA assets cannot be met from disposal proceeds, which are reducing. This would need to be funded from Corporate Reserves.	0	270
If there are further delays in co-locating EH beyond mid 2014/15	0	60
If the disposal of General Fund assets realises a value, which when the 4% allowance is applied, is less than the costs of disposal. Anything above the £100k TTS reserve will be funded from Corporate Reserve as agreed during the 2013/14 closing meeting.	0	182
Total	**0**	**1,072**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	**2013/2014 MTFS Target**	**On Track (Green)**	**In Progress (Amber)**	**Delayed/ At Risk (Red)**
	£000s	**£000s**	**£000s**	**£000s**
Transport & Technical Services	(2,725)	(2,130)	(255)	(340)

Currently there are three schemes on red status:

- Planned increases in Licensing fee income of £30k which is subject to consultation and yet to be confirmed.
- Bi-borough service review savings from co-location £60k.
- Plans for advertising on Pavements generating income of £250k cannot be progressed due to lack of demand.

5. Comments from the Executive Director

The overall position is an unfavourable variance of £45k against a net budget of £15,772k. The key risks to the 2014/15 budget are set out in Table 3 above.

Progress in all budget areas will continue to be monitored closely by the Executive Director and the management team who will exercise the necessary financial controls to ensure that the department achieves its targets by year-end.

APPENDIX 9a: CONTROLLED PARKING ACCOUNTS (CPA)

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Activity Area

Activity Area	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Pay & Display (P&D)	(12,613)	396	222
Permits	(4,690)	107	92
Civil Enforcement Officer (CEO) Issued Penalty Charge Notice (PCN)	(6,814)	(141)	(114)
Bus Lane PCN	(915)	106	129
CCTV PCN	(616)	(566)	(728)
Moving Traffic PCN's	(5,814)	(339)	(629)
Parking Bay Suspensions	(1,530)	(1,771)	(1,173)
Towaways / Removals	(352)	47	53
Expenditure and Other Receipts	13,046	(151)	(121)
Total	**(20,298)**	**(2,312)**	**(2,269)**

2. Variance Analysis (include Action Plans to Address Forecast Overspends)

Activity Area	Variance £000s	Explanation & Action Plans
Pay & Display	396	There has been a decrease in machine cash receipts of 2.4% as compared with the first 4 months of 2013-14. This is partly offset by an increase in Smart Visitor Permit receipts. However the forecast is lower than last year's outturn, and is lower than budgeted.
Permits	107	A reduction in the receipts over the first 4 months of 2014-15 has resulted in a forecast lower than budget.
CEO Issued PCN	(141)	CEO issued PCNs have been forecast at a similar level as in 2013-14, but the recovery rate has improved, resulting in an improved forecast
Bus Lane PCN	106	Bus Lane PCNs have been forecast at a similar level as in 2013-14.
CCTV PCN	(566)	CCTV parking PCNs have been forecast to continue at a similar level as in 2013-14.
Moving Traffic PCN's	(339)	The numbers of moving traffic offences are 4% less than in the same period in the previous year, resulting is a reduced forecast. However, this is offset by an increase in the recovery rate, meaning that the forecast remains higher than budgeted.
Parking Bay Suspensions	(1,771)	Parking bay suspensions receipts have continued at a higher than budgeted level, following the change in pricing structure in 2013-14 and an increase in the volume of suspensions requested, including an increase in longer term suspension requests.
Towaways / Removals	47	The unfavourable variance is due to a shortfall in receipts from fines of (£305k) compared to a budget of (£352k).

Activity Area	Variance £000s	Explanation & Action Plans
Expenditure and Other Receipts	(151)	A delay in the introduction of IT requirements has caused a delay in the co-location and the full implementation of the new Bi-borough staffing structure for the Parking Office. This has resulted in the need for additional staffing at a cost of £83k. This is offset by budgets of £100k for a CCTV enforcement vehicle and £100k for IT that are not expected to be used. There is also an underspend expected on the P&D machine maintenance contract and on the amounts spent on registering PCN debts with the county court.
Total	**(2,312)**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Changes in legislation around CCTV parking enforcement	0	600
Total	**0**	**600**

4. Comments from the Executive Director

The TTS Parking department is forecasting a favourable variance of £2,312k against a net budget of (£20,298k). Activity is broadly assumed to be in line with the previous year, but with an improvement in the payment rate for penalty charge notices and increases in the number and value of parking bay suspensions. Parking suspensions are running well ahead of budget including some longer term suspensions that started in 2013/14 but which extend into 2014/15

APPENDIX 10: HOUSING REVENUE ACCOUNT

BUDGET REVENUE MONITORING REPORT – PERIOD 5

1. Variance by Departmental Division

Departmental Division	Revised Budget	Variance Month 5	Variance Month 3
	£000s	£000s	£000s
Finance and Resources	14,552	(95)	(95)
Housing Services	9,370	(215)	6
Commissioning and Quality Assurance	4,090	(103)	0
Property Services	2,077	(6)	(17)
Housing Repairs	13,359	0	86
Housing Income	(75,698)	4	13
Housing Options	400	(53)	(79)
HRA Central Costs	0	0	0
Adult Social Care	48	0	0
Regeneration	331	45	0
Safer Neighbourhoods	577	0	0
Housing Capital	27,864	0	
(Contribution to)/ Appropriation From HRA General Reserve	**(3,030)**	**(423)**	**(86)**

2.Variance Analysis with Action Plans to Address Forecast Overspends/(Underspends)

Departmental Division	Variance £000s	Explanation & Action Plans
Housing Services	(215)	Underspends are forecast on legal costs (£110k), salaries (£102k) and miscellaneous running cost budgets (£3k)
Commissioning and Quality Assurance	(103)	Underspends are forecast on salaries (£13k), decant and management transfers (£80k) and legal costs (£10k).
Other	(105)	There are no other individual divisional variances greater than £100k/(£100k).
Total	**(423)**	

Table 3: Key Risks

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Housing Development Programme: if the Council's housing development projects progress in accordance with approved plans, then the associated costs will be capitalised. However, if projects do not progress, or need to be redesigned, then an element of the design costs incurred will need to be written off to revenue.	250	1,389

Risk Description	Lower Limit	Upper Limit
	£000s	£000s
Strategic Regeneration: the latest forecasts indicate that there are emerging cost pressures associated with the operational management of the Regeneration function. Officers are currently reviewing the position with a view to identifying savings to eliminate this risk.	0	44
Advertising hoarding income: Building and Property Management (BPM) advise that a shortfall is likely following delays in letting various sites due to a retendering process and other planning delays. There will also be an associated General Fund variance as the delays in letting the sites will result in a reduction in fees payable to TTS, as these are to be paid based on income generated.	105	130
Trade Waste Charges: a realignment of the bill of quantities by ELRS and SERCO has resulted in a proposed increase in charges. This is currently under review by the Estate Services Manager.	60	112
Total	**0**	**600**

Table 4: MTFS Progress (with explanations of schemes at red status)

Department	2014/2015 MTFS Target	On Track (Green)	In Progress (Amber)	Delayed/ At Risk (Red)
	£000s	£000s	£000s	£000s
Housing Revenue Account	3,299	3,299	0	0

Table 5 HRA General Reserve

	B/Fwd	Budgeted (Contribution to) /Appropriation from General Reserve	HRA Variance (Surplus)/ Deficit	Forecast C/F
	£000s	£000s	£000s	£000s
HRA General Reserve	**(7,494)**	**(3,030)**	**(423)**	**(10,947)**

6. Comments from the Executive Director

The Housing Revenue Account currently forecasts an under-spend of (£423k) for 2014/15, a movement of £35k from the CRM 4 position. The movement relates mainly to the following:

- Regeneration: external legal professional advice costs of £45k in excess of the approved budget

- Other: a number of minor adjustments to forecasts across several divisions (£10k).

The Council has received a challenge from Wilmot Dixon Partnerships to a procurement process. In September 2013, the stay which had prevented the Council from signing the proposed new Repairs and Maintenance contract with MITIE was lifted and this contract is now signed. However, the challenge to the procurement process remains and a court hearing took place in July 2014. The Council expects to know the outcome of the hearing in October 2014.

APPENDIX 11 - VIREMENT REQUEST FORM

BUDGET REVENUE MONITORING REPORT – PERIOD 5

Details of Virement	Amount (£000)	Department
GENERAL FUND:		
Draw down from the Housing Benefits Reserve to fund temporary staff who are supporting an improved Housing Benefits return position	(200)/ 200	FCS
Tempory virement from the Placements Budgets to Community Independence Budgets to cover the shortfall in MTFS Savings Customer Journey work stream which won't be achieved until 2015/16	(287)/ 287	ASC
Total General Fund Virements (Debits)	**487**	
HRA:	0	
Total HRA Virements (Debits)	**0**	

Departmental Name Abbreviations	
ASC	Adult Social Care
FCS	Finance & Corporate Services
HRA	Housing Revenue Account

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
FUNDING OF IMPROVEMENT PLAN TO ACHIEVE A MORE CUSTOMER FOCUSED REVENUES & BENEFITS SERVICE	
Report of the Cabinet Member for Finance – Councillor Max Schmid and the Cabinet Member for Social Inclusion – Councillor Sue Fennimore	
Open Report	
Classification - For Decision **Key Decision**: Yes	
Wards Affected: All	
Accountable Executive Director: Jane West , Executive Director Of Finance & Corporate Governance	
Report Author: John Collins, Director of H&F Direct	**Contact Details:** Tel: 020 8753 1544 E-mail: john.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report requests one off funding of £290,000 from the Council's Efficiency Project Reserve in order to implement an action plan to create a more customer focused revenues & benefits service, together with reducing the time taken to deal with customer queries.

1.2. This is one off funding to cover additional resource for 5 months in order get the service up to date and undertake more stakeholder engagement which will then inform required resources to maintain improved performance thereafter.

1.3. The Housing Benefits element of H&F Direct is failing to provide customers with a high performing service, and delays in processing claims create error demand and result in residents missing rent payments and being threatened with eviction. This has extremely negative impacts on residents and can also lead to increased costs for the Council addressing errors and helping those facing eviction.

1.4. Following an independent review of the revenues & benefits service, there are 24 recommendations of actions that will improve performance times, and change the focus of the service to one that is more customer focused, providing more support to vulnerable/ disadvantaged residents in dealing with council tax and benefit related matters.

1.5. The review recognised that the service was not sufficiently resourced to deliver these improvements but the suggested actions from the review have been turned into an implementation plan that is attached at Appendix 1 to this report.

1.6. This will require 15 additional fte resources over a 5 month period to get the service up to date, and then determine the required resourcing levels going forward to maintain the improved performance.

2. RECOMMENDATIONS

2.1. That approval be given to the funding of the £290,000 required to implement the action plan outlined in this report.

3. REASONS FOR DECISION

3.1. Over a number of years the staffing levels within H&F Direct (Benefits) have reduced from 130 to 60 fte, with staff having a generic Council Tax/ Benefits role.

3.2. The focus (and the reductions in staff) was based on ensuring the assessment of claims are accurate to maximise benefit subsidy reimbursement, together with moving residents to using on-line self service.

3.3. This included the cutting of some staffing roles that were specifically to support residents and other stakeholders (e.g,. CAB, Action for Disability and specific RSL Liaison roles).

3.4. Improvements required to performance levels (ensuring the assessment of claims are not delayed, responding to queries) and providing more support to residents in relation to the self service agenda may require additional staffing resources.

3.5. It is difficult to predict the additional resources required for this whilst there is a backlog of work, as this in turn creates error demand. The plan is to clear the backlog and then determine whether the existing resourcing levels are accurate to take the service forward..

4. INTRODUCTION AND BACKGROUND

4.1 Pre 2005, the council tax and benefits services were separate.

4.2 Council Tax was in Finance and Housing Benefits part of the Housing Department.

4.3 Council Tax was a national top performer, having achieved the first 3 star certification under the Best value regime (for performance and customer focus) and been acclaimed as the top revenue service in the country by the national revenue association. Collection rates were in the top 5 of inner London Councils.

4.4 *Falling standards from 2007*

In 2007, the council tax and benefits services were brought together, and staff undertook a generic council tax and benefits role (the first in London). The focus of the service was changed from speed of assessing claims to that of reducing the amount of errors (i.e. a stricter approach to compliance with the benefit regulations and a focus on avoiding overpayments), and reducing staff numbers (down to a current 60 for benefits) on the back of :

- The generic working model
- moving customers to more self service and
- anticipating the impact on workloads of welfare reform changes (including Universal Credit).

This meant that some of the more customer –focused roles/ processes (and therefore resource intensive roles) that were part of the service were removed.

An example of these were:

- The deletion of two liaison staff who provided the voluntary sector organisations and public sector landlords with liaison points to address queries.
- The deletion of a dedicated team of three who undertook customer service training, technical training and development and addressed training needs that arose out of performance monitoring.
- Closing a drop-in benefits reception service (and replacing it with an appointments only system)
- Stopping triaging appointments (to avoid unnecessary visits) – and dealing with the issues over the telephone

4.5 That change of focus had the following impacts:

- Council tax collection remains in the top 5 in inner London
- Housing Benefit staff numbers have reduced to 60

- subsidy is now accurate (the last audit had an error of 0.01% of the claim)
- Overpayments caused by local authority error are within the DWP threshold to achieve 100% subsidy (worth over £600k per year)
- We have seen an increase in the time to assess claims,
- a stricter approach to ensuring that claims are only paid when all DWP requirements have been met
- introduction of on-line benefit applications, with DWP risk assessment
- a shift in responsibility to the applicant to provide the supporting information required without prompting
- introduction of a self service appointment system
- expectations that third sector and landlords will use e-services and promote self service for their tenants
- a stricter adherence to DWP timescales, which has led to more claims being deemed cancelled (where required evidence has not been received by the due date)

Collectively, these changes have seen Hammersmith and Fulham's performance suffer and be amongst the poorest in London.

Performance figures issued by the DWP for Quarter 4 of 2013/14 are in the table below:

LONDON	2013/14					
			New Claims			CoC
		Barnet	6		Kensington and Chelsea	
		Hillingdon	10		Tower Hamlets	4
		Lewisham	14		Islington	4
		Brent	14		Redbridge	5
		Kensington and Chelsea	17		Camden	5
		Sutton	17		Barnet	5
		Islington	18		Enfield	6
		Richmond upon Thames	19		Hounslow	6
		Camden	19		Kingston upon Thames	6
		Hackney	20		Lewisham	6
		Ealing	20		Sutton	6
		Hounslow	20		City of London	6
		Harrow	21		Hillingdon	7
		City of London	21		Brent	7
		Bexley	21		Richmond upon Thames	7
		Southwark	22		Harrow	7
		Enfield	23		Newham	8
		Wandsworth	24		Southwark	8
		Tower Hamlets	24		Lambeth	8
		Croydon	24		Merton	9
		Lambeth	25		Ealing	10
		Barking and Dagenham	26		Havering	11
		Havering	27		Barking and Dagenham	11
		Redbridge	27		Wandsworth	11
		Kingston upon Thames	27		Bromley	12
		Bromley	28		Hackney	12
		Westminster	29		Waltham Forest	13
		Newham	30		Haringey	14
		Merton	31		Bexley	15
		Hammersmith and Fulham	31		Hammersmith and Fulham	18
		Waltham Forest	34		Greenwich	31
		Greenwich	38		Westminster	..
		Haringey	38		Croydon	..

New = New claims the number is the average number of days to assess a new claim from receipt to assessment

CofC= Change in Circumstances. Once a claim is in payment, anything that then changes it (e.g change in income, change in dependants etc) is regarded as a change in circumstance. This is the average number of days to action such a change.

.. = no return (these figures are complied from monthly returns that LA's have to submit to the DWP – no return means there is a unresolved data query)

4.6 In more general terms, the council has not had a central –customer' champion to develop and implement strategies that support the move to on-line self service, and identify where assisted self service is required for those digitally excluded. This means we have not seen the channel shift that our staff numbers and timescales are predicated on.

4.7 **How can the service deliver a more customer focused approach?**

In order to inform this, we have completed an independent review of how the service is organised, and our interpretation and application of benefit policies. The review recognises that the service is under resourced compared with other top performers.

A survey of London Boroughs a few years ago identified that H&F had a staff to workload ratio of 1: 646 (the lowest ratio in London) whilst top performers such as RBKC had ratios of 1:385.

Despite this, the review has a number of actions that can be implemented which should both improve performance and deliver a more supportive service for residents..

4.8 A simple solution is to improve the time taken to assess new claims and changes in circumstance by increasing staffing levels (identified in the independent report) and some change to the organisational structure of the service.

4.9 As turn round times improve, this should avoid complaints over delays, reduce error demand and reduce cases of possible evictions, which have costly implications for the council.

4.10 Whilst there is a backlog of work (albeit reducing) there is an element of the workload that is error demand, as residents chase up assessments, responses to e-mails and increase telephone calls.

An assessment of where telephone calls were received from the same telephone number within a 4 week period indicates that this could be as much as 32% error demand.

4.11 It is difficult to predict what the required resources would need to be if the service was up to date, as this should reduce many areas of the existing workload.

5. PROPOSAL AND ISSUES

5.1. Meetings have been held between H&F Direct staff and Councillor Schmid (Cabinet Member for Finance) and Councillor Fennimore (Cabinet Member for Social Inclusion).

5.2. These have identified some IT performance related problems, together with communications and challenges around the current matrix-style management approach, which replaced more traditional team working some time ago.

5.3. These issues are being investigated and will be dealt with as part of the improvement review.

5.4. An action plan has been developed which is dependent on the following being agreed:

5.5. It is proposed to increase staffing levels by 15 fte for 5 months in order to bring the backlog of work up to date and assess on going requirements.

5.6. Business Case

A one-off investment in resources of £290k will allow the service to:

- reduce backlogs of work
- process changes in circumstances quicker
- establish presence at CAB
- ensure One Place has benefit support officers
- enable residents to get quicker appointments (current waiting times on average 5 days)
- provide speedier response times to telephone enquiries
- reduce error demand
- reduce workloads on voluntary sector regarding benefit issues
- improve rent collection

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. Whilst this investment has been calculated on engaging agency staff, there are a number of options available to resource dealing with the backlog.

These are still being investigated, but include:

6.2. The short term direct engagement of agency staff

6.3. Short term engagement of a contractor (for instance Capita) for certain aspects of the backlog. This may present some procurement implications.

6.4. A short term transfer of Council Tax telephony enquiries to Agilisys, which would free up exiting benefit resources to deal with the backlog..

6.5. A mix of the above.

6.6. Costs are awaited for 6.3 and 6.4, which can be defined further if funding is approved.

7. CONSULTATION

7.1. Some internal staff consultation has taken place between the Cabinet Members for Finance and Social Inclusion and members of staff within H&F Direct by way of face to face meetings. This has identified a number of issues that will be addressed going forward, including some IT performance related issues, communication and the challenges of matrix management working.

8. EQUALITY IMPLICATIONS

8.1. Not required

9. LEGAL IMPLICATIONS

9.1 There are no legal implications arising from the recommendation to agree additional funding. If the Council decides to appoint a contractor to carry out the work, because the value exceeds the EU threshold, there will need to be a procurement exercise in accordance with the EU procurement rules. If the Council engages agency staff there will not be such a requirement. The Contracting Out (Functions of Local Authorities Income-Related benefits Order 2002 allows for the outsourcing of this function. This section should include the legal power relevant to the proposal must be set out together with any future possible legal implications

Implications verified/completed by: (LeVerne Parker, Chief Solicitor and Head of Regeneration Law Bi-Borough Legal Services 020 7361 2180)

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. It is proposed to draw down £290k from the Efficiency Projects Reserve to fund the service improvements set out in the report. The funding will provide for improvements over a 5 month period during which an assessment will be made of on-going requirements. Should this result in increased future expenditure then this will need to be taken account of within the Council's financial plans. Implications verified/completed by: (Andrew Lord, Head of Strategic Planning and Monitoring, Ext 2531),

11. RISK MANAGEMENT

11.1. *Not applicable*

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. *Not applicable*

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Revenues & benefits service review (Exempt)	John Collins Ext 1544	FCS

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
TRI-BOROUGH MANAGED SERVICES – FINANCE AND HUMAN RESOURCES (TRANSACTIONAL SERVICES)	
Report of the Cabinet Member for Finance – Councillor Max Schmid	
Open report A separate report on the exempt Cabinet agenda provides exempt information in connection with the procurement process.	
Classification - For Decision K**ey Decision:** Yes	
Wards Affected: None	
Accountable Executive Director: Jane West, Executive Director of Finance and Corporate Services	
Report Author: Caroline Wilkinson (Head of Finance Systems, Controls and Payments)	**Contact Details:** Tel: 020 753 1813 E-mail: caroline.wilkinson@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. In February 2013, Cabinet agreement was given for H&F to call off a contract from the Managed Services framework for the provision of transactional Finance and HR services (referred to as “Lot 1”). Westminster City Council (WCC) had led the procurement for this framework, with assistance and funding from H&F and the Royal Borough of Kensington and Chelsea (RBKC). WCC remain the owners of the framework contract, which was awarded to British Telecom (BT).

1.2. The call-off contract with BT covers a range of transactional finance and HR services, which will be delivered from their shared service centre in the North East of England. Strategic capability and decisions making for both Finance and HR is being retained in-house.

1.3. This service was due to go live on the 1st April 2014, but it was agreed to reset this initial go-live following a number of challenges with the

implementation phase. A further decision was taken in July 2014 to reset the go live until the 1st April 2015. However, further funding will be required to allow the programme to continue to this new implementation date.

1.4. The original Cabinet Paper agreed funding of £4.15m to cover all costs (for both Finance and HR) to implementation, with proposed annual savings of £1.28m as a result of the move to Managed Services and a payback of 3.4 years. This was split into a cashable general fund element of £800k, with the remainder relating to schools, HRA and non-cashable areas. Further funding is now being requested to cover costs until the re-set go live date.

1.5. It is proposed that these costs are met from the existing Managed Services reserve.

2. RECOMMENDATIONS

2.1. That further funding be allocated to Lot 1 of the Managed Services programme from reserves, as per the exempt report.

3. REASONS FOR DECISION

3.1. The recommendation to provide further funding is based on the need to implement this out-sourced service so that it can deliver the following benefits:

- Savings from adoption of the managed services are significant;
- Adoption of services enables a greater Tri-Borough working and achievement of existing and future savings targets; and
- Provides support to the Pan-London Athena Programme strategy of convergence across London Authority corporate services.

4. INTRODUCTION AND BACKGROUND

4.1 In 2011, Westminster established itself as the lead borough for the Managed Services element of the Pan-London strategy. Shortly after Westminster was recognised as lead for the Athena Managed Services work stream, Tri-Borough discussions recognised the value of a combined procurement, and common systems and processes stance for effective cross-borough working. Since then the Managed Services programme has been managed by Westminster with full engagement with, and funding from, LBHF and RBKC.

4.2 As well as generating savings in its own right, Tri-borough Managed Services enables the delivery of savings elsewhere across the Tri and Bi-

borough services. A combined back-office solution will enable all three Councils to be working in the same way, using the same processes. With this new single operating model, the potential for further efficiencies in "customer" service areas from more streamlined processes will become possible, reducing back-office processing costs and allowing more resources to be diverted to "front line" services.

4.3 The Cabinet report of February 2013 agreed that H&F would call-off a contract from the Managed Services Framework for Lot 1 services, and allocated funding of £4.15m for programme implementation costs. Due to agreed deferments in the go-live date, this funding is no longer sufficient to cover implementation costs until the revised go-live date of the 1st April 2015. It is therefore requested that further funding is allocated to allow the successful implementation of this service.

5 PROPOSAL AND ISSUES

5.1 Original Savings and Funding Assumptions for Lot 1

5.1.1 In the February 2013 Cabinet paper it was forecast that the programme would deliver annual savings of £1.28m to H&F. When the proposed transition costs of £4.15m were taken into consideration, this resulted in a payback period of 3.4 years. The table below summarises these figures.

Table 1: Summary of Costs, Savings and Payback Period

	Summary of Costs and Savings
Current Costs (£m pa)	2.88
New Contract Costs (£m pa)	1.50
ICF Contribution (£m pa)	0.10
Savings (£m pa)	**1.28**
Transition (£m)	4.15
Payback[1]	**3.4**

5.1.2 The annual savings were a combination of some departmental savings which were already included in the MTFS, and additional Finance and HR savings which were then added to the medium term budget plans.

5.1.3 The table below shows the breakdown of the original £4.15m of funding which was allocated to the Lot 1 programme with explanations as to how these estimates were arrived at.

[1] Higher LBHF ICF costs in Years 1 and 2 of the contract reduce the annual saving by £110k pa for these years. This increases the payback period from 3.24 to 3.40.

Table 2: Breakdown of Transition Costs from February 2013 Cabinet Report

Type of Cost	Estimate (£m)	Notes
Bidder Transition Cost	0.30	Bidder transition costs are set out in their pricing documentation.
Hosting of Existing systems (dual running)	0.83	There will be the requirement to run existing systems in parallel with the managed service to fulfil statutory requirements.
Redundancy	0.35	This is an estimated value
Interface rework	0.58	With a best practice approach being adopted, existing interfaces from business systems will need to be reviewed and updated to comply with new requirements
Loss of Profit from HFBP Joint Venture	0.12	Reduced systems support and work from HFBP may reduce the profit share received by LBHF
Tri Borough Programme Management Costs	0.68	These programme costs ensure the programme is delivered on time and to specification
H&F Programme Management Costs	0.66	These programme costs ensure the programme is delivered on time and to specification.
H&F Communications	0.05	
H&F Training	0.08	
H&F Legal	0.05	
Data Cleanse	0.15	This is a significant piece of work with the onus on the Council to cleanse all its finance and HR data to the standards required by the Managed Service to streamline and regularise processes in the future
Contingency for Staff Retention during Transition	0.30	This ensures departmental staff are able to input to the process and are fully able to implement the new solution
Total	**4.15**	

5.2 Further Cost Assumptions

5.2.1 Further funding is being requested for the implementation of Lot 1. The impact of this change on the payback period is reflected in Table 1 of the exempt report.

5.2.2 Table 2 in the exempt report reflects where funding has already been spent and the forecast total spend figure for each area assuming a go live date of the 1st April 2015.

5.2.3 The 2014/15 forecast spend figures in the table above are not all additional costs as a result of the delay to go-live. Some costs only become effective at go-live ie. redundancy or BT transition costs, and hence slip into the final year of the programme. The key areas of additional spend as a result of the delay are:

5.2.4 **Hosting of Existing Systems** – The original cost assumption of £830k was to cover the running of our existing finance and HR systems until part way through 2014/15 to cover the transitional period, existing contract requirements and finance processes such as closing the accounts.

5.2.5 The revised go-live date of 1st April 2015 means that a number of finance system contracts are now having to be renewed to ensure consistency of service until go live and to cover the closing of accounts for 2014/15.

5.2.6 Tri Borough Programme Costs – The programme implementation team has been retained in 2014/15, and covers all aspects of the programme. This includes

- HR and Finance System Build, all aspects of testing (integrated systems testing, user acceptance testing. operational acceptance testing etc.
- data (extraction, cleansing, transformation of data and loading)
- change management
- programme management (includes PWC costs)

5.2.7 The additional cost reflected in Table 2 of the exempt report is based on retaining the full team until May 2015, and half of the team in June 2015. This is to reflect the fact that programme support will still be needed in the immediate post go-live period.

5.3 Funding Additional Costs

5.3.1 It is proposed that the additional costs are funded from the existing Managed Services Reserve.

6 OPTIONS AND ANALYSIS OF OPTIONS

6.1 This report is seeking additional funding for the extension to an existing contractual arrangement which has already been entered into, rather than authority to embark on a new programme. There is therefore limited scope for option appraisals. However, where possible, varying options have been considered to minimise costs. These include:

6.1 Discussions with HFBP and system suppliers to minimise contract extension periods where possible, and balance risk against cost when deciding how to support systems in the future, eg. minimal, skeleton support for legacy systems in 2015/16 as they are not being used for transactions, the cheapest data centre option for housing finance systems once they are no longer needed and are for audit/archive purposes only.

6.2 Re-organisation of the programme management structure and governance to ensure that it balances effective delivery with value for money.

7 CONSULTATION

7.1 Within H&F there are 34 permanent FTEs who are subject to outsourcing. In addition, a small number of permanent staff employed by H&F Bridge Partnership will also be affected. The staff at risk are subject to TUPE legislation and have the right to migrate to the new supplier. Consultation with both affected staff and trade unions has already taken place in relation to this programme.

7.2 Affected staff and trade unions have been kept fully informed by both senior management and HR about delays to the programme and any resulting impacts on staff.

8 EQUALITY IMPLICATIONS

8.1 This paper does not make any recommendation for changes to the original Managed Services equalities impact assessment. The paper relates to financial management of the programme and not to its predicted outcomes and their effects on service users and other impacted parties. Therefore there are no direct equality impacts.

8.2 Implications verified/completed by: (David Bennett, Head of Change Delivery, Innovation and Change Management Division – 0208 753 1628)

9 LEGAL IMPLICATIONS

9.1 The change to the contract price will have to be implemented in accordance with the Change Control Procedure in the contract, unless that procedure does not apply to changes such as this; in that case the contract will have to be varied by way of a deed of variation.

9.2 Contract variations are subject to Procurement Law which makes certain variations are unlawful particularly those which alter the balance of the commercial risk in the contractor's favour, e.g. where it is paid more for doing what it should have done anyway. Provided that the price of the change has been calculated so as to ensure that it fairly reflects the extra work / costs properly incurred by the contractor and the extent to which, if any, it is responsible for the delays, the risk of a successful challenge is low

9.3 Implications verified/completed by: Keith Simkins Principal Solicitor 020 7361 2194

10 FINANCIAL AND RESOURCES IMPLICATIONS

10.1 The report provides an update on the implementation of the Managed services framework for Lot 1 services. Additional costs will be incurred due to the delay in the go-live date. These will be funded from the existing Managed Services Earmarked reserve.

10.2 Savings of £1.28m per annum are expected following implementation. In addition the move towards a single operating model will result in more efficient working across the Council.

10.3 Implications completed by Andrew Lord, head of Strategic Finance and Monitoring, Ext 2531.

11 RISK MANAGEMENT

11.1 Managed Services is a significant change programme with procurement programme and change risk management being the responsibility of Westminster City Council. Finance and Human Resources systems are inherently highly complex by their nature and in 2013 the Council was exposed, amongst many others, to a high risk situation with the collapse of the software provider of the finance system, 2E2. Whilst this position was stabilised and an alternate provider stepped in to provide immediate continuity, Managed Services was seen, in part for the finance system, as a long term solution to this risk. The programme has had two revisions to its go-live date and the consequence of this has impacted on such areas as;

- early realisation of benefits from the programme.
- staff retention.
- upgrades, extensions or renewals to existing hosted systems, and their cost.

11.2 The report highlights some of the mitigations required as a consequence of the delays. These mitigations are to be noted in the form of a service resilience plan for the Managed Service. Successful delivery of a Managed

Finance and Human Resources service would contribute positively to the management of Strategic Risk number 1, managing budgets and finance risks, Risk number 4, business resilience through a stable finance system, Risk number 8, maintaining reputation and service standards and Risk number 9 identification and management of fraud.

11.3 Implications completed by: Michael Sloniowski Bi-borough Risk Manager ext 2587.

12 PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1 The revised go-live date of 1 April 2015 has required some suppliers to be approached for a second time to negotiate contract extensions. This has limited the ability to obtain best prices for applications essential to maintaining consistency of service to go-live.

12.2 Implications verified / completed by: Mark Cottis, e-Procurement Consultant. 0208 7532757.

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1.	Managed Services Costing Working Papers (Exempt)	Caroline Wilkinson x1813	FCS – Corporate Finance

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
BETTER CARE FUND PLAN REVISED SUBMISSION	
Report of the Cabinet Member for Health and Adult Social Care - Councillor Vivienne Lukey	
Open Report	
Classification - For Decision **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care and Health	
Report Author: Cath Attlee, Whole Systems Lead, Adult Social Care	**Contact Details:** Tel: 07903956961 E-mail: cattlee@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper reports on the requirement on each Health and Wellbeing Board to resubmit the Better Care Fund (BCF) Plan, which was previously agreed in March 2014 and submitted to the Department of Health (DH) in April. The report explains that the plan contains some additional material and revision following further guidance and a revised template from DH and the Department for Communities and Local Government (DCLG).

1.2. The key national changes relate to the Pay for Performance and Risk Sharing arrangements which mitigate the risk of local areas failing to achieve the key target of reduced emergency admissions, but reduce the investment in integrated care, and potentially increase the risk to social care.

1.3. Our revised submission includes more detailed financial modelling particularly around the development of a community independence service, which is a key element of the plan and provides partners with greater confidence of the deliverability of the five outcomes measured within the plan.

1.4. Local NHS investment reduces the risk to social care of non-delivery of the reduced emergency admissions target, since social care costs will be covered. However, there continues to be a risk to the whole system of the new arrangements generating additional demand, and this will need to be closely monitored.

2. RECOMMENDATIONS

2.1. To agree the Better Care Fund Plan Revised Submission and to proceed with the implementation of the plan, including the development of the Community Independence Service (CIS).

2.2. To note that Cabinet will be asked to make further key decisions during the implementation of the Better Care Fund programme and plans.

3. REASONS FOR DECISION

3.1. Development of an integrated Better Care Fund Plan is a requirement of the Department of Health and the Department for Communities and Local Government. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Hammersmith and Fulham Health and Wellbeing Board.

3.2. In July 2014 the DH/DCLG wrote to Health and Wellbeing Boards requiring a resubmission of the BCF Plan to strengthen the plans and provide greater confidence that the integration of out of hospital services would be delivered to reduce pressure on hospital care. Cabinet is asked to approve the resubmitted plan.

4. INTRODUCTION AND BACKGROUND

4.1. The BCF is “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”. A national allocation of £3.8bn was announced in the summer of 2013 for this purpose.

4.2. The BCF does not come into full effect until 2015/16, but an additional £200m was transferred to local government from the NHS in 2014/15 (on top of the £900m already planned) and it is expected that Clinical Commissioning Groups (CCGs) and local authorities will use this year to transform the system. Consequently, a two year plan for the period 2014/16 had to be put in place by March 2014.

The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community settings. This will build on CCG Out of Hospital strategies and local authority plans expressed locally through the Community Budget and Integration Pioneer programmes.

4.3. The Better Care Fund Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including HealthWatch, and reflects the shared aspirations for integrated care.

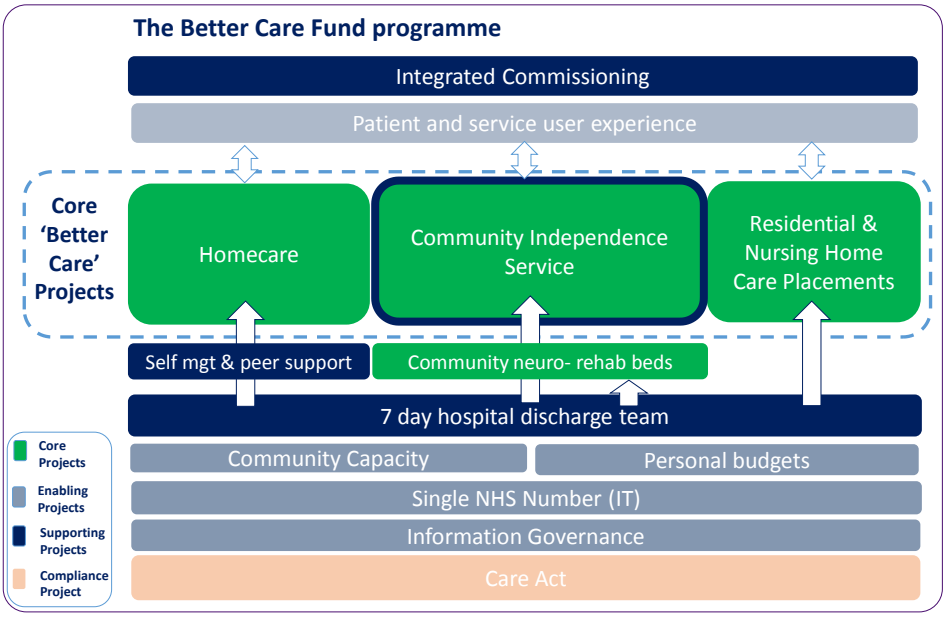
4.4. The outcomes to be achieved through the BCF are:

- A reduction in permanent admissions to residential care home
- Increased effectiveness of re-ablement
- A reduction in delayed transfers of care from hospital
- A reduction in emergency admissions to hospital
- An improvement in patient/service user experience
- Improvements in health-related quality of life for people with long term conditions.

5. REQUIREMENT FOR RESUBMISSION

5.1. The Health and Wellbeing Board approved the Better Care Fund Plan 2014-16 in March 2014 and the Plan was subsequently submitted to NHS England on 4th April. A summary of the BCF schemes is captured in the diagram below.

Enabling Better Care in Triborough



5.2. The Tri-borough BCF Plan was considered of good quality by NHS England (NHSE), the Local Government Association (LGA), DH and DCLG, and the three authorities were among a small number approached in July to be "fast-track" BCF authorities, providing a further example to other authorities of how an acceptable BCF Plan could be developed (although this offer was declined). The plan was rated 2nd nationally following more detailed work on finance and metrics and external assurance.

5.3. Other parts of the country, however, were not able to submit satisfactory plans. In addition concerns were expressed, particularly by the hospital sector, about the arrangements for local risk sharing and pay for performance. A key ambition of the BCF is reducing pressures arising from unplanned admissions to hospital. There was a lack of confidence in the ability of CCGs and local authorities to deliver the necessary changes to achieve this ambition within the timescale and, consequently, a fear that funding would be transferred from the NHS to local authorities but that acute activity would continue unabated.

5.4. Consequently, in July 2014, Health and Wellbeing Board Chairs received letters from the DH and the DCLG announcing some changes to the BCF Programme. The changes related to the Pay for Performance and Risk Sharing arrangements which commence in 2015-16.

5.5. Each area was asked to demonstrate how the BCF Plan will reduce emergency admissions, as a clear indicator of the effectiveness of local

health and care services in working better together to support people's health and independence in the community.

5.6. A proportion of the performance allocation (the local share of the national £1bn performance element of the £3.8bn fund) will be payable for delivery of a locally set target for reducing emergency admissions (they suggested at least 3.5% reduction). The balance of the allocation will be available upfront to spend on out of hospital NHS commissioned services, as agreed by the Health and Wellbeing Board. This provides greater assurance to the NHS and mitigates the financial risk to acute hospitals of unplanned acute activity. If the target for reducing admissions is not met, a proportion of the £1bn funding will remain with the NHS and not transfer to the BCF for joint use.

5.7. The original BCF guidance proposed that performance payments would be based on progress against four of the six national conditions and progress against the five national metrics and one local metric would be used to determine the level of payment for performance. Following July's national change to the Better Care Fund, only the indicator of unplanned admissions to hospital will determine payment for performance . Hospital providers have been asked to confirm agreement with the proposed reduction in non-elective activity.

5.8. Imperial NHS Trust and Chelsea and Westminster Hospital Foundation Trust have provided confirmation of agreement, subject to a detailed review of the CIS model to validate planning assumptions in relation to reduced emergency admissions and to understand fully the impact of the proposed changes on the care pathway, quality and safety, and workforce implications. The activity changes are reflected in the CCGs' QIPP and SAHF plans and will be reflected in their contracts with the trusts for 2015-16.

6. THE REVISED BETTER CARE FUND PLAN

6.1. The key changes from the BCF Plan previously approved by the Cabinet Member and by the Health and Wellbeing Board are as follows:

6.2. Target reduction of around 3.5% in total emergency admissions replaces the previous metric of approximately 5% reduction in *avoidable* emergency admissions. Funding linked to achievement of this target will be released by the CCG into the pooled budget on a quarterly basis, depending on performance, starting in May 2015, based on Q4 performance in 2014-15.

6.3. The remainder of the £1bn national fund (the performance element of the £3.8bn) will be released to the CCG upfront in Quarter 1 in 2015-16.

6.4. If the locally set target for reduction in emergency admissions is achieved, all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. Achievement will be measured against the total figure for the whole area, not just against those activities within the BCF Plan.

6.5. If the target is not achieved, the remaining performance money will not leave the local area, it will remain with the CCG to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board.

6.6. The system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. The revised arrangements need to be taken into account in both CCG and Local Authority planning for 2015-16.

6.7. Local authorities nationally have expressed concerns at the changes which step back from the core purpose of promoting locally led integrated care and reduce the resources available locally to protect social care and prevention initiatives.

6.8. However, within the Tri-borough area there is confidence that the target level of reduction in emergency admissions can be achieved so that the maximum level of allocation will be transferred to the BCF pooled budget for integrated services.

6.9. The NHS commissioned services can include NHS spend on those services currently commissioned by the local authority on behalf of the NHS or commissioned jointly through s75 agreements, which form a significant element in the Tri-borough BCF.

6.10. There is, however, a risk to Adult Social Care from these changes and the position will need to be monitored closely through the year to assess progress against target and the impact of any shortfall in the pooled budget on integrated services. A reduction in emergency admissions is likely to lead to an increased use of social care which needs to be funded.

6.11. The revised plan provides additional material in relation to the following areas:

- **The case for change** – analysis and risk stratified understanding of where care can be improved by integration, which has informed the key BCF

workstreams of community independence services including reablement and 7 day working.

- **A plan of action** – a clear evidence based description of the delivery chain which will support a reduction of emergency admissions, developed with all local stakeholders and aligned with CCG, local authority, provider and whole system strategies.

- **Strong governance –** confirmation of local management and accountability arrangements and description of tracking arrangements to monitor the impact of interventions, take action to address slippage, and robust contingency plans and risk sharing arrangements across providers and commissioners locally.

- **Protection of social care** – this reflects existing funding transferred via s256 from NHS England for current levels of work, plus new funding for Care Act responsibilities.

- **Alignment with acute sector and wider planning** – evidence of alignment with the NHS two-year operational plans, five year strategic plans, and plans for primary care as well as the local authority. Evidence is provided that providers are engaged in the BCF programme and have understood the impact of the plan on their services.

6.12. In addition the revised BCF Plan sets out in more detail the amount of funding going into carer support and the nature of that support.

7. CORE COMPONENTS OF THE BETTER CARE PLAN: the Community Independence Service and Integrated Operational Services

7.1. A core component of the BCF Plan is a new Community Independence Service (CIS). It accounts for more than half of the financial benefits of BCF to the three councils. It is a single service for all three boroughs. It integrates community health and social care services. This kind of service is often called “intermediate care.” It helps people in four ways:

(i) It is a single point of referral for intermediate care services. It is also the natural point of referral to the Adult Social Care assessment teams for people who need long-term services. It is an important starting-point for the new pathways that we are developing in the Customer Journey programme. Earlier this year, the research phase of Customer Journey told us that customers and health and social care professionals alike are confused about where to go for help. (We will explain this and other developments in Customer Journey in a paper later this year.)

(ii) The service quickly helps people who are very unwell with care at home. This is known as “rapid response,” which often involves nurses visiting within two hours of a referral to the CIS. Sometimes the crisis needs help from another profession, like a social worker or home care worker, because it is social not medical. For example, a family carer might be sick and the person they care for at risk because there is no-one to look after them. The rapid response service continues to help people while their situation stabilises, typically for between three and five days. It expects to help 70% of people who are referred avoid a stay in hospital.

(iii) The CIS is designed to help between 700 and 800 people in each borough avoid admission to hospital in 2015/16. This is significant and accounts for most of the financial benefits of CIS. But it is a small proportion of all unplanned admissions to hospital. Many people will continue to go to hospital. CIS helps when they no longer need care in hospital and are well enough to leave. This part of the service is called in-reach, and involves CIS staff working with staff in hospitals to plan for safe and timely discharge to the community, and to their own home as often as possible.

(iv) CIS helps people regain their independence following a crisis, whether the CIS managed the crisis at home or helped the person to come home following a stay in hospital. It offers integrated medical and social therapies. For most people it involves some combination of rehabilitation from a therapist, who might help them regain their mobility; and some “re-ablement,” in which people learn or relearn the skills and confidence to manage at home. It helps people avoid repeated crises and dependence on long-term care services—the services that consume most of Tri-borough’s Adult Social Care budgets.

7.2. Since May 2014 the Tri-borough BCF programme has developed a business case for this CIS.The business case explains why a single Tri-borough CIS that integrates community health and social care services is better value than three borough specific services and any service in which the health and social care elements are not integrated. The design supposed in the business case is based on Hammersmith & Fulham’s Virtual Ward CIS but includes successful features of existing services in other parts of Tri-borough.

7.3. The business case is based on a detailed statistical study of Tri-borough’s intermediate care services, including the CIS and re-ablement services of all three councils. From this baseline, it estimates the investment that is required to reduce unplanned admissions to hospital by 3.5% per year between 2015 and 2018, which is the principal performance target of the Better Care Fund. The estimate of investment allows for:

i) underlying growth in demand and costs from demographic change and inflation
ii) the additional cost to adult care of keeping people who would otherwise be in hospital in community services
iii) the additional demand that is created when new and better services create capacity for people with needs that existing services cannot meet.

7.4. The investment is calculated to help with BCF's main objective—reducing unplanned admissions to hospital. But in the same way that the investment allows for secondary effects of that investment, our estimates of savings include benefits in areas other than reduced hospital admissions—savings that mostly benefit the CCGs who pay for those admissions. CIS improves the quantity and quality of intermediate care and has direct financial benefits to hospital trusts and to the local authorities. Hospitals benefit because their beds are occupied only by people who need hospital care. This gives them more capacity to help during periods of high demand and to offer planned care, like elective surgery. It also reduces their losses when people stay in hospital for longer than they are funded by the NHS payment by results system. Good rehabilitation and re-ablement help people recover and stay will, so avoiding recurrent crises. They help reduce repeated trips to hospital and also the need for long-term social care services like residential care and home care, on which most of the Council's Adult Social Care budgets are spent.

7.5. The model of costs and benefits shows that an integrated, Tri-borough CIS saves money for all six Tri-borough commissioners: three CCGs and three councils. The savings do not fall proportionately across the commissioners. This section explains how the CCGs and councils have made the distribution costs and benefits fairer.

7.6. The CIS services that are in scope of the new CIS, and on which it will build, cost about £18.9m in 2014/15 of which about £6.5m is Adult Social Care CIS and re-ablement services. Investment of £4.6m in staff (including £2m social care), IT, and equipment will create total savings of £8M: a net saving of £3.4m. The savings come from:

i) providing medical care at home and hence avoiding a trip in an ambulance; a visit to Accident and Emergency; a stay in hospital; and often all three.
ii) shorter stays in hospital because CIS provides "post-acute" medical care at home

iii) more help to get well after a crisis, and so less need for long-term health and care services, especially residential care services.

7.7. The CCGs' return on investment is greater than the councils'. If the CCGs and councils invested the amounts we have estimated in our model in just their own elements of the service and also took savings only from their own budgets then

i) the CCGs would invest £1.7M in medical staff next year and save £4.5M mostly in reduced hospital activity.

ii) the councils would invest £2.9M mostly in social care staff and services and save £3.5M by reducing need for care homes and home care. (The model sums up estimates for each CCG and councils)[1].

7.8. In the absence of BCF, there would be a strong case to improve intermediate care for financial reasons and to offer a better service. (For example, a new CIS is a clear requirement of the "Customer Journey" programme of quality improvement to operational adult social care service.) The financial case for the service we have designed in BCF is less appealing to the councils than to the CCGs. But all six organisations need to participate if we accept that single Tri-borough service integrating community health and care services is more efficient and more effective overall than one that does not. We therefore need a fairer way of sharing benefits. Instead, as part of the wider budget-pooling arrangements in BCF, the CCGs have agreed they will fund all local authority investment in the new CIS in 2015/16. This means that the total net benefit to all the councils increases from £0.6M to about £5.2M. (The savings to each council can be found in Table 1). It also provides an opportunity to redeploy highly trained professional staff from long-term teams to CIS as part of the Customer Journey reforms.

8. DESIGNING AND IMPLEMENTING THE SERVICE

8.1. The BCF team believes that the implementation should establish the new service; invest in staff and systems; and focus on achieving the 2015/16 performance targets and savings. It should not seek to procure or create new organisations to deliver the service. Instead, the team believes that, so far as possible, existing providers should work under new contracts with better performance management and incentives.

[1] Figures for LBHF can be provided on request.

8.2. The councils have agreed that we will develop new management arrangements which are required to enhance our CIS services. This may involve one council acting as the lead provider CIS social care. A subsequent paper will explain this proposal when the details are clearer.

8.3. The CCGs are designing a new contractual relationship with their providers in which one is likely to act as a prime contractor or at least a lead provider coordinating the work of the rest. The CCGs are developing a fair and transparent means of choosing a lead.

8.4. A lead social care provider working with a lead NHS provider reduces the number of provider organisations accountable directly to the BCF commissioners from six to two. But the question arises, why not one provider?

8.5. Forming the new CIS with a single provider, or at least a single lead provider, for the beginning of the new service does not appear to be feasible.

8.6. Each Tri-borough council is a commissioner and provider of their existing CIS. They cannot account to a NHS lead provider in their role as CIS provider while also being a commissioner to whom that single NHS provider accounts.

8.7. Nor can the councils act as single lead provider for the whole CIS service because, again, each is a commissioner of the service and therefore has a conflict of interest. (It is also uncertain that we could accept clinical accountability for the health care component of CIS.)

8.8. These concerns appear largely theoretical, and would be likely to affect the management of risk if the new service suffered problems in the first year. Two providers, one social care and one health, working closely would seem better to support the important work of creating a new service quickly and achieving the first year's benefits. Beyond these new contractual arrangements for the first year of the new service, the commissioners believe that we should change the employment conditions of front-line staff as little as possible during implementation.

9. RISKS

9.1. Payment for performance in the Better Care Fund is based on reductions in unplanned admissions to hospital. The national formula for those arrangements is explained elsewhere in this report. The CIS is the means by which we will prevent large numbers of unplanned admissions. We

also expect that it will save money in other ways. The risks to those savings are as follows:

i) BCF does not achieve its target admission-avoidance
ii) The NHS do not convert the reductions in activity to cashable savings
iii) CIS increases activity in community beyond the forecasts in our cost benefit model. For example, the councils use less home care and more care home beds to manage demand than we planned, increasing our costs and reducing savings.

9.2. The mitigation is as follows:

i) The target for admission-avoidance is set around the national recommended level. It was repeatedly checked during the development of the business case and appears to be achievable and prudent.
ii) The cost-benefit analysis is cautious about other benefits. It allows margins of error where it makes assumptions that affect benefit. For example, it allows 15% contingency in case we underestimated the number of referrals for re-ablement that are required to keep people at home and out of care homes
iii) The business case, which has been agreed by CCG governing bodies, established five principles for risk-sharing. They say that the councils are paid for reducing activity and do not depend on realisation of cash savings in the NHS.
iv) The risk-sharing principles require a benefit monitoring system that can quickly identify a gap between the forecasts in the business case and the performance of the service.
v) The risk-sharing principles requires the commissioners to establish conditions on which any commissioner may withdraw from the service if it does not behave as expected and causes them unacceptable financial risk.
vi) The CCGs and councils are developing a risk-sharing agreement as part of the design and implementation of the new service.

10. CONDITIONS OF PAYMENT AND SHARING RISKS

10.1. The BCF requires CCGs and councils to share the financial consequences if the service does not reduce unplanned admissions to hospital. The national Payment for Performance arrangements provide the total funding to the CCGs. It is then applied against two elements: reduction in emergency admissions; and NHS commissioning of out of hospital services. The emergency admissions funding is released into the BCF pool on the basis of achievement of the target, assessed at the end

of each quarter from Q4 2014-15. The remaining funds are put into the BCF pool for investment in out of hospital services.

10.2. The CCGs can choose to invest additional funding into the BCF pool, and the Tri-borough CCGs have chosen to do this. Consequently, the risks to Tri-borough Adult Social Care are less than elsewhere because the CCG has committed to covering social care costs of the CIS in 2015-16, whether or not the emergency admissions target is achieved.

10.3. There is, nevertheless, a risk to the whole system of the new BCF services failing to deliver a reduction in emergency admissions (thus releasing resources for investment) and, potentially, increasing service demand by identifying unmet need. Consequently, close and frequent monitoring of implementation and outcomes will be required during 2015-16 to understand both the direct and indirect consequences of BCF implementation.

11. CONSULTATION

11.1. The revised BCF template seeks evidence of provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions have been held with major providers, acute and community, during June-September to increase their awareness of the detailed BCF programme. The strategic plans already agreed with local hospitals include a significant shift of work into the community and a reduction in emergency admissions.

11.2. Shaping a Healthier Future (SaHF) and the Out of Hospital Strategies set out the plan to reconfigure hospital services to focus on the needs of patients. These plans have been developed and consulted upon, with local authority, acute, community and mental health services and other local stakeholders fully engaged. The plans contained in the BCF are consistent with SaHF plans to shift work to community / primary care settings.

11.3. Acute Trusts are aware of the Better Care Fund and its intention to strengthen and harmonise the approach to community care and confidence in out of hospital provision, particularly through links to the Urgent Care Boards. The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. Arrangements for further engagement at Chief Executive level prior to plan re-submission are in progress. There will also be further engagement with all providers over the coming months to

involve them in co-design of in depth solutions facing the health and social care economy in Tri-borough.

11.4. The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, informed by patient and service user feedback. The approach to developing the BCF is characterised by co-design and co-delivery, supported by extensive stakeholder engagement, including with clinicians, other CCGs and local authorities, provider organisations and national bodies.

12. EQUALITY IMPLICATIONS

12.1. There no detrimental impact on equalities of health or access to health – improves access for people with long term conditions.

12.2. Implications verified/completed by: David Evans, Business Manager, Adult Social Care 020 8753 2154.

13. LEGAL IMPLICATIONS

13.1. The DH and the DCLG have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

13.2. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003, which will allow for the inclusion of the Disabled Facilities Grant.

13.3. Implications verified/completed by: Andre Jaskowiak, Senior Solicitor, Bi-Borough Contract Law Team. Tel: 020 7361 2756.

14. FINANCIAL AND RESOURCES IMPLICATIONS

14.1. It is estimated that the programme will contribute to the delivery of around £13m in savings across Tri-borough partners by the end of 2015/16, if targets are fully met, as shown in the table below.

14.2. We have constructed a detailed financial and activity model which demonstrates the linkages and flows of costs and benefits across health and social care as a result of the new proposed CIS. The model is based on current data and agreed assumptions of the technical working group. At the core of this is the new Community Independence Service and the linkages between that service, homecare and residential and nursing home placements.

14.3. The model enables the local authority and CCGs to take an informed view over the different pressures and costs of redesigning core components of our of hospital care and the subsequent shift in activity and flows of people in order to come to a mutually beneficial agreement over the impacts and associated reimbursements. This is required to provide reassurance to the local authorities that social care will not be negatively impacted by the BCF.

14.4. The revised BCF Plan includes figures based on current estimates of costs and savings. The BCF ensures the continued protection of social care funding through grant to be maintained, provides for Care Act funding, provides for the 2015/16 new investment costs for social care for the CIS to be paid by Health and should generate savings on an ongoing basis.

14.5. The BCF brings together a number of existing funding sources for savings, summarised in the Table 1. The BCF in 2015/16 ensures that Tri-borough receives funding for the Care Act (£558k for LBHF), all the investment costs of the new Community Independence Service (£870k for LBHF) and should generate recurrent savings (£1.63k in LBHF in 2015/16). It also protects social care by continuing to pass through the Social Care to Benefit Health funding, currently worth £4.2m in LBHF.

Tri-borough Better Care Fund Financial Summary (September 2014)

Organisation	Holds the pooled budget? (Y/N)	Minimum contribution (15/16) '000	Actual contribution (15/16) '000	Anticipated Savings (15/16) '000
Westminster City Council	Y	*1,379*	*23,686*	2,281
Royal Borough of Kensington and Chelsea	Y	*874*	*22,254*	1,359
London Borough of Hammersmith and Fulham	Y	*1,052*	*48,622*	1,630
Central London CCG	N	*13,553*	*32,932*	2,511
West London CCG	N	*17,830*	*34,235*	2,633
Hammersmith and Fulham CCG	N	*13,148*	*31,533*	2,311
BCF Total		**47,836**	**193,262**	**12,725**

Actual savings will be tracked by borough or, where at tri-borough level, will be pro-rated by population. Our intention is for the local authorities to hold the pooled budget, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, either LA or CCG.

14.6. Implications verified/completed by: Rachel Wigley, Director of Finance, Adult Social Care 020 8753 3121

15. RISK MANAGEMENT

15.1. See Section 9 above and the risk matrix contained with the BCF Plan attached.

15.2. Implications verified/completed by: Mike Rogers, Head of Business Analysis, Adult Social Care 020 7641 2425

16. PROCUREMENT AND IT STRATEGY IMPLICATIONS

16.1. There are no procurement and IT strategy implications immediately arising from this report. The BCF Plan does include the implementation of IT and Information Governance developments which will be the subject of separate reports, as will any service procurements required as part of the development of services.

16.2. Implications verified/completed by: Sherifah Scott, Head of Procurement, Adult Social Care 020 7641 8954

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix 1: Better Care Fund Plan 2014-16 Resubmission September 2014

Appendix 2: BCF Plan 2014-16 Finance and Outcomes Spreadsheets 2014

Triborough Better Care Fund – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	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
Boundary Differences	Co-terminus (limited exceptions) The Plan covers all three boroughs so the CCG boundary exception is not relevant to the narrative. The finance section sets out Local Authority funding by borough and CCG funding by CCG so the NHS figures for Westminster are split between CLCCG (78%) and WLCCG (22%).
Date agreed at Health and Wellbeing Board:	Original plan agreed 24/03/2014, 2nd revised plan agreed 19/09/2014
Date submitted:	04/04/14 (1st Revised plan submitted 09/07/14, 2nd revised plan submitted 19/09/14)
Minimum required value of BCF pooled budget: 2014/15	£2,590,000
2015/16	£47,836,000
Total agreed value of pooled budget: 2014/15	£156,143,602
2015/16	£193,094,230

b) Authorisation and sign off

Signed by Fiona Butler

Dr Fiona Butler
Chair,
NHS West London CCG

Date: 19th September 2014

Signed by Councillor Mary Weale

Councillor Mary Weale
Cabinet Member for Adult Social Care &
Public Health, RB Kensington and Chelsea
And Chair, RBKC Health & Wellbeing Board

Date: 19th September 2014

Signed by Dr Ruth O'Hare

Dr Ruth O'Hare
Chair,
NHS Central London CCG

Date: 19th September 2014

Signed by Councillor Rachael Robathan

Councillor Rachael Robathan
Cabinet Member for Adults &
Public Health, Westminster City Council
And Chair, WCC Health & Wellbeing Board

Date: 19th September 2014

Signed by Dr Tim Spicer

Dr Tim Spicer
Chair,
NHS Hammersmith & Fulham CCG

Date: 19th September 2014

Councillor Vivienne Lukey
Cabinet Member for Health and Adult Social Care
LB Hammersmith and Fulham
And Chair, LBHF Health & Wellbeing Board

Date: 19th September 2014

c) Related documentation

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref	Document	Synopsis
D1	**"Living Longer, Living Well" Pioneer Application June 2013**	The vision for whole system integrated care in North West London, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people's care; and systems will not hinder the provision of integrated care.
D2	**"Shaping a Healthier Future" NHS North West London**	The strategy for future healthcare services in North West London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
D3	**Out of Hospital Strategies**	NHS West London CCG, NHS Hammersmith & Fulham CCG, and NHS Central London CCG's strategies for commissioning and delivering better care for people, closer to home. These focus on local care provided out of hospital, integrating with the future development of acute services across the region.
D3	**Joint Strategic Needs Assessment (JSNA)**	Joint Local Authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities for each of the 3 localities.
D4	**Joint Health & Wellbeing Strategy(JHWS)**	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the 3 localities.
D5	**Joint Commissioning Intentions**	A single view of commissioning intentions across the Triborough health and social care landscape. The CCGs commissioning intentions for 2014/15 have been mapped against each other and also against the Triborough market statement (which brings together Local Authority Adult Social Care commissioning intentions across Westminster, Kensington & Chelsea, and Hammersmith & Fulham).
D6	**CIS Business Case**	This business case argues for the development of a detailed single specification for a Triborough Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster.
D7	**Delivering Seven Day Services**	North West London's vision to be an early adopter for 7 day services across health and social care.

Ref	Document	Synopsis
D8	**Individual CCG QIPP, operating and Local Authority corporate and service plans**	Detailed plans by the CCGs and Local Authorities for the funding and delivery of services and associated efficiency targets for 2014/15 and 2015/16.
D9	**Borough/CCG Health and Wellbeing Partnership Agreements**	S75 Partnership Agreements established between each Local Authority and CCG as a framework within which integrated commissioning can be implemented; along with annually agreed service schedules of those services jointly commissioned or in a pooled budget.
D10	**Draft BCF Communications and Engagement Plan**	Draft plan for involving stakeholders in the development, implementation and evaluation of the BCF.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Integration across the health and social care system is a key theme in the Triborough's Joint Health and Wellbeing Strategy (JHWS). 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. These include:

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

The vision across the Triborough 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 includes the *Shaping a Healthier Future* service reconfiguration programme that builds on extensive analysis by a series of Clinical Working Groups to develop suitable models for clinical services, culminating in the 2011 Commissioning Strategy Plan. This set out the case for a shift in the balance of resources between acute and community provision, leading to a detailed strategy to localise care close to individuals' homes, to centralise specialist care, and to integrate care for people with long term conditions and the elderly.

Supporting the highest risk proportion of the population who consume the majority of resources is a particular focus, and the consequences of these changes in need and environment are already evident. Critical services have started to be centralised where necessary to deliver higher quality care (e.g. 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.

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 and living well. They want care delivered by people and organisations that show dignity, compassion and respect at all times.

This strategy is centred around 3 core principles:

1. **People will be empowered to direct their care and support**, and to receive the care they

need in their homes or local community

2. **GPs will be at the centre** of organising and coordinating people's care

3. **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 the 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.

To do this, our starting point is our patients and service users themselves. The following 3 "personas" are examples of those which have been developed to capture the experience of typical service users. They bring together feedback from real people and from the frontline professionals who are working to help them today. They allow us to focus our interventions on meeting the needs of individuals and work with them on the things which are most important to them.

Asmita

- *Asmita is 66 and lives in Westminster. She has a low income and lives alone in a rented basement flat. She is recently widowed. Her husband, who was her carer and organised her medicines also used to translate for her as English is not her first language*
- *She often feels lonely as her family lives abroad and she cannot communicate easily with her neighbours.*
- *Asmita has multiple long term conditions including diabetes, arthritis, chronic heart failure and early onset dementia. However, she does have some capacity at the moment.*
- *She receives a number of different services which include meals on wheels, two homecare visits a day to help her dress. Since her husband died, she makes frequent 999 calls and associated A&E visits. Her medicines are delivered by the pharmacy but she often misses her regular doses.*

April

- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently taking warfarin following general anaesthetic for her second operation.*
- *She regularly visits her GP for blood pressure checks and has high levels of anxiety, leading to panic attacks. She has an informal support network in her block of flats, but her daughters live*

abroad and will not be returning to the UK.

- *She has physio services for her hips and accesses transport services for hospital appointments. April has capacity at the present time, but is at high risk of losing her independence. She would benefit from help in the home to keep her in her current accommodation for as long as possible. She would benefit from some computer literacy, for example, to help with shopping, general contact etc.*

Les

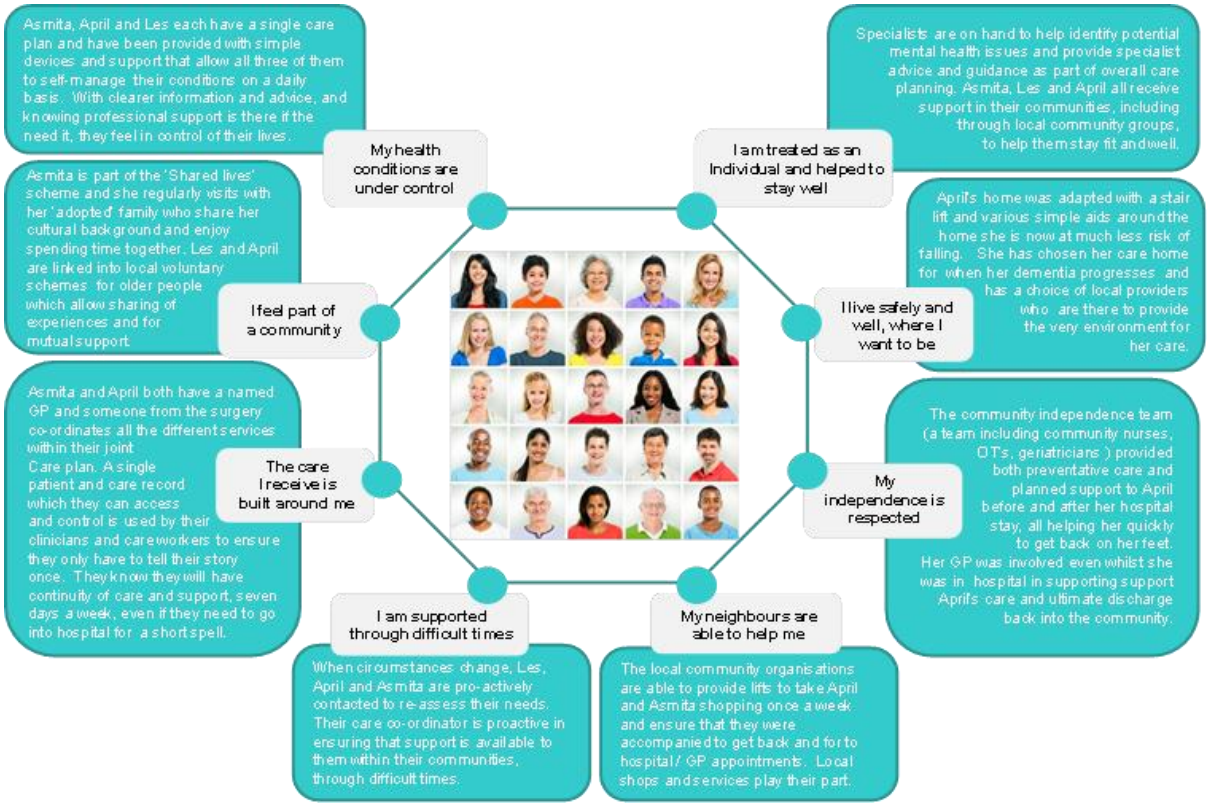
- *Les lives in Hammersmith. He has two children. He lives on his own in social housing and is currently unemployed.*
- *Les feels isolated. He receives services in a reactive way, although he is on the brink of receiving more proactive services. He does not have a care manager.*
- *Les has multiple long term conditions including diabetes (which may not have been diagnosed at this stage). He is a smoker who has alcohol issues and heart problems. He also has mental health problems (a combination of depression and dementia).*
- *He frequently uses Charing Cross Hospital A&E (visits are often alcohol-related). He has lots of disconnected referrals to care managers, social workers and district nurses. With the right advice and support Les could potentially care for himself.*

b) What difference will this make to patient and service user outcomes?

As our work and engagement in this area has evolved, increasingly we have been able to identify 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 exacerbating conditions/capacity
- In need of 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
- Socially isolated
- Multiple long term conditions

Our vision for 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.



This work starts and ends with the individual experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas. This is about not simply looking at people in terms of the cost of their care, or the types of interactions they currently have with local public services, but looking further to the root cause of the challenges many experience today, and how these can be converted into more positive experiences and outcomes in the future.

For Asmita, April and Les – typical individuals who are being supported by a range of local health and social services within the Triborough today, but have been identified as being at high risk of losing their independence – our focus is on helping them to manage their physical or mental health conditions, and enabling them to live safe, well and comfortably in their own homes and communities for as long as possible.

In practice, this means that from 2015/16 we will work towards the following vision:

- **The care I receive is built around me:** Asmita and April both have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which they can access and control is used by the clinicians and care workers who are involved in their care, to ensure they only ever have to tell their story once. They know they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell.

- **My health conditions are under control:** Asmita, April and Les each have a single care plan and have been provided with simple devices and support that allow all three of them to self-manage their conditions on a daily basis. With clearer information and advice, and knowing that professional support is there if they need it, they feel in control of their lives

- **I feel part of a community:** Asmita is part of the 'Shared lives' scheme and she regularly visits with her 'adopted' family who share her cultural background and enjoy spending time together. Les and April are linked into local voluntary schemes for older people, which allow sharing of experiences and for mutual support.

- **I am supported through difficult times:** When circumstances change, Les, April and Asmita are contacted to re-assess their needs. Their care co-ordinator is proactive in ensuring that support is available to them within their communities, through difficult times.

- **My neighbours are able to help me:** The local community organisations are able to provide lifts to take April and Asmita shopping once a week and ensure that they were accompanied to get back and forth for hospital and GP appointments. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- **My independence is respected:** The community independence team (a team including community nurses, OT's, geriatricians) provided both preventative care and planned support to April before and after her hospital stay, all helping her quickly to get back on her feet. Her GP was involved even whilst she was in hospital, supporting April's on-going care, and ultimate discharge back into the community

- **I live safely and well, where I want to be:** April's home was adapted with a stair lift and various simple aids around the home she is now at much less risk of falling. She has a choice of local providers who are there to provide the very best environment for her care.

- **I am treated as an individual and helped to stay well:** Specialists are on hand to help identify potential mental health issues and provide specialist advice and guidance as part of overall care planning. Asmita, Les and April all receive support in their communities, including through local community groups to help them stay fit and well.

As a result of these changes, Asmita, Les, April and those around them feel confident in the care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including their local A&E departments, are significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission. They routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

Over the next 5 years, community healthcare 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.

Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well.

We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

At the heart of this will be multi-disciplinary teams delivering an integrated Community Independence Service that will provide a rapid response to support individuals in crisis and help them to remain at home. The Community Independence Service will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our re-ablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

The aim is to reduce the volume of emergency activity and planned care activity in hospitals through the use of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the provision of Community Independence Services, will mean we will eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans are therefore designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and the individuals they care for in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that individuals can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provision of General Medical Service contracts, including named GPs for individuals aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

As a result of all of these changes, some GPs may have smaller list sizes with more complex individuals and with elements of basic care delivered by nurse practitioners; and in the acute sector, our specialist clinicians will work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a "whole person" way.

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 CCG and Local Authority commissioners will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities. In partnership with NHS England we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible and in doing so live healthy and well lives.

In order to track the results, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the Triborough are integrated around the NHS number, and individual information is shared in an appropriate and timely way.

We are ensuring related activity will align by working in close collaboration with the other boroughs in Northwest London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Our plans are aggregated into the Pioneer Whole Systems Plan in order to accelerate learning and joint planning. The NWL Integration Board provides oversight to this process, as described in the governance section; with each locality Health & Wellbeing Board taking the lead in approving local

joint commissioning plans.

3) CASE FOR CHANGE

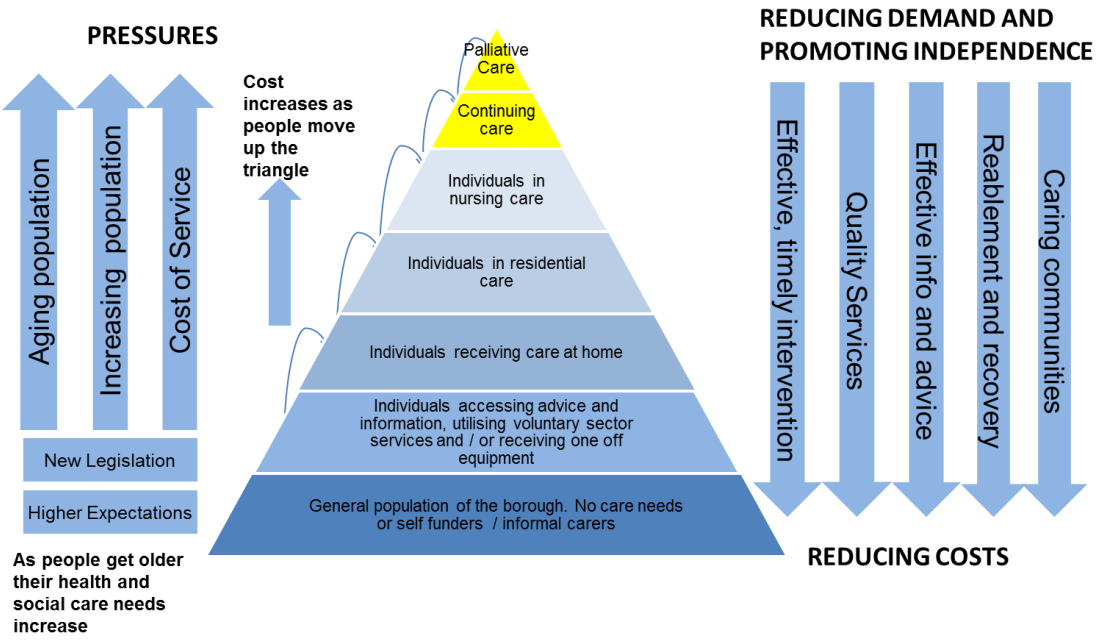
Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The demographic pressures of an ageing population with increasingly longer term, complex care needs and the downward pressure on public finances have compounded and require urgent and innovative responses from the health and social care sector.

There is a clear need for integration to support the shift in the centre of gravity away from treating people in expensive and often inappropriate acute settings and towards treatment and support for people in their own homes.

The diagram below sets out a summary of the pressures that are facing the health and social care system, and highlights the importance of integration and effective community care to help relieve some of these pressures.

Pressures and potential solutions for the local health and social care economy.



Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. Integrated care allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals. Creating networks of providers that deliver care across professions will make it possible to deliver innovative person-centred models of care, based around multi-disciplinary teams.

The Triborough Local Authorities and CCGs are already aware of the benefits of the integrated care model and have introduced various services that have improved the quality of care. The schemes that have been developed vary significantly in the populations they target, the design of the programme,

and the stage of implementation. In general, the efforts so far have been small in scale and tackled the problem piecemeal, which is insufficient in the face of the challenges ahead.

In addition, people's current experience of health and care services is often disjointed and fragmented. Each individual providing care may be doing a good job, but taken as a whole the individual and their family experience care that can be poorly coordinated and confusing. Our objective must be to deliver better organised care at home which therefore avoids preventable emergency stays in hospital, or long-term dependency on institutional care.

The Triborough Local Authorities and CCGs are uniquely placed to be in the vanguard of health and social care integration nationally, not only due to the partnership amongst the Local Authorities and combined approach to commissioning, but also due to the multiple change programmes already in progress across North West London which are transforming and reshaping the local health and social care economy.

Across the Triborough health and social care environment, there is already a shared commitment that:

- People are enabled and supported to stay as healthy and as independent as possible for as long as possible
- People are supported to live in the most appropriate place according to their choice and needs and are able to maintain maximum control over their lives.

The BCF creates a pooled fund to catalyse integrated working and is entirely compatible with whole systems integrated care programme, both of which deliver tangible multidisciplinary and integrated services and teams focused on delivering benefits to distinct cohorts of the population.

The current system does not always allow commissioners and providers to best meet the needs of service users. People who use services have identified three key reasons for frustration in their service experience that commissioners and providers can address through the enablers of whole systems integrated care that is at the heart of our vision (described in Section 2a).

Reason 1: Service users feel disempowered in a reactive care system
People who use services are disempowered by a reactive care system that focuses more on dealing with problems after they arise than prevention. This creates too many avoidable admissions, which can be unpleasant for services users and expensive for the system. The system is not set up to help people to not need acute services in the first place. We need to empower individuals to direct their own care, keeping them in their homes and local communities as much as possible.
Reason 2: Service user experience is confusing
Those with long term or complex conditions must interact with health and social care services frequently, but they receive fragmented and varied care. There can be a bewildering array of providers that may not appear to communicate with each other, and sometimes it is not clear to service users who is in charge. People may have to repeat their story multiple times to different providers, which makes accessing care a frustrating experience. National Voices has published several 'webs of care', designed by service users or their organisations to illustrate these challenges. We need GPs to be at the centre of organising and coordinating people's care.
Reason 3: Providers can find it hard to work together
There is sometimes little information flow between providers, which is frustrating for health and

social care professionals as well as patients and service users. This can be a barrier to collaborative working, and current funding and budget systems can make it hard to reallocate resources to where they are needed most. The system also needs to reward outcomes rather than activity. We need to help providers collaborate, and not get in their way.

Risk stratification

Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. Grouping the population helps to ensure that the models of care address the needs of individuals, holistically, rather than being structured around different services and organisations.

Through our Whole Systems Integrated Care Programme, a framework for grouping the population has been agreed for NWL, based on four primary organising characteristics:

1. Type of condition and age
2. Social and demographic factors
3. Utilisation risk (risk stratification)
4. Behaviour.

A summary description of groups based on these characteristics is in the table below:

Description of the groups

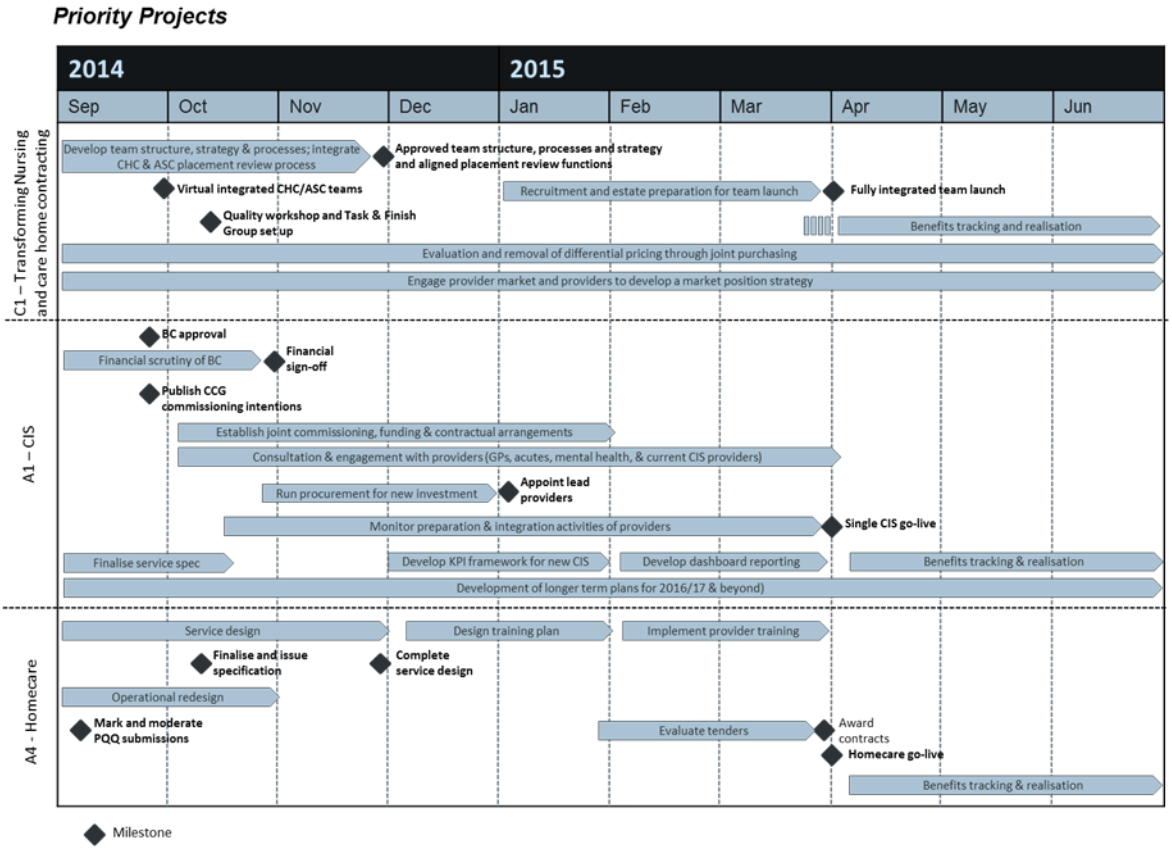
	Description of group
1 Mostly healthy adults <75	▪ People aged between 16-75 who are mostly healthy and do not have LTCs, cancer, serious and enduring mental illness, physical or learning disabilities and advanced organic brain disorders ▪ Includes those who have a defined episode of care, e.g., acute illness with full recovery, maternity
2 Mostly healthy elderly (>75) people	▪ Same as group 1 but for those who are above the age of 75
3 Adults (<75) with one or more LTCs	▪ People aged between 16-75 who have one or more long-term conditions, e.g., HIV, COPD, diabetes, heart disease ▪ Includes common mental illnesses, e.g., depression, anxiety
4 Elderly (>75) people with one or more LTCs	▪ Same as group 3 but for those who are above the age of 75
5 Adults and elderly people with cancer	▪ People aged above 16 who have any form and stage of cancer
6 Adults and elderly people with SEMI[1]	▪ People aged above 16 who have a mental-health problem (typically people with schizophrenia or severe affective disorder) who experience a substantial disability as a result of their mental-health problems, such as an inability to care for themselves independently, sustain relationships or work
7 Adults and elderly with advanced organic brain disorders	▪ People aged above 16 who have a decreased mental function resulting from a medical disease rather than a psychiatric illness; includes dementia as well as other conditions such as Huntington's and Parkinson's disease
8 Adults and elderly people with learning disabilities	▪ People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills ▪ Excludes mild conditions that does not have an impact on social relationships or work
9 Adults and elderly people with severe and enduring mental illness	▪ People aged above 16 who have a FACS eligible physical disability ▪ Excludes physical disabilities, including sensory disabilities, that are not FACS eligible ▪ FACS eligibility includes an inability to perform 3 or more household tasks
10 Adults and elderly people who are socially excluded[2]	▪ People aged above 16 who have chaotic lifestyles who often have limited access to care ▪ Includes the homeless, alcohol and drug dependency

1 Severe and enduring mental illness
2 For example, the homeless, people with alcohol and drug dependencies
Source: Whole Systems Integrated Care module working group

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The summary below shows high level activities and milestones for the main schemes that drive the majority of financial benefits in our plan.



b) Please articulate the overarching governance arrangements for integrated care locally

Across the Triborough, we have invested significantly in building strong governance that transcends traditional boundaries. The governance arrangements described below are designed to ensure all 6 sovereign entities are central to decision making without creating grid lock.

An Integration Partnership Board (IPB) provides a forum for Cabinet members and CCG Chairs (described in Section 4c below). The IPB 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 matured well. Joint commissioning intentions have been written this year covering all of our CCGs and Local Authorities, and Health and Wellbeing strategies have been developed based on the Joint Strategic Needs Assessments. 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 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 referred to above. This will enable us to put in place the new pooled budget required by April 2015. We anticipate that this will be hosted by the Local Authorities, 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.

Regular briefings to the Cabinet in each borough are designed to help to ensure that there is effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Cabinets are the constitutional forum for key decision making and a core part of the due process for the changes envisaged in this document, which also include scrutiny and challenge across each locality.

Across North West London, the North West London Whole System Integration Board, which combines health and Local Authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography.

Through appropriate governance processes, we will ensure there is a comprehensive view of the impact of changes across North West London on the Triborough, and vice-versa; and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

To deliver the ambition contained in our BCF, we recognise the need to develop our strategic and operational governance arrangements. Our Joint Executive Team (JET) acts as the single accountable team for the implementation of the BCF Programme and delivery of the BCF outcomes and indicators. The JET includes the Chief Officer and Chief Financial Officer and Managing Directors of the CCGs, and the Executive Director and Adults Leadership Team from the Triborough Local Authorities.

The JET reports to the 3 council members and 3 CCG chairs (see Governance Structure diagram below). In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Since the local government elections in May 2014, it is important to note that there is a new administration in the London Borough of Hammersmith & Fulham. The governance process will

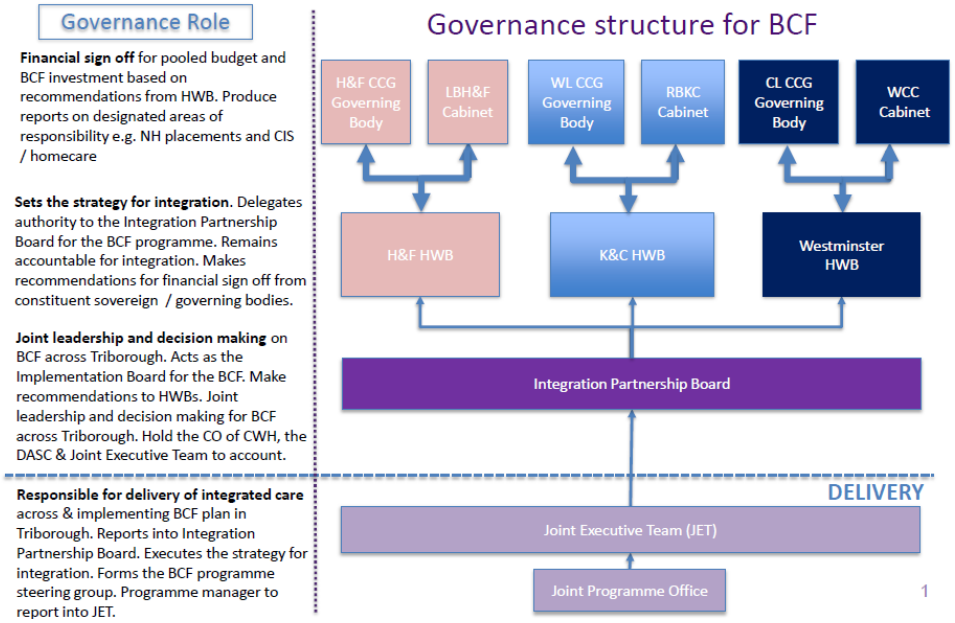
ensure engagement and approval at the appropriate level. We continue working together across the Triborough to build strong relationships and deliver the best possible outcomes for the population we serve.

Hammersmith and Fulham Labour Local Authority has given commitment to working on and delivering out of hospital care for their residents. However, this does not mean they support the plans to change the function of the A&E at Charing Cross. The BCF was agreed by the previous administration and the new Labour Council reserves their position currently on the alternative provision locally and offer to H&F residents until they have seen the detail and evidence on quality of GP access and performance.

Joint commissioning of community independence and re-ablement services will enable us to procure integrated and effective services in the community and in people's homes, preventing unnecessary admissions to hospital and reducing length of stay for those who are admitted.

Our business case for the contracting of nursing and residential care home placements demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. Our Local Authorities have a strong track record in this area and we are therefore looking at options for our CCGs to delegate this responsibility to the Local Authorities. We envisage that these joint arrangements would enable us to remove current gaps and duplication in procurement and improve oversight of quality and safety within this area of service provision.

The first step in doing this will be to pool our funding for these services, and to establish one team who will be responsible for managing the health and social care budget for these functions (including assessment, brokerage and in-house provision). There will be an agreed joint programme budget and agreed tolerances within which the programme will be managed, in line with current financial delegated authorities. If the programme looks likely to fall outside these tolerances for cost, quality or time it will be raised as an issue. The programme will be managed in stages with financial sign off at each stage. The programme office will provide a central role in providing control, reporting and assurance mechanisms. There will be a strong performance framework in place to monitor and manage the programme in line with its agreed purpose. Due process will be followed for all financial sign off, in line with statutory responsibilities. The diagram below outlines our governance structure across Triborough.



We will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Better Care Fund. We maintain a principle of pooling as much health and care funding as is sensible to do so, and a focus on developing our joint commissioning and outcomes frameworks to drive quality and value, reflecting the needs of our local communities as identified through the joint strategic needs assessment and captured in the Health and Wellbeing Strategies.

The IPB will act as the BCF implementation Board. They will be accountable for the delivery of the BCF programme.

JET will be responsible for delivery and report into the IPB. A joint programme office will be established to oversee, manage and co-ordinate this major transformation programme across the 6 partner organisations, to ensure the effective engagement of partners – service users, carers, citizens as well as service providers – and to evaluate the success of the programme, reporting to the IPB and Health and Wellbeing Boards on progress in achieving the outcomes agreed.

A central joint programme office will also ensure effective management of interdependencies within and between programmes, outline the critical path, manage and mitigate risks, monitor and measure benefits and outcomes, help to drive forward integration and provide assurance of investment decisions.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health & Care Budgets
	B3	Community Capacity
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

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
1) The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently.	This will impact on the sustainability of current social care funding and plans.	5	5	25	LAs	We will work with other local authorities across the country to monitor closely the anticipated impact of the Care Act.	We have undertaken an initial impact assessment of the effects of the Care Act and will continue to refine our assumptions around this as we deliver upon the associated schemes. We believe there will be potential benefits that come out of this process, as well as potential risks.
2) Procurement and HR lead in times.	Delay in scheme implementation.	4	4	16	CCGs/ LAs	Flag where timelines not being met	Ensure procurement and HR requirements understood and planned for and that these departments understand importance of timely implementation.
3) Shifting of resources to fund new joint interventions and schemes.	Destabilises current service providers, both in the acute and community sector.	4	4	16	HWB	Drop in quality of service of some providers. Closure of certain services.	Our current plans are based on the agreed strategy for North West London, as outlined in "Shaping a Healthier Future". The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Whole System Integrated Care programme, allowing for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process. We will establish strong mechanisms for involving service providers, both statutory and independent, in our programme.
4) Lack of detailed baseline data and reliance on current assumptions.	Finance and performance targets for 2015/16 onwards are unachievable.	4	4	16	CCGs/ LAs	Baseline data reviewed to test validity and whether refresh required	The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
5) Plans developed lack sufficient detail to enable effective implementation.	Implementation is slow and targets are not achieved.	3	4	12	Programme	Set clear timelines for delivery and ensure met.	Programme office will provide support to workstream leads to ensure completion of plans and practical achievable steps to implementation.

[1] Scale of 1-5, Low to High – Risk Rating = impact x likelihood

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
6) Operational pressures restrict the capacity of the workforce.	Unable to deliver the required investment and associated projects.to make the vision of care outlined in our BCF submission a reality.	4	4	16	CCGs/LAs	Monthly review of implementation progress to identify early any slippage in delivery	Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. We will build on existing arrangements such as the Whole Systems Integrated Care Programme which have already established some of the infrastructure and mechanisms for engagement, data gathering and analysis, and work closely with public health and the academic community to add value to our own capacity.
7) Improvements in the quality of care and in preventative services fail to translate into the required reductions in acute and nursing / care home activity by 2015/16.	Impacts on the overall funding available to support core services including social care and future schemes.	4	4	16	HWB	We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches.	We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches. We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. Financial modelling will include impact of changes on social care to ensure that social care is not disproportionately disadvantaged by the programme.
8) Risks associated with pooled budgets including longer term funding commitments and liabilities for withdrawal.	Unanticipated pressures on authority budgets. Reduced flexibility in year.	3	3	9	CCGs / LAs	Monthly/quarterly monitoring of activity and spend to provide early warning of variations from plan and disproportionate impacts.	The three local authorities and CCGs have established Health and Wellbeing Partnership Agreements which contain the necessary legal and financial framework to protect local sovereignty while facilitating partnership and collaboration. During 2014-15 the terms of the new pooled budgets will be developed, consulted up on and agreed to provide all authorities with the confidence and trust they need to go forward.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
9) Failure to meet the national conditions and performance outcomes agreed with NHSE.	Results in a need for external support (reputational damage)	2	3	6	CCGs / LAs	The programme office will ensure that we monitor carefully, understanding the attribution of outcomes between workstreams both within the BCF programme and externally,	Performance against the national metrics is already strong locally, so the setting of additional stretches is challenging and there is a risk of double counting. Take steps to address slow performance as soon as a problem is identified.
10) Lack of engagement from front line staff because do not buy in to the integration agenda or lack the skills.	Integrated services not effective and do not deliver better customer experience	3	3	9	Service providers	Review changes in work culture over the agreed period and evaluate staff commitment and delivery of integrated offer	Changing organisational structure is not necessary or sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care as well as the efficiency and effectiveness of delivery.
11) There is a risk of further national policy changes (such as additional adjustments to BCF funding, or restrictions on the use of funding).	Increase the strategic risks to Local Authority partners and lead to their withdrawal from the plan	3	4	12	Programme management	Close monitoring of developments	The Joint Executive Team will continue to work effectively to progress BCF plans and jointly review and discuss any further changes that may affect plan viability or increase collective or organisation specific risks ensuring that social care is protected.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
12) There is a risk that current challenges to local governance arrangements leads to delays in decision making.	The decision making process will create a blockage in implementation plans of schemes	3	3	9	LA/Programme Management	Close monitoring of developments	It is hoped that independent review of the partnership currently in progress will help to clarify what is needed to maintain effective working relationships in the Triborough.
13) There is a risk that misalignment of planning cycles (specifically the LA need for input to the 2 year MTFP cycle to include 16/17, vs. CCG financial plans and BCF allocation that are not defined beyond 15/16) leads to delay in decision making.	Planning cycles are not aligned with delivery of schemes and therefore key decision-making checkpoints are not met	3	3	9	Programme Management	Work closely with LA and CCG governance leads to mitigate	Close working between the finance teams across health and social care to share early stage plans and assumptions, with regular review of progress and issues.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Some 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

These principles suggest that the BCF can be made to work by keeping on top of the management information and refining the service model so that the required net benefits are achieved. There is of course the significant 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 currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. In addition, the risk will be managed through financial planning, which will include the setting aside of reserves and contingencies to manage risks.

The implementation of Whole Systems Integrated Care models, including capitated budgets across health and social care, will also help to manage the risk beyond 2015/16. Early implementers are currently developing their detailed plans to move into operation from April 2015, with shadow financial arrangements in place.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF is 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. Other programmes include:

- Adult Social Care Transformation (ASC Transformation)
- Whole Systems Integrated Care (WSIC)
- Primary Care Transformation (PC Transformation)
- Shaping a Healthier Future (SaHF)

There is strong alignment in the visions of for these programmes:

- They 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
- They 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

We are working together because as our populations grow, we share a commitment that local services should support individuals, their families and communities in living longer, and living well. Our understanding of physical and mental health is growing all the time, and new treatments are becoming available which make conditions that would have been untreatable in the past, into manageable "long-term" conditions.

Yet, while expectations are rising about the quality of life and support possible into old age, at the same time our resources are coming under ever-greater pressure, and there are real variations in the quality and results of care achieved across our populations.

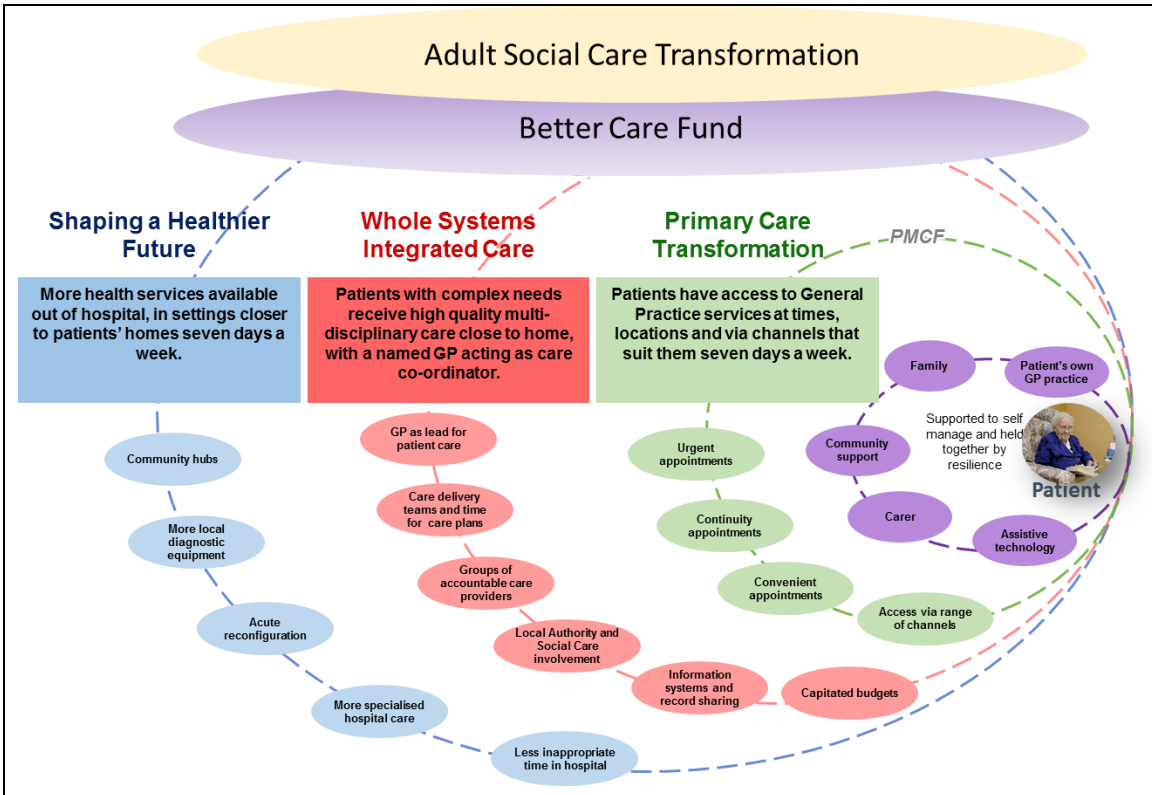
We believe that the future lies in services that are constructed around the people that they are intended to help; services which work jointly with individuals and their carers, to keep them independent and well. Each programme plays a distinct role in achieving these goals. In every area, there are "live" services today upon which our communities depend. By investing in the future, we can build upon the best of what exists today, and ensure that no-one falls between the gaps.

As demand increases and resources tightens, we need to "shift" towards better co-ordinated, person-centred care in our communities. This shift is not driven by cost efficiencies, but by the wishes of people to remain living safely and independently within their homes and communities rather than in hospitals or council-funded residential and nursing homes. With the right support, community and home-based care is often the best place for treatment. As a result, and if we are successful, we may have less need for hospital beds and institutional homes – but we will still need both, and overall we should be delivering more care, not less.

Each of these programmes are interlinked, designed to create integrated teams to deliver services that are constructed around the people that they are intended to help. These are services that will work jointly with individuals and their carers and will help them to remain independent and stay well.

Interlinking of transformational programmes across Triborough

The diagram below provides a visualisation of how the transformational programmes align:



Through programme structures and close working arrangements, we are ensuring that related activity aligns by working in collaboration with neighbouring CCGs and boroughs to co-design approaches to integrating care. This aims to ensure that shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

As described in Section 6a, the range of transformational programmes across NWL, including BCF, are aligned to deliver the overall vision of improving health and social care for the local population.
In the 3 CCGs' 2 year operating plans, CLCCG, WLCCG and H&FCCG have set targets for some key outcome ambitions that relate to initiatives within the BCF and align with the overall strategic vision and objectives. These key outcome ambitions include:

- Ambition for improving health-related quality of life for people with long term conditions
- Ambition for reducing emergency admissions
- Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and in the community

The 5 year strategic plan for NWL sets out how the 8CCGs, including the 3 CCGs that cover the Triborough area, and their partners will work collaboratively to transform the health and care landscape across the region in order to achieve its shared vision, deliver improved outcomes and

patient experience, ensure a financially sustainable system and meet the expectations of individuals using health and social care services. It sets out the collective plans and priorities of the eight CCGs working in partnership with NHS England and has been developed in line with NHS England planning guidance.

In particular the section within the 5 year strategic plan that focuses on Whole Systems, highlights the BCF and the need for all local areas to develop BCF plans. It is noted that these local BCF plans are an important stepping stone in the journey to long term transformation, with their focus on bringing together health and social care resources to deliver personalised and integrated care.
It also notes that the vision, principles and co-design work undertaken within the Whole Systems programme has been fundamental to the development of the BCF plans in each borough.

BCF plan alignment with Local Authority plans
The 3 Local Authorities in Triborough are running a strategic Adult Social Services Transformation Programme. This is an overarching 3 to 5 year programme that will:

- Help achieve savings of £45m over three years
- Meet the increased demand for care services from an ageing population and the requirements of the new Care Act
- Improve the experience of people by making services clearer and easier to use and more joined up

The programme focuses on aligning assessment and care management services within ASC to create a consistent core service offer and operating model; building more personalised community delivered care services that help people to be more independent; integrating social services with health, focusing on intermediate short-term care and care for people with disabilities and long-term health conditions.

The portfolio of programmes within the Triborough BCF plan align with the overall objectives for the Triborough Adult Social Services Transformation Programme and will contribute to the savings that need to be achieved.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

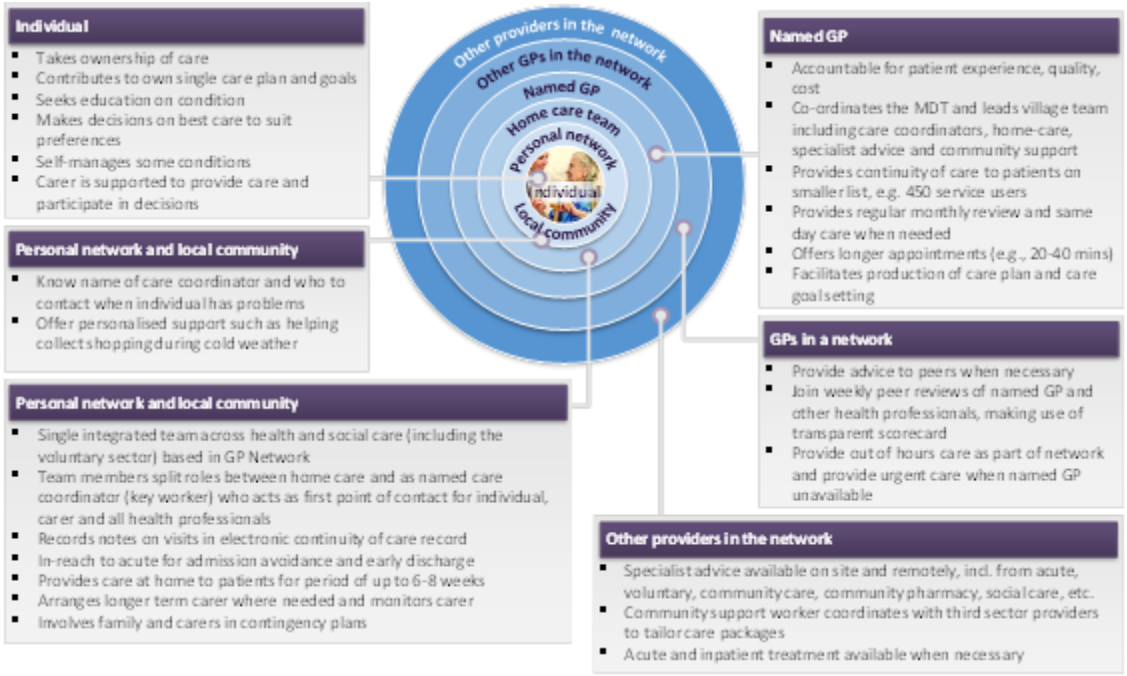
At the heart of the vision for whole systems integrated care – where care is proactive accessible, coordinated and personalised – General Practices (GPs) will be at the centre of organising and coordinating care for practice populations, both as individual practices and in networks delivering care seven days a week.

GPs are developing new ways of working and there is a programme of primary care transformation which sits alongside whole systems integration to support them. Some of the transformational initiatives include:

- Developing local GP networks to enable GPs to work together, share learning and resources (with the support of the PMCF)

- Introducing 7 day working in primary care
- Ensuring that a proportion of the significant additional investment in out of hospital care will be in general practice (£190m annual revenue investment).

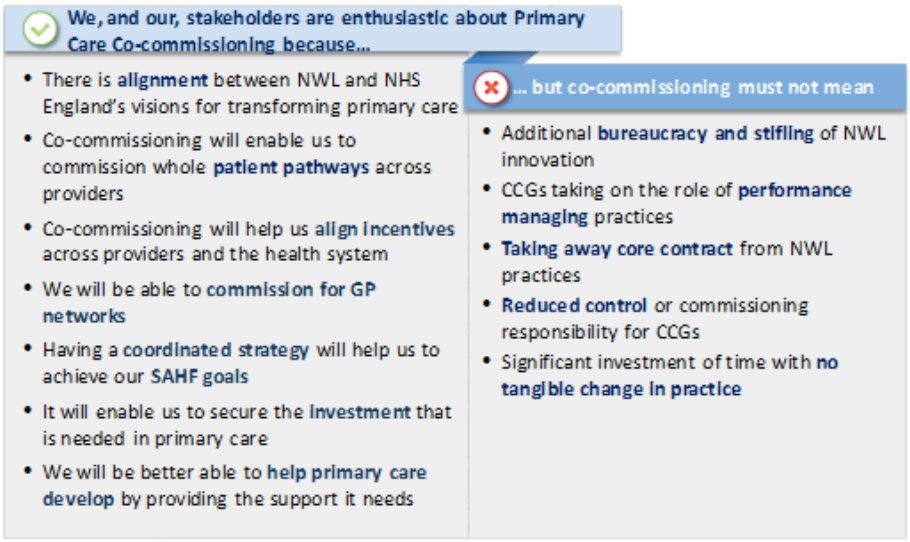
This will put the patient at the centre of their care, with a wide range of levels of care to support them.



Co-commissioning of primary care services is a way of enabling the changes being implemented. GPs want individuals to participate in a new model of care but need to develop and implement supporting contractual mechanisms that encourage both innovation and sustainability. It is felt that these mechanisms will be best established by the Triborough CCGs and NHS England working together as co-commissioners.
Current constraints faced by CCGs and NHS England to drive the transformation in primary care include:

- CCGs unable to shift funding from other parts of the health system to primary care, or make investments in enablers such as estates or IT
- Lack of local management resource in NHS England to drive change or proactively manage performance
- Paradox for the CCGs of being elected by GPs and being best placed to understand local needs versus requiring some 'distance' from general practice in their discharge of public funds

Commissioners across Triborough believe that co-commissioning needs to be about helping general practice to secure the right level of investment, provide greater flexibility to innovate and support GPs to improve quality of care and achieve better outcomes for individuals.



Proposals for Primary Care Co-commissioning

There are a number of models that can achieve Primary Care co-commissioning. CCGs have worked closely with NHS England, general practices across the region, lay members and other relevant stakeholders to explore the different options available, and have confirmed that the most appropriate model is for 'joint commissioning' arrangements, whereby CCGs and area teams make decisions together, potentially supported by 'pooled funding' arrangements.

Currently, an Expression of Interest has been submitted to NHS England (in June 2014) to pursue this model and there is consideration as to whether a shadow form of a joint committee may commence in November 2014, which could lead to a 'live' joint committee in operation from April 2015. Discussions about the responsibilities and functions of the joint committee are on-going, with a focus on commissioning rather than contract management or performance management.

Alignment of BCF plans with plans for Primary Care co-commissioning

As described in section 2, the BCF is an enabler to support the overall transformational portfolio of work being undertaken to deliver better outcomes and experiences for the population. Primary Care co-commissioning is a key enabler to supporting change that will impact both some of the schemes within the BCF as well as the wider whole systems integrated care programme.

Ultimately, having the Triborough CCGs and NHS England work together as co-commissioners will support the achievement of the vision for whole systems integrated care centred around Primary Care, with its priorities outlined below:

1. Enhanced patient and public involvement
2. Improved quality of services by improving standards and reducing clinically unexplained variations
3. Greater integration and therefore more efficient and effective use of resources and workforce
4. Reduced health and care inequalities with greater transparency and accountability.

Supporting the third priority the BCF is focused on developing improved ways of working for both the health and social care elements of the system. The BCF is redefining how different providers, with GPs at the heart of the system, will work together to deliver care.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting social care services in the Triborough means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility thresholds is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

A key component of the Triborough BCF plan is the additional investment in social care through the Community Independence Service to enhance rehabilitation and re-ablement services, reducing hospital re-admissions and residential / nursing home admissions.

Rehabilitation services will be delivered via an integrated CIS across health and social care, operating 8am to 8pm, 7 days a week, providing time-bound rehabilitation (therapies) for referrals via the Single Point of Referral service by treating people with non-complex conditions in a community setting. The team will respond to all referrals within 24 hours and commence care within 72 hours.

Reablement services will also be delivered via a multi-professional rapid response service (covering medical, nursing and social care), operating 8am to 8pm and 7 days a week. This will provide face to face assessment at home within 2 hours of referral, support up to 5 days following referral and providing referrals to ongoing support.

It is anticipated that the Community Independence Service will contribute to a reduction in admissions to residential and nursing care, and to lower level care packages to support people in the community in addition to enabling many clients to delay their need for long term care. However, it may also lead to additional pressure on social care by shifting the level of needs from continuing health care to local authority funded care and to short term pressures on social care for those people supported at home rather than in hospital. This additional pressure has been acknowledged in the financial arrangements developed for the Better Care Fund in Tri-borough and the proposed flow of funding into the local authorities to support this programme of work.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been

identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

There is protection of Adult Social Care through existing funds for "Social Care to Benefit Health" (>£11m across the Triborough), which will be via CCGs from 15/16. There is also funding from the CCGs through the BCF of £1.8m to support implementation of Care Act duties. Non-recurrent funding of £2.8m for new investment into the CIS in 15/16 will be funded by the CCGs. The total projected savings for social care set out in the BCF (£5.3m) will accrue as projects develop.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The implementation of the Care Act presents both opportunities and challenges for the Triborough which will be met with a strong commitment. The Act presents an opportunity for greater consistency in the delivery of care focussed on the wellbeing and outcomes for people, integration, carer involvement, transparency and personalisation. Key challenges arising from implementation of the Care Act, include:

- The impact of the reforms in terms of affordability including the impact arising from increased support for carers and self-funders
- Developing a shared understanding of the funding allocations
- Clarity about IT system requirements
- Developing the market and local communities, and the supporting information and advice to enable wider choice of care and support
- Working collaboratively across the Triborough and with external partners to deliver greater integration and partnership
- Clear communications with all stakeholders either involved in implementing the reforms or affected by them
- Workforce implications within the Triborough and externally

We have focussed on attaining compliance with the Care Act by April 2015 when the first tranche of deliverables are due. We have reviewed existing policy to align it to the Act followed by a review and redesign of the operating model and supporting infrastructure.

This will result in holistic assessments that enable improvements to provision of primary, secondary and tertiary services that help prevent, reduce or delay needs for care and support. Low care need will be met through effective care navigation, providing sufficient guidance on available local support, as a central component of the BCF redesign.

Those with low level need must be supported to stay healthy and independent, delivering preventative services to ensure needs do not escalate. Timely and accurate signposting allows for independent decision making and individual ownership of need reducing the pressure on health and social care professionals. A key enabler in adopting service user independence is the role of the carer and therefore a structured support service will be implemented (including carers assessments) to recognise the contribution of carers.

v) Please specify the level of resource that will be dedicated to carer-specific support

The level of resource dedicated to Carers' Services in 2015/16 is £1,931,875 which reflects funding for: assessment, advice, information and support, primary care navigators, personal budgets and health and wellbeing projects as well as respite care and short breaks.

The breakdown of resourcing is as follows:

Borough	Local Authority	CCG	Total
Hammersmith & Fulham	£230,200	£203,100	£433,300
Kensington and Chelsea	£116,450	£324,125	£440,575
Westminster	£641,700	£416,300	£1,058,000
TOTAL	£988,350	£943,525	£1,931,875

Figures taken from the s75 Service Schedules 2014/15.

vi) Please explain to what extent has the Local Authority's budget been affected against what was originally forecast with the original BCF plan?

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the Local Authorities to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible.

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Act requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

North West London was awarded "Early Adopter" status by the NHS England/NHSIQ Seven Day Services Improvement Programme, meaning that we have a responsibility to progress the 7 day services agenda at scale and pace. The Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (JHWS) have helped us to identify the main areas where integration and joint working will improve outcomes and informed our commitment to drive forward 7 day services.

The 7 Day Services programme is an overarching programme which includes a number of projects, many of which will be delivered through existing work streams. The work streams closely linked with

the BCF programme relate to social care and primary care providers.

Additional funding was identified within the Triborough area during the winter period of 2013/14 to facilitate 7 day services in health and social care. This enabled partners to assess what additional capacity is required to develop an on-going 7 day service offer and to evaluate how successful the approach is to facilitating discharges and avoiding un-necessary admissions.

Further work is also being undertaken to understand the Adult Social Care Customer Journey, including interfaces with health providers to enable timely assessment and transfer, and 7 day services in social care will be considered as part of this work.

A costed plan for 7 day services has been developed in 2014 for implementation in advance of the 2014/15 Winter period as part of the Triborough Resilience Plan and this will provide a basis for the establishment of 7 day services throughout the year from 2015/16.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health services use the NHS number as the primary identifier in correspondence.

Social services are in the process of adopting this, and we are committed to ensuring that use is universal across the 3 Local Authorities of the Triborough. The business case for this project has been signed off by the relevant governance bodies and the project is currently entering Phase 1. The technical changes required to achieve this have been defined and budget approved. The NHS number will be the primary identifier across all 3 localities by April 2015.

The information governance requirements to support data sharing have been defined and work is in progress as part of the BCF to embed them (see further details below).

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

We are committed to adopting systems based upon Open APIs and Open Standards. We already use:

- System One, a clinical computer system that allows service users and clinicians to view information and add data to their records
- Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record
- Carefirst 6, a software solution to provide a range of services and content to social care, while allowing the involvement of health care partners

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and

analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

By Autumn 2014, our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record. The BCF will help ensure this happens by joining up Health and Social Care data across the Triborough, linked as above via the NHS number.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

All of this will take place within our Information Governance framework, and we are committed to maintaining 5 rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users and patients should be treated confidentially and respectfully
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them should be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

Triborough local authorities are working closely with the NHS to put in place strong IG arrangements as part of the wider programme of integrated working and these will be completed during the autumn of 2014.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

An Integrated Care Programme has been implemented across local CCG areas that involves risk stratification of practice populations and review by multi-disciplinary groups, followed by implementation of care planning and case management as appropriate.

H&F CCG/ LBHF and WL CCG/ RBKC use the ICP risk stratification tool, modified from the Combined Predictive Mechanism (CPM), which has identified 4% of the population at high risk of hospital admission. CL CCG/ WCC uses WellWatch and are planning to transition from an approach which selects individuals on the basis of pathways, to one based on selecting individuals on the basis of their relative risk score. WellWatch may begin to use the ICP risk stratification tool in the future.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

We stratify segments of our population based on risk. The segments identified as high risk are (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) individuals over 75. The multi-disciplinary groups within each borough also use these segments as a basis for focussing their discussions.

Based on these four indicators, approximately 4% of our population is at high risk of hospital admission. Based on the algorithm and our stratification, we then closely monitor those classified as at high risk of hospital admission within the next year.

The Early Adopter pilots being proposed by the CCGs as part of the Whole Systems Integrated Care programme reflect a commitment by GP networks to undertake systematic risk stratification and care planning for their high risk populations and to develop an integrated response to providing treatment and care.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Each Triborough locality has set different targets around care planning:

- In H&F CCG/ LBHF, they are working towards the 4% having a joint care plan and accountable professional
- In WL CCG/ RBKC, all individuals with a risk score of 20 or over will be care planned, and those with a risk score of 65 or over will be case-managed
- In CL CCG/ WCC, WellWatch Case Management Services will care plan for those in the 61-91 centile risk stratified cohort

Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission.

Under the Integrated Care Programme, around 2% of individuals have a care plan, and this will increase to 4% to account for the population that has been identified as high risk. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as individuals' ages, to make its predictions.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The BCF is a key enabler for whole systems integration. Through patient and service user workshops, interviews and surveys, we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

At a Local Authority and CCG level, service users and carers are involved in developing person centred services and each Health and Wellbeing Board has adopted the National Voices approach, involving service users in identifying local measures of success.

Triborough Adult Social Care (ASC) has completed a Customer Journey project as part of the ASC transformation programme to understand better the views of service users and carers on their experience of social care. This builds on the information already received through the national survey and will inform our integrated operational working.

Feedback on the draft BCF indicated that there was great interest and enthusiasm from the voluntary and community sector, service users and carers, and representatives such as Healthwatch to be involved in taking forward integrated health and care.

A North West London Patient and Public Representative Group has been established, including CCG Patient and Public Involvement lay members, representatives from Healthwatch and from service user and carer groups to ensure that the patient perspective is reflected in all our programmes as they develop.

We will be building on these existing approaches to develop a strong service user and community voice within the Better Care Fund to ensure that our integration plans deliver better outcomes and experiences for all our citizens. The draft engagement plan is included in the supplementary documents.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans.

i) NHS Foundation Trusts and NHS Trusts

At programme level, the BCF plan reflects a number of existing programmes which have included health providers as active participants. Together with a range of local social care providers, and our voluntary and community sector as a whole, providers are now being engaged in developing future plans.

Details of existing consultation work can be found in supporting documentation including the Out of Hospital Strategies for each Triborough locality, and *Living Longer and Living Well*, our successful

application to become an Integrated Care Pioneer. A joint commissioner and provider forum across North West London forms a core part of the co-design work in our Whole Systems Integrated Care Programme. A number of the BCF workstreams are particularly relevant to our community health services providers and we are involving them closely in these developments.

We are developing our Communications and Engagement Plan to include a range of ways in which provider representatives, including front line staff, can be involved in the development, implementation and evaluation of all our programmes. Clinicians and other practitioners will play a key role alongside service users and carers in ensuring that the BCF makes a positive difference to people's lives

For some schemes there is already regular engagement with stakeholders from across the organisations involved, including relevant managerial leads, clinical leads and decision makers. For the Community Independence Service, where stakeholders have not yet been immediately involved in the project, concerted effort has been made to ensure that they have been consulted and informed of its progress through existing forums, such as Whole Systems Design Groups, Locality Meetings and Urgent Care Board. Whole Systems groups have been the primary vehicle for clinical and service user engagement, and will be the route used to consult on future models and their implications for providers. The Urgent Care Board, as the forum at which providers come together, has been used to ensure that acute and community providers are aware of progress with the initiative through a number of presentations at the board on CIS. In addition, specific engagement events have been held to communicate CIS programme intentions. These included a learning session, held at the University of Westminster in June, with attendance from acute, community and ASC providers and a presentation at subsequent ASC Leadership and operations team events.

ii) Primary care providers

There has been engagement with primary care providers through the Whole Systems Design and Locality Groups and through the Whole Systems Integrated Care engagement groups which have been used to inform decisions and monitor progress. We will increase the level of engagement with primary care providers in the next phase of the programme following from the detailed communications and engagement plan that is in production.

iii) Social care and providers from the voluntary and community sector

As part of creating the Triborough Market Position statement, dialogue on the BCF programme has been undertaken through existing forums with voluntary sector providers across Triborough. In developing the Better Care Fund plans for the future we are looking to link this wider range of social care and community providers to the Whole Systems forum as a reference group for the BCF and for the wider Health and Wellbeing programmes.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Transformation plans have been developed and consulted upon with Local Authority, hospitals,

community and mental health services and other local stakeholders fully engaged.

Achieving our targets will require significant investment in primary and community care and reduced acute activity, as described in the Out of Hospital Strategies. In Shaping a Healthier Future, we set out major changes in how services will be configured in our health economy over the next 3-5 years.

The North West London Whole Systems Integrated Care (WSIC) Programme and related initiatives are focussed supporting these developments through improving patient pathways to reduce hospital stays, by number and length of stay. We have evaluated our proposed changes on the Value for Money criterion. These covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The analysis indicates that commissioner forecasts over the five years (across NWL) involve a gross QIPP of £550m, with reinvestment in out of hospital services of £190m.

Our local community health services provider, Central London Community Healthcare (CLCH) and mental health trusts, Central and North West London Mental Health NHS Foundation Trust (CNWL) and West London Mental Health Trust (WLMHT) have been fully involved in the development of community services and in the co-production of different models of care to deliver the changes described above. The WSIC pilot schemes will see providers working together to offer integrated services to improve both patient experience and value for money.

We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so individuals can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings.

If we do not deliver activity reductions through improved out of hospital care, we expect most sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit. We anticipate that the changes proposed will have a significant impact on community services, and both statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan. We will be assessing this impact scheme by scheme in the next few months.

Over the course of 2015/16, through delivery of the BCF schemes and in particular a new single integrated Triborough Community Independence Service (and crisis response team) we expect to achieve a reduction in emergency admissions and delayed transfers of care equivalent to an average reduction in activity across the Triborough of approximately 5%.

The detailed table below provides the breakdown of numbers per Trust and splits the impact into 2 types: A&E admission avoidance and reduction in mon elective admissions.

Chelsea & Westminster

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	114	206,532	192	23,668
West London	301	571,094	506	64,068
Hammersmith and Fulham	197	357,030	230	30,053
Total	**612**	**1,134,657**	**928**	**117,789**

ICHT

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	496	898,597	834	102,978
West London	416	789,286	699	88,545
Hammersmith and Fulham	492	891,669	575	75,057
Total	**1404**	**2,579,553**	**2109**	**266,580**

GSTT

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	122	221,026	205	25,329
West London	0	0	0	0
Hammersmith and Fulham	0	0	0	0
Total	**122**	**221,026**	**205**	**25,329**

UCLH

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	55	99,643	92	11,419
West London	0	0		
Hammersmith and Fulham	0	0		
Total	**55**	**99,643**	**92**	**11,419**

The success of the Out of Hospital strategies across the 3 localities can already be seen by increased packages of homecare enabling better care closer to home and for individuals to be cared for within their own communities. The impact of this, as expected, has resulted in extra costs for ASC. This additional cost will be funded by CCGs and the teams are working together to demonstrate this linkage and enable the funding flows from CCG to ASC.

The Trusts are already aware of the BCF schemes at an operational level through the links to the Urgent Care Boards and how the schemes will strengthen and harmonise the approach to community care and confidence in out of hospital provision. The BCF Plan and in particular the Community Independence Service have been discussed at Chief Executive level with our local hospital and community providers to ensure a full understanding of the implications and how the BCF programme will contribute to the delivery of already agreed strategies for out of hospital care. This is reflected in the provider commentaries at Annex ii. We will also be working with all our providers over the coming months to further engage them in co-design of in depth solutions facing the health and social care economy in Triborough.

We have an agreed 5 year plan in NW London to implement SaHF which will create 5 major hospitals and also a significant shift of work to community / primary care setting. This will result in a significant reduction in emergency admissions. The plans contained in the BCF are consistent with this. For 14/15 contracts with both Imperial and Chelsea and Westminster hospitals a run rate reduction of 5% in emergency admissions. The proposals in the BCF are a continuation of this. We have not yet agreed the SLA for 15/16 and will be expecting them to contain the impact of the proposals in the BCF.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

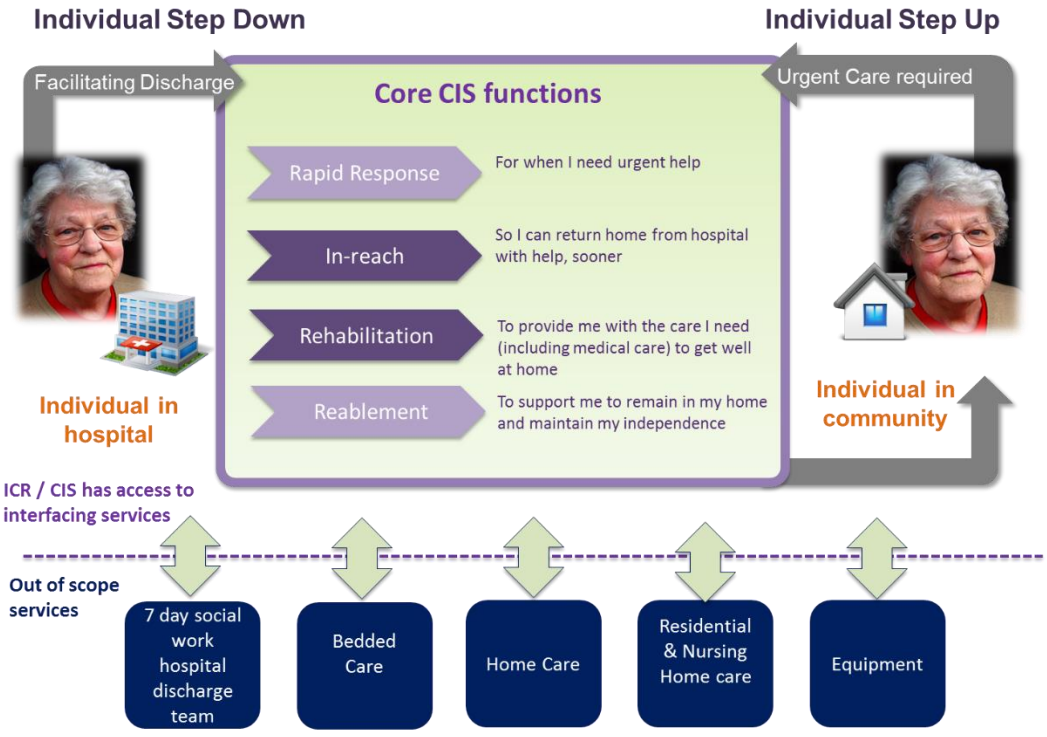
For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
A1
Scheme name
Community Independence Service
What is the strategic objective of this scheme?

As part of the BCF planning process, a detailed business case has been prepared to assist decision making by Triborough LAs, CCGs and Health & Wellbeing Boards in September 2014. It proposes the way forward to develop a Triborough Integrated Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the local population.

The Community Independence Service provides a range of functions including rapid response services to prevent people going into hospital, and rehabilitation and reablement which enable people to regain their independence and remain in their own homes.

Below is a simple visual of the proposed CIS model from the perspective of a person using the service:



Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

The aim is to develop a single model of care, working across the Triborough area to replace a range of variable specifications across the existing, often duplicated, services. The single service model

specified is both integrated across health and social care and multi-disciplinary (nursing, medical, therapies and social care) and operates 7 days a week. The proposal is to provide rapid and responsive care to support patients at risk of admission to hospital, enabling hospital inpatients to be transferred in a timely manner to community settings, and ensuring recovery. This service is to be jointly commissioned across health and social care and delivered across the three CCG and Triborough ASC service areas.

There are four overall features to this model of care:

1. Intensity of support to deliver care at home
2. Collaborative multi-disciplinary working
3. Effective information sharing
4. Best use of workforce skills

And four core elements:

1. Rapid Response
2. In-Reach
3. Non-Bedded Intermediate Care/Rehabilitation
4. Reablement

Target patient cohort

The target patient cohort includes:

- Individuals with long term care requirements who need support to prevent crises or deterioration
- Individuals who require support following discharge from hospital
- Individuals who need support to prevent (or delay) admission into hospital.
- Individuals who want to regain their independence at home or in another community setting.
- Individuals who require urgent care.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare NHS Trust
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham
London Central and West Urgent Care Centre
Central and North West London NHS Foundation Trust
West London Mental Health NHS Trust
Allied Healthcare

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National drivers

The demographic pressures of an ageing population combined with budgetary pressures and increasing costs exacerbates an already challenging environment. At present, care is fragmented across the health and social care provision and the approach to managing long-term conditions is outdated.

Local population need for intermediate care

As well as the health and social care economy in Triborough, there are also national pressures. The intention for community care, of which the proposals for CIS form a part, is that resources will be

made available to support the delivery of high quality care, with people in control of their care, within a viable and sustainable health and social care economy.

In July 2014, an assessment of the population need for Intermediate Care in the Triborough was completed. It considered:

- What is the need for intermediate care services in the local population?
- Do existing services meet this need?
- How will need change over the next 20 years?

The report identified the following key findings:

- Intermediate care services are mainly (but not exclusively) used by older people. Based on data from Hammersmith & Fulham, three-quarters are 71+ and 92% are 56+.
- Demographic change is likely to mean that need for intermediate care will increase by around 40% over the next 20 years, as the number of older people and the number of people with long-term conditions increases.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £23,514,141
Investment:- £2,681,180
New delivery costs:- £1,931,318
Existing costs:- £18,901,643

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £8,019,589
Savings from payments to acute providers:- £4,543,982
Savings form care home providers:- £3,475,607

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

New governance and management arrangements will need to be established to effectively manage the new Triborough CIS from April 2015 onwards. It is proposed that an operational management committee is established with representation from across the 6 commissioning organisations and that it will also include provider representation. The Committee will meet monthly to review performance and take key decisions in the ongoing delivery and development of the CIS. A single framework of Key Performance Indicators (KPIs) will be developed with associated dashboard reports to enable transparency of service delivery performance and enable the tracking of both costs and benefits.

The Committee will also track the development of the provider programme of integration and interoperability initiatives across the multiple providers to ensure that the 'transition year' achieves the target of delivering a 'single' service.

What are the key success factors for implementation of this scheme?

Key principles have been identified that will underpin successful implementation:

- Maintain strong relationships with other transformational programmes across NWL and the Triborough
- Develop genuine joint working between commissioners and providers to overcome challenges that arise
- Ongoing communications with all stakeholders to establish confidence in the CIS and its ways of working
- Ensuring cultural and behavioural change sits alongside process and system change

Scheme ref no.
A2

Scheme name

Community Neuro Rehab Beds

What is the strategic objective of this scheme?

To increase investment in additional community and bed based capacity, particularly for neuro-rehabilitation, and to extend the community rehabilitation period up to 12 weeks in the community including Homecare.

There is further work to do to confirm the costs and benefits of this scheme after plan submission. Costs and benefits sit with health.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

The rehabilitation services are commissioned across Triborough with the objective of providing goal focused interventions to facilitate the restoration of a person to regain optimal functioning (physically, psychologically and socially) to the level he/she is able or motivated to achieve (DH 2008).

This project will focus on the additional provision of neuro beds across Triborough with the aim of reducing delayed transfers of care.

Work to be undertaken as part of this scheme includes:

a. Establish the current referral and delivery pathway for bedded and non-bedded community rehabilitation /neuro-rehabilitation services
b. Analyse current need/demand for and waiting times for community based and other specialist hospital rehab/neuro-rehabilitation
c. Analyse performance of community rehab provisions (bedded & non-bedded) – nos. of referrals, LOS, waiting times (referral to 1st intervention)
d. Quantify the 13/14 costs in delivering the current rehabilitation/neuro-rehab service pathway
e. Redesign service pathway (assessment to delivery) for community rehab/neuro-rehab to reduce DTOC, LOS in specialist neuro-rehabilitation services and admissions to care homes
f. Specify the service types required to deliver the new service pathway
g. Quantify the cost of delivering the new service pathway
h. Quantify the potential saving if new service pathway is delivered (including any assumption)

Target patient cohorts

Patients who require rehabilitation services to regain a loss of physical, mental or social functionality

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare NHS Trust
Imperial College Healthcare NHS Trust
Chelsea and Westminster NHS Foundation Trust
Alexandra rehabilitation unit (RBKC)
Ellesmere rehabilitation unit (RBKC)
Thamesbrook rehabilitation unit (RBKC)
Athlone rehabilitation unit (WCC)
Farm Lane rehabilitation unit (LBHF)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Intermediate care and rehabilitation delays remain a consistent issue in the two acute hospitals - Chelsea & Westminster Hospitals (CWH), and St. Mary's Hospital (ICHT).

The table below shows the total numbers of delay days lost reported to NHS England relating to intermediate care and rehabilitation for the first three quarters of 2013/14.

Delays per borough area - intermediate, rehab	**1st April – 30th June**	**1st July – 30th September**	**1st October – 31st December**	**Total**
Kensington & Chelsea	124	144	313	581 days
Westminster City Council	391	197	147	735 days
Hammersmith & Fulham	164	107	104	375 days

The solution requires a multi- pronged approach for bedded provision, including:

- Better demand and capacity modelling to understand current and future need
- Redesigning a clinically efficient as well as a cost effective care pathway
- Streamlining (and in some cases changing) the referral pathway from acute to test community capacity/capability to provide rehab support in community based settings
- Re-designing existing community rehab provision (bedded and non-bedded) to provide step down neuro-rehab support for people to reduce DTOC in acute and LOS in specialist (short - medium term)
- Improving the process of access and communication into current bedded provision
- Bolstering home based capacity within Community Independence Service (CIS) - to reduce need for bedded provision - including readily access to medical support
- Commissioning additional rehabilitation capacity or changing the existing use of some of the current rehab beds
- Ensuring that community teams (neuro/Stroke ESD) to follow up patients in specialist neuro-rehab and work with ASC to support them back into community

Further micro analysis of the summary data on DTOC associated to intermediate care and rehabilitation indicate that approx. 50-60% of the acute bed days relate to neuro-rehabilitation.

In addition the mapping of current community based rehab/neuro-rehab services (bed and non-bedded) indicate a gap and need for:

I. Step down neuro-rehab bedded services to provide disability management to support those waiting for specialist neuro-rehab, as well as facilitate discharge from specialist rehab services.
II. Step-down neuro- rehab for people with functional and organic mental health needs/presentation who require both physical and cognitive rehabilitation to meet their needs.

Lack of step down neuro-rehab options within our bedded provision mean that the system is unable to provide informed and cost effective 'maintenance' neuro-rehab when a person is experiencing a wait for specialist neuro-rehab intervention. This is therefore likely to lead to longer length of stay in costly specialist centres for some people as they become more debilitated and dependent whilst waiting for specialist services.

Initial quantification work undertaken in CWH and modelled across ICHT indicates a requirement for community based step-down neuro-rehab of between 15 – 20 beds across Triborough areas. This could potentially increase to 29 beds if the needs of Ealing and Hounslow areas are included.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £2,808,000 (new delivery costs – draft subject to further work)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Total:- £1,417,758 (draft subject to further work) Cashable savings from payments to acute providers:- £849,918 (as above) Cashable savings from payments to community providers:- £567,840 (as above)
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This will be determined with further work on this scheme, following prioritisation to date on scheme A1 Community Independence Service.
What are the key success factors for implementation of this scheme?
As above

Scheme ref no.
A3
Scheme name
Homecare
What is the strategic objective of this scheme?
To successfully commission, procure and implement a new Homecare service in Tri-borough that will better enable our patients and service users to remain independent in their own homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of care The programme aims to commission, procure and implement a new and improved homecare service across the 3 Tri-borough LAs. The service will be based on: • Achieving outcomes for people using services, moving away from "time and task" focused provision • Providers working directly with people using services to agree details of care and how outcomes will be achieved • Ensuring that dignity and compassion are core values in the service • A measured integration of health and social care tasks over the life of the contract • People being helped to feel a part of their local community In order to achieve the above, we will need to deliver on a number of objectives. The main objectives have been set out below: 1. Development and sign off of a comprehensive service specification 2. Development, issue and evaluation of a pre-qualifying questionnaire (PQQ) and invitation to tender 3. Training needs analysis and workforce development plan for new providers and other existing providers with which the new service will be dependent on 4. An agreed plan of integration of social care and health care tasks over the course of the contract 5. A new e-monitoring system to support the monitoring and evaluation of the new Homecare service 6. Financial and information sharing protocols between Tri-borough Adult Social Care and Health 7. An agreed means to monitor and evaluate quality of care provided by new providers **Target Patient Cohorts** People who wish the Councils to arrange a care at home service on their behalf following an assessment of their need.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:
Central London Community Healthcare NHS Trust
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a national and local consensus that the current system of home care provision is not fit for purpose and cannot meet the increasing levels and complexity of need. The population of people that are being supported to live at home now have a range of complex needs and this population is increasing. Current activity and future projections show that home care services need to be able to support more people who have increasingly complex care needs. This requires greater integration with Adult Social Care services and Primary and Community Health Care provision.

In addition, in the current system, qualified nurses are spending time undertaking basic tasks that could be conducted more cost effectively by an unqualified resource, therefore releasing time for increased case management to registered nurses in the community. The LAs' & CCGs' commissioning intention to move towards an enablement model of care such as the Community Independence Service has also meant that the on-going long term care approach is required to adapt. The current system fails to capitalise on the health and well-being gains during the reablement period by providing a service that supports people by doing tasks for them. Key issues currently experienced include;

- Dissatisfaction from the LA regarding the high number of providers in the homecare market with varying quality outcomes and poor patient experience (as demonstrated in the skills for change report)
- Difficulty for CLCH to fully recruit to nursing posts and retain experienced staff leading to inconsistency in workload distribution
- Failure for CLCH to ensure that appropriate health tasks are delegated to unregistered nursing staff leading to highly paid nurses provided low level healthcare support.

As part of the homecare initiative a consultation report was produced by Frameworks 4 Change, an independent provider who facilitated the consultation events on behalf of the Tri-borough. In summary, people felt that the key features of any new service should be:

- Consistency of care worker
- A service which looks more widely at people's lives including outcomes for them
- A more streamlined assessment process
- Integrated care provision
- Support for people to lead good lives.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

New joint contractual arrangements following homecare procurement will provide better information to enable an understanding of drivers of cost. In the meantime, health and social care partners will jointly review long term trends within homecare to identify any systemic shifts in activity and if necessary undertake joint causal analysis to understand those movements.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

There are clear service improvement objectives associated with this scheme but BCF plan savings are not currently predicated on it.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are clear objectives in the scheme workplan to define monitoring and evaluation approach.

What are the key success factors for implementation of this scheme?

There are dependencies with the Customer Journey programme which is required to develop a solution to both the functional and business change requirements of the care at home programme.

The programme is dependent on the direct payments project delivering a suitable direct payments option for customers in time for contracts going live in April 2015.

Scheme ref no.

B1

Scheme name

Patient/Service User Experience and Care Planning

What is the strategic objective of this scheme?

This scheme focusses on developing two key aspects of care delivery:

- Patient and Service User Experience
- Self-management and Peer Support

To improve the way patient, service user and carer experience data is gathered, analysed and used to inform commissioning decisions and to work with support patients and communities to have greater control over their health and wellbeing by co-designing self-management programmes and interventions.

Better use of data in commissioning and a focus on evidence-based co-design of self-management and peer support programmes will positively impact patient experience and health and care outcomes.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

There are two interdependent tasks within the project;

- The first will develop in partnership with patients, service users and carers, an improved and integrated approach to data collection (quantitative and qualitative, experiential), consolidation and use. Outputs from this work will include a framework for engagement across all BCF schemes, underpinned by co-design principles. This will facilitate a more consistent and effective approach to the capture and use of patient experience data in commissioning.
- The second task will review and co-design self-management and peer support programmes and interventions; this will include the creation of specifications and subsequent development, implementation, monitoring and evaluation of these programmes. This task will help ensure patients and communities have greater control over their health and wellbeing.

This scheme will focus on:

- Service users, carers and adults with a long term condition, or at risk of a long term condition
- All GP practices within the three Triborough localities
- Hard to reach communities particularly those in deprived areas
- Vulnerable homeless adults

The development of self-management and peer support programmes/interventions will target in particular those with COPD, Cancer, Diabetes and/or Dementia. It will also seek to address the prevalence of long term conditions in black and minority ethnic communities, and in deprived communities. Importantly, this scheme will also deliver practitioner - based self-management training and development to professionals.

Our approach to each task will include the following stages:

1. Project mobilisation – PID, implementation plan, communications

2. Scoping and gap analysis - existing patient experience data and existing self-management programmes across the Triborough
3. Refining requirements in partnership with patients, service users, carers, 3rd sector providers and other key stakeholders and co-designing new approaches to capturing and using patient experience information. Collection and review of existing data and information and development of baseline positions against which to compare future performance
4. Development and implementation of best practice models and evidence based, co-designed programmes
5. Monitoring, evaluation, streamlining and feedback: describing how patient experience and insights are driving evidence-based decision-making and integrated care programmes across the Triborough. Describing how this is driving the development of a sustainable approach to self-management and peer support across the Triborough

Target patient cohorts

- People with a long term condition or at risk of developing a long-term condition
- Seldom-heard groups
- Vulnerable homeless people
- All GP Practices within the three CCG boroughs
- Hard to reach communities in particular within deprived areas

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- A significant amount of quantitative and qualitative data is collected on patient experience but this is not consistent across the Triborough, nor is it consolidated in a way that makes it easy to use in commissioning decisions
- There are gaps in our understanding of 'patient experience' and inefficiencies in the way we use this information to design and improve services
- We have responded to the NHS outcomes framework (domain 4), which states that the NHS should collect and use patient experience information in real time and use it for service improvement
- This will support delivery against the NHS Patient Experience Framework which draws attention to coordination and integration of care across health and social care systems
- Evidence supporting increased self-management can be found within:
  - The Health Foundation 'Co-creating Health'
  - NHS Outcomes Framework - domain 2
  - Transforming urgent and emergency care services in England
  - The Cochrane Collaboration - Self-management education programmes
  - Kings fund self-management and long-term conditions

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total: -£500,000 (new delivery costs)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and

is not working in terms of integrated care in your area?

In line with good practice, a feedback mechanism will be developed to ensure patients, service users, communities and the public are informed about changes to service commissioning or delivery as a result of their feedback. This scheme will also be governed through the following:

- Programme Board for the Better Care Fund
  - A Board comprising of key stakeholders for the Better care fund who meet monthly
  - The board will provide sign-off for key deliverables and resources
  - The quality review process should check to identify any: errors, omissions, misunderstandings, false assumptions, ambiguity and non-compliance with any local quality standards.

- WSIC Lay Project Group
  - A group comprising of lay representatives who meet bimonthly
  - The group will provide the mandate for the project and ensure that project delivery is transparent, accountable to local people, and aligned with the patient experience framework and co-design principles

What are the key success factors for implementation of this scheme?

- Ensure that the engagement and communication co-design approach is aligned with the full BCF programme
- Ensure the right stakeholders are included and engaged early and appropriately and ensure resources are approved
- Ensure the designed approach identifies and focuses on gaps
- Gather the specific demographic and patient cohort information required, drawing on other BCF schemes
- Co-design with service users, patients and carers, use local knowledge and ensure an effective feedback loop
- Ensure modelling within the WSIC includes long term conditions
- Identify appropriate infrastructure/ platform for interactive internet based forums
- Ensure any procurement commences as soon as possible after project approval
- Ensure there is rigour in setting targets and indicators for success are clearly defined and measurable

Scheme ref no.

B2

Scheme name

Personal Health and Care Budgets

What is the strategic objective of this scheme?

To extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

This is a compliance project which must be live by April 2015. This project will build on the existing Personal Health Budgets to:

- Ensure that the PHB programme for continuing healthcare is rolled out across all care groups in a consistent manner, with evaluation and quality assurance mechanisms developed and monitored.
- Ensure that the Triborough CCGs and local authorities are ready to implement Personal Health Budgets for Long Term Conditions from April 2015
- Building on current arrangements, develop an integrated approach to the provision of personal budgets and personal health budgets, including direct payments, so that customers who are eligible for both budgets can use these to commission an integrated package of services.

During 2014/15 the project will:

- Implement Personal Health Care Budgets for Continuing Healthcare across all Children's and Adult Care Groups as required by NHS Operating Plan
- Consolidate arrangements for care management and financial management of direct payments of customers with PHBs, through the local authorities
- Scope and Pilot Personal Health Care Budgets for Adult with Long Term Conditions for implementation in April 2015
- Integrate Social Care Personal Budgets and Personal Health Budgets for Long Term Conditions through Integrated Care Pathways and Provision
- Prepare an Organisation and Workforce Development Plan for Front Line Health and Social Care Staff in the Implementation and Case Management of Personal Budgets for Long Term Conditions
- Scope the Financial Impact of Implementation for LTC on Existing Contracted Community Services
- Develop and implement a Quality Assurance Programme for Personal Health Budgets
- Commission a JSNA – Long Term Conditions (refresh) to inform the 2015 programme
- Develop Learning Networks across Health and Social Care to embed person centred planning and effective use of personal budgets

Target patient cohorts

- Children
- Older People
- Physical Disabilities
- Learning Disabilities
- Mental Health

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget, and this becomes a right to have a budget in October 2014. Personal health budgets are an NHS Mandate commitment and one of the tangible ways the NHS can become becoming dramatically better at involving people, and empowering them to make decisions about their own care and treatment.

The provision of Personal Health Budgets for Long Term Conditions is expected to be an NHS England Requirement for April 2015.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £100,000 (new delivery costs)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

NHS England Personal Health Budgets Delivery Team have developed a Self-Assessment Tool – Quality Markers of Progress which enables CCGs to self-assess and then benchmark their progress across other CCGs in London and Nationally.

What are the key success factors for implementation of this scheme?

- Ensure that policy guidance is the result of sufficient and appropriate engagement with all relevant stakeholders and financial scrutiny
- Accurate evaluation of the pilot scheme before roll-out to a wider volume of service users

Scheme ref no.

B3

Scheme name

Community Capacity

What is the strategic objective of this scheme?

To design and implement a project that develops community capacity and assets across Triborough.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The overarching objectives of the programme are:

1. To identify and map community and citizen assets in Queens Park and White City in relation to independence, health and wellbeing
2. To identify gaps and strengths in community and citizen assets
3. To mobilise community assets effectively and sustainably
4. To identify citizen and community level insights about where social capital can be strengthened or optimised
5. To design and deliver substantial, innovative interventions and actions which are co-produced with public and community sector
6. To make a measurable difference to key demand and quality indicators within the health and care system (e.g. urgent care demand, social isolation, residential/nursing care referrals)

There will be a requirement eventually for three projects to be completed:

The Design is Project 1 of a larger programme. Project 2 would consist of **Mobilisation and Trial Delivery**. Project 3 would consist of **Evaluation, Authorisation and Mobilisation and Tri-borough wide implementation.**

At this stage, the proposal is for Project 1 only. Within Project 1, we are suggesting 8 main components as follows:

- Discovery/framing
- Community asset mapping
- Asset valuation
- Trial design
- Business case
- Authorisation
- Mobilisation (part)

The trial design would develop a basket of outcome, system usage, process and experimental measure which would feed into an evaluation design for the trial (possibly involving Oxford Brookes as an academic partner).

The sorts of interventions and approaches to be included within the trial are:

- Self-care
- Public health interventions
- System leadership
- Demand segmentation – identifying high demand groups where there is potential for change
- Behaviour identification and behaviour change

- Social mobilisation via community networks e.g. faith groups
- Asset based working with natural networks such as families, friends, neighbours

The design process and trail could attract external funding and support.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This will be decided in more detail during the design phase.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Success of the community budget pilot
- Assumption that investment in neighbourhood networks and/or local area coordination can unlock these assets to provide supportive communities and contribute to reduced. This is set out in a number of reports including The Generation Strain, Collective Solutions to Care in an Ageing Society, IPPR, April 2014
- Assumption that Neighbourhood networks or local area coordinators benefit from being run by community organisations who can involve volunteers and neighbours in everyday tasks, and from being provided with a medium term funding agreement (5 years in Leeds).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

N/A at this stage

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A at this stage

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Project steering group to be established. Project partner to be appointed to deliver project to time and budget. Steering group to oversee outputs and address any obstacles encountered

What are the key success factors for implementation of this scheme?

- Successful design and strategic alignment of the scheme
- Sufficient engagement and consultation with local community providers

Scheme ref no.

C1

Scheme name

Transforming Nursing and Care Home Contracting

What is the strategic objective of this scheme?

To create a single care home placement contracting team across health and social care and to develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care

The purpose of this project is to align available resource and develop a consistent, joint approach to contracting, quality assurance and safeguarding across Continuing Healthcare (CHC) and Adult Social Care (ASC) nursing and residential placements and will realise quality improvements and process and cost efficiencies though integrated working practices and more proactive market management and engagement.

The **objectives** of the project are to:

- Improve the quality of the placement experience through implementation of a more streamlined and integrated ASC/CHC customer journey
- Improve process efficiencies
- Realise cost savings by improving value-for-money in parallel with service quality
- Establish an integrated ASC/CHC placements team that will implement a consistent approach to contracting and brokering placements and ensure a joint response to safeguarding issues across the Triborough
- Improve governance and reduce process barriers to achieve efficient contracting and purchasing Triborough ASC and CHC placements
- Achieve more rounded pricing and consistency of contracts across ASC/CHC placements within the Triborough
- Singular ASC/CHC invoicing for providers.
- Evaluate, align and optimise placement review resources cross ASC and CHC placements
- Improve contract management and quality monitoring
- Embed placement reviewing officers/nurses within the joint ASC/CHC team to improve information sharing around quality assurance and safeguarding.
- Foster relationships with providers to tailor services to meet the needs of the Triborough population to optimise capacity, improving quality and placement outcomes.
- Identify opportunities for proactive management of the provider market to optimise provider relationships, optimise placement outcomes and future proof placement activities.

Target patient cohorts

Patients whose care needs demand placement in a nursing or care home

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

It has been identified that when people require institutional care, their needs are higher and more complex. This is due to the fact that the UK population is living for longer with more complex health and social care needs. At the same time funding levels for both the NHS and local authorities are decreasing and patients wish to remain as independent as possible for as long as possible. There is therefore a need to commission improved residential and nursing homes that is 'fit for purpose' - safe, cost effective and quality driven.

An analysis of 2012/13 benchmarking data across the Triborough local authority highlights a wide range in price (between 22 and 102% difference) for similar placements across the three boroughs. For spot placements alone, £1.2m could be saved just from bringing 25% of the higher cost placements into line with the lower cost placements. The benchmarking data and analysis shows that in terms of average weekly expenditure (gross, by service and client group), Triborough spend exceeds the inner London benchmark for:

- Older people in nursing care
- Older people in residential care
- Adults with a learning disability in residential care
- Adults with a mental illness in nursing care
- Adults with a physical disability in nursing care

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £711,000
Investment:- £111,000
Existing costs:- £600,000
N.B. these costs include costs from scheme C3: Integrated Commissioning

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £1,200,000 (cashable savings from payments to acute providers)
N.B these benefits include benefits from scheme C3: Integrated Commissioning

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

New governance and management arrangements will need to be agreed to enable the CCGs to retain sight of continuing healthcare placement activities hosted by the local authority. The means by which the CCGs will remain accountable for the continuing healthcare budget, and the local authority for the adult social care budget, will be determined once the host arrangement for the team is confirmed. Establishment of an operational management committee, with representation from the 6 commissioning organisations and larger providers, is anticipated. Regular provider-commissioner forums are also anticipated to foster and strengthen provider relationships communication channels. Regular contract monitoring and quality assurance meetings will also be needed, at regular, repeat intervals, involving commissioner and provider representatives. Providers will be monitored against pre-agreed quality assurance metrics and key performance indicators to enable transparency of service delivery performance and enable the tracking of both costs and benefits.

What are the key success factors for implementation of this scheme?

- Achieving a shared vision (between local authority and Health stakeholders) of what constitutes quality in terms of nursing and residential care
- Developing a single contracting and brokerage team with an embedded, co-located placement review function to inform brokerage activities and more strategic commissioning of placements
- Avoiding cost-shifting between continuing healthcare and adult social care placements
- Focusing on quality and value – rightsizing contracts and continued evaluation of care package against needs (stepping down care requirements where appropriate)
- Strengthening of provider relationships and proactive market management to achieve quality and sustainability within the sector

Scheme ref no.

C2

Scheme name

Review of Jointly Commissioned Services

What is the strategic objective of this scheme?

To review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

Each CCG and Local Authority in Tri-borough has an existing S75 Partnership Agreement in place with an agreed Service Schedule of jointly commissioned schemes. The majority of these are lead commissioning arrangements where the local authority contracts on behalf of the CCG. There are a small number of pooled budgets.

This project will review all of the schemes within these programmes to evaluate the outcomes being achieved and the effectiveness of the commissioning and contracting approach in order to inform commissioning intentions for 2015/16 and recommend how these services should be commissioned in future.

The project will deliver:

- A report for each CCG and Local Authority on the schemes currently being jointly commissioned, containing a description of the services, an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of CCG Out of Hospital and LA strategies and the rest of the BCF programme and indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Target patient cohorts

- Older people
- Learning disabilities
- Mental health
- Carers
- Children with special needs

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The review will provide the evidence base to inform the assumptions on which services are redesigned or provided in the Commissioning Intentions.
Documents that will make up the evidence base include:

- A report for each CCG and Local Authority on the schemes currently being jointly commissioned, containing a description of the services, an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of CCG Out of Hospital and LA strategies and the rest of the BCF programme and indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £159,149,444 (existing costs)
Review existing s.75 services:- £110,803,620
WCC s.75 LD placements currently under review:- £10,502,949
Existing s.256 pass-through funds (including LA joint commissioning team spend):- £11,125,000
Existing community services:- £22,710,000
Carers:- 1,931,875
Reablement s.256:- £2,076,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Total: £1,839,245 Efficiency savings: £1,385,045 (S75 review) Cashable savings from payments to community providers: £454,200 (existing community services)
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The evaluation methodology will be considered by the BCF Executive Group and agreed before implementation. Progress reports will be received monthly to ensure that the project is on track and any problems are dealt with in a timely fashion since the project is time critical.
What are the key success factors for implementation of this scheme?
The services included in the Joint Commissioning Schedules link into a number of other BCF workstreams as well as other plans, for example the Learning Disabilities and Mental Health Commissioning Strategies. Success will rely on the services being evaluated within those wider contexts, not simply of themselves.

Scheme ref no.
C3
Scheme name
Integrated Commissioning
What is the strategic objective of this scheme?
To address the current fragmentation in commissioning across Triborough health and social care commissioners. In designing the new commissioning structures, the project will seek to understand, validate and address existing issues.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Model of care and support</u> It will review how services are currently commissioned and contracted and identify better ways to commission integrated services. It will therefore link with Scheme C2 which reviews those services currently joint commissioned and those community health services which could be jointly commissioned in future. This scheme will ensure that these developments contribute to the overall objectives of the Better Care Fund and are linked to make most effective use of resources and systematically review those associated aspects (such as assistive technology and housing support) which will add value to the programme. Key project objectives include: • Review the as-is model for ASC joint commissioning • Develop shared understanding between LA and CCGs of current issues • Design and implementation of new commissioning structures **<u>Target patient cohorts</u>** All patients with long term conditions who require an integrated response.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioners: West London CCG Royal Borough of Kensington and Chelsea Central London CCG Westminster City Council Hammersmith and Fulham CCG London Borough of Hammersmith and Fulham

Providers:
Central London Community Healthcare
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham
Imperial College Healthcare NHS Trust
Chelsea and Westminster Hospital

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

More effective integrated commissioning will support the delivery of high quality integrated care

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £711,000
Investment:- £111,000
Existing costs:- £600,000
N.B. these costs include costs from scheme C1: Transforming Nursing and Care Home Contracting

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £1,200,000 (cashable savings from payments to acute providers)
N.B these benefits include benefits from scheme C1: Transforming Nursing and Care Home Contracting

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

TBD

What are the key success factors for implementation of this scheme?

- Agreement that more integrated commissioning will improve efficiency, value for money and have a resultant positive impact on service users
- Accurate understanding of current risks and issues as well as all opportunities for improvement

Scheme ref no.

D1

Scheme name

Information Technology

What is the strategic objective of this scheme?

To implement IT solutions to link Triborough Adult Social Care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support
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. As part of this initiative we will:

- Implement a mechanism to ensure NHS numbers are up-to-date, validated and available in the ASC. This will be a key identifier which will facilitate creating a single view of a client's record
- Undertake an exercise within the ASC system to ensure there is only one unique record per client/service user
- Form a joint project group with appropriate representation from CCGs, key health care

providers, ASC and IT system providers

- Identify the data sets to be shared by ASC and Health Care with lead users from LA and Health Care providers (and potentially users and carers themselves)
- Agree through robust options analysis, the most appropriate manner of achieving IT integration. There are a number of options available, for example:
    - Building direct interfaces to ensure systems are fully integrated
    - Data warehouses which hold information centrally to create a 'single view of a client'
    - Middleware which views information centrally to create a 'single view of a client'
- Specify the agreed option and if necessary procure relevant providers
- Pilot for a specific service function
- Test and Implement

Target patient cohorts

N/A

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Currently, people often fall through the cracks between GP's and Care and Support provided in the community. Issues include:

- people having to re-tell their story every time they encounter a new service
- people not getting the appropriate support that they need because different parts of the system don't talk to each other or share information and notes
- vulnerable people often with complex needs not being readily identified and supported across multiple settings of care, increasing risk, costs and delivering poor outcomes
- older people discharged from hospital to homes not adapted to their needs, only to deteriorate or fall and end up back in A&E – cutting emergency readmissions will bring a much better experience for patients
- home visits from health or care workers at different times, with no effort to fit in with people's requirements
- patients facing long waits in hospital before being discharged in part because of inadequate coordination between hospital and social care staff

This scheme aims to solve these problems locally by attempting to integrate the Social Care and GP IT systems.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £810,558
Investment:- £609,881
New delivery costs:- £200,677

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

D1 is an enabler to transforming health and social care. It does not directly contribute directly to the performance measures included as part of the Better Care Fund (BCF) submission. However, good quality data and systems integration will be critical for the success of many of the other projects

included in the BCF.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
One single Project Manager will be responsible for delivering this scheme- a joint appointment using a combination of existing resources and specialist contract resources. Ideally this will be completed as a partnership led project with both GP representation and Social Care.
What are the key success factors for implementation of this scheme?
• Sign off and release of funding • Engagement with BCF scheme D2

Scheme ref no.
D2
Scheme name
Information Governance
What is the strategic objective of this scheme?
To implement IG solutions to link tri-borough social care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Model of care and support</u> Sharing of information between the NHS and Local Authorities is a critical enabler for the commissioning and provision of integrated services to our residents. In addition to providing the information technology to enable information to be shared between staff and with service users themselves, we need to ensure that we have robust information governance arrangements to protect people from the misuse of data, while ensuring that data is shared appropriately to keep people safe, provide integrated treatment and care and improve health and wellbeing. This scheme will ensure we have the necessary policies, procedures and practice in place and implemented. This is an enabler project for many of the BCF schemes. The project will deliver: • A review of information governance arrangements in Adult Social Care and Children's Services in the Tri-borough Local Authorities and recommendations for action to address areas of weakness • Delivery of action on the recommendations to put in place all the necessary arrangements to meet the requirements of Caldicott2 • Actions to develop practical but safe mechanisms for the sharing of data between the Local Authorities and the NHS for the purpose of integrated commissioning and contracting • Actions to develop practical but safe mechanisms for the sharing of data between the Local Authorities and the NHS for the purpose of providing integrated services • Actions to develop practical but safe mechanisms for the sharing of data between the statutory authorities and independent providers of services for the purposes of providing integrated services **<u>Target patient cohorts</u>** N/A
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioners: West London CCG Royal Borough of Kensington and Chelsea Central London CCG Westminster City Council

Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Others:
Caldicott Guardians
IT leads within Local Authority and NHS
IG leads within Local Authority and NHS

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Work on the WSIC Early Adopters has emphasised the importance of IG working between the Local Authorities and the NHS to deliver data analysis for planning, and information sharing for customer care planning and delivery.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

N/A

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Triborough Adults, Children's and Public Health Information Governance Group has been established to oversee the project. This will include representation from the NHS for the consideration of data sharing issues between authorities.

An IG specialist consultant has been recruited to undertake the review of current arrangements and make recommendations for action necessary to establish and maintain strong IG within the local authorities and between them and the NHS and independent sector partners. This work has been completed.

An IG Lead will be identified going forward who will work closely with NHS IG leads and as part of the London Network of Caldicott Leads.

The IG project will report into the BCF Executive Group and through them to the BCF Programme Board.

What are the key success factors for implementation of this scheme?

- Engagement with customers, both service users and carers, involving them fully in their assessment and care planning and ensuring they understand the way in which information may be shared in order to improve their care pathway is also part of the Customer Journey work being undertaken by Triborough Adult Social Care
- Appropriate infrastructure to prompt and record both the customer identifier (NHS number) and consent is being implemented through the Frameworki system now being used by the local authorities
- Infrastructure for sharing information between the various NHS bodies is being established as both GPs and community health services adopt the use of SystemOne

Scheme ref no.

D3

Scheme name

Care Act Implementation

What is the strategic objective of this scheme?

To implement the key requirements of the Care Act (detailed in the Care Act Impact Analysis) within the required timescales.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Care Act sets out key proposals for reforming the way in which adult social care (ASC) is funded. This includes a proposed Care Cap, which limits the lifetime costs an individual has to pay for their care, and the accompanying infrastructure required to manage the cap. At the same time, the Care Act will also impact upon the duties and functions provided by ASC services. Processes and practices will need to be reviewed to ensure that they are not only compliant with the new legislation but that the way in which we deliver care will enable us to deliver the changes required.

A report completed by a task and finish group in ASC in January 2014 recommended that a programme of work be carried forward in order to meet the legislative requirements set out in the Care Act. The report contains an impact analysis of each clause and prioritises the work that should be addressed in order of priority. The work in the Care Act Implementation Project according to the prioritisation methodology set out in that report. In summary the key requirements that the project will focus on are:

a) Duties on prevention and wellbeing
b) Duties on information and advice (including advice on paying for care)
c) Duty on market shaping
d) National minimum threshold for eligibility
e) Assessments (including carers assessments)
f) Personal budgets and care and support plans (reviewing the RAS to make sure we meet legislative requirements)
g) New charging framework
h) Safeguarding
i) Universal deferred payment agreements
j) Extended means test
k) Capped charging system
l) Care accounts

<u>Project Timescales</u>

The scale and complexity of this work is such that it needs to be managed as part of a separate project. Large scale change is required, across many different areas of the department. The Care Act replaces more than a dozen pieces of legislation and changes will range from minor (such as duties simply modernise existing law) to major such as for duties that are both new in law and in practice (such as advocacy, information and advice, care account etc.).

The first wave of legislation is due to be implemented in **April 2015,** with the remaining funding reforms in **April 2016**. Sub-groups will be responsible for scoping, delivering and implementing this change within a tight timeframe, taking account of and informing on-going Tri-borough projects, such as the commissioning review, and especially the Customer Journey Review. Successful implementation of the Care Act will require robust project management of a series of complex work streams.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

Royal Borough of Kensington and Chelsea
Westminster City Council
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme is a necessary enabler for implementing policy change/

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Total:- £1,888,288 Investment:- £138,850 New delivery costs:- £1,749,438
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
N/A
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
It is proposed that the project will be overseen by an Implementation Board co-chaired by the Triborough Executive Director of ASC and by the Triborough Director for Finance. Membership of the board will consist of a range of Triborough ASC officers, including participation of corporate colleagues in HR, Legal Services and Policy. The implementation board will meet on a monthly basis and oversee the delivery and implementation of the project. Portfolio Deliver Steering Group (ALTT) and Implementation Board to monitor. Stakeholder relationship with LGA, ADASS and London Councils will ensure that outputs are reviewed / informed with peers' methodologies and approaches to Care Act implementation.
What are the key success factors for implementation of this scheme?
• The Care Act updates the legislation which underpins social care practice and procedures. It is key that staff fully understand the Act. Staff will need to undergo training. Legal experts may be required to deliver some of this training. Initial legal training session for Members and senior management has been scoped and costed (to be provided by Belinda Schwer). More will be required • A clear communications programme will be required to underpin the implementation of the Act to ensure that staff and residents are appropriately engaged and prepared for the changes • In order to meet the requirements of the Care Act and support its implementation several projects will need to be undertaken. These projects are yet to be decided but the below states what some of the larger projects are likely to be: o Review of RAS o Development of local intelligence regarding self-funders o Development of local market intelligence o Review of assessment / review processes o Procure advocacy services • The Care Act will lead to a large increase in assessments and reviews, in the main from self-funders but also from carers. National guidance is that areas may wish to undertake 'early' assessments and reviews; 6 months prior 1st April 2016 • Training for operational staff will be needed to understand and implement new legal framework

D4
Scheme name
BCF Programme Implementation and Monitoring
What is the strategic objective of this scheme?
To successfully programme manage the BCF schemes, ensuring that each scheme delivers promised outcomes on time and to the right standard.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The programme management scheme is an enabler for the BCF. This scheme sits at the centre of the Triborough BCF and acts as the coordination point for all schemes.

The team will develop and manage a set of programme and project plans, tracking and mitigating risks and issues and managing the resource pool across the schemes. They manage progress against the plans and work with the LA and CCG to ensure that all decisions and documents pass through the appropriate governance mechanisms.
They will coordinate between the LA and CCG teams and provide regular updates to steering groups.

Target patient cohorts
N/A

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme is a necessary enabler for the programme. The schemes are based on PRINCE2 and MSP management principles.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total: £307,800 – NR Investment

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Regular review of management approach
- Flexible resource for programme and project management

What are the key success factors for implementation of this scheme?

N/A

ANNEX 2i – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Chelsea and Westminster Hospital
Name of Provider CEO	Tony Bell OBE
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,900
	2014/15 Plan	11,805
	2015/16 Plan	11,193
	14/15 Change compared to 13/14 outturn	905
	15/16 Change compared to planned 14/15 outturn	-612
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 612

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We agree with the overall direction of travel of the Triborough BCF programme and its constituent projects and the principle of the service changes that commissioners are trying to make. We have seen and had the initial opportunity to discuss the detailed business case for a new single TB Community Independence Service (CIS). It is understood that this forms the core of the BCF programme.

		A process is being put in place for us, as provider leads, to review and interrogate the CIS financial model which has generated detailed planning assumptions relating to an assumed reduction in non-elective (general and acute) admissions in 2015/16 compared to planned 2014/15 outturn. Interrogation of this model should help to satisfy us with regard to any specific assumptions and any reduction in activity.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We can confirm that our local CCG Commissioners have confirmed that their BCF assumptions are within existing QIPP and SAHF plans. Therefore will be contained within current CWFT strategic plans. What we cannot confirm at this stage without completion of the process indicated in stage 1 is the final impact on planned activity and contract value for 2015/16 or subsequent years. Commissioners have outlined in the business case that the next planned phase of implementation will involve a period of engagement with providers and commissioners to work through the detailed implications during Qs 3-4 2014/15. It is important to emphasise that this exercise should also reflect: 1) Impact of revised model of care on care pathways; 2) Impact on clinical governance, quality and performance 3) Impact on workforce 4) Impact on contract activity and values Once we have satisfactorily completed the planning process described, and gained assurance as to how the key outstanding items will be addressed, we will be able to fully assure ourselves of the deliverability of planned outcomes.

ANNEX 2ii – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Imperial Healthcare NHS Trust
Name of Provider CEO	Tracey Batten
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	27,206
	2014/15 Plan	27,027
	2015/16 Plan	25,623
	14/15 Change compared to 13/14 outturn	- 179
	15/16 Change compared to planned 14/15 outturn	-1,404
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-1,404

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15**	See attached letter

	outturn?	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2iii – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Guy's and St Thomas' NHS Foundation Trust
Name of Provider CEO	Sir Ron Kerr CBE
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	2,201
	2014/15 Plan	2,330
	2015/16 Plan	2,208
	14/15 Change compared to 13/14 outturn	129
	15/16 Change compared to planned 14/15 outturn	-122
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 122

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15**	

	outturn?	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2iv – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	University College London Hospital
Name of Provider CEO	Sir Robert Naylor
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	1,684
	2014/15 Plan	1,061
	2015/16 Plan	1,006
	14/15 Change compared to 13/14 outturn	- 623
	15/16 Change compared to planned 14/15 outturn	- 55
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 55

For Provider to populate:

	Question	Response

1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Hammersmith and Fulham

1. Reduction in non elective activity	
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	20,896
Change in Non Elective Activity	-741
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds Figures in £	
Financial Value of Non Elective Saving/ Performance Fund	1,343,249
Combined total of Performance and Ringfenced Funds	3,800,000
Ringfenced Fund	2,456,751
Value of NHS Commissioned Services	13,152,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	4,833	10,097	15,489	20,896
Cumulative Change in Non Elective Activity	-111	-259	-445	-741
Cumulative % Change in Non Elective Activity	-0.5%	-1.2%	-2.1%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	201,487	268,650	335,812	537,300

Health and Wellbeing Funding Sources

Hammersmith and Fulham

Please complete white cells

	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Hammersmith and Fulham	49,720	48,622
Total Local Authority Contribution	**49,720**	**48,622**
CCG Minimum Contribution		
NHS Hammersmith and Fulham CCG		13,148
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**13,148**
Additional CCG Contribution		
NHS Hammersmith and Fulham CCG	**12,630**	**18,385**
Total Additional CCG Contribution	**12,630**	**18,385**
Total Contribution	**62,350**	**80,155**

Summary of Health and Wellbeing Board Schemes

Hammersmith and Fulham

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	19,023	78,397			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	-	1,428	3,287	3,287	58k and non-recurrent CIS implementation costs of £870k (totalled in D
Other	-	330			
Total	**19,023**	**80,155**		**3,287**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		12,282
Continuing Care		-
Primary Care		-
Social Care		870
Other		-
Total		**13,152**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	(384)	
Increased effectiveness of reablement	-	(431)	
Reduction in delayed transfers of care	-	(251)	
Reduction in non-elective (general + acute only)	-	(1,442)	1,343
Other	-	(1,433)	
Total	**-**	**(3,941)**	**1,343**

D44 includes A&E savings as well as NEL admissions avoidance

Health and Wellbeing Board Expenditure Plan

Hammersmith and Fulham

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
A1 Community Independence Service	Social Care		CCG			NHS Community Provider	CCG Minimum Contribution		870
A1 Community Independence Service	Community Health		CCG			NHS Community Provider	Additional CCG Contribution		538
A1 Community Independence Service	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	4,487	4,487
A1 Community Independence Service	Community Health		Local Authority			Local Authority	Local Authority Social Services	1,906	1,906
A2 Community Neuro Rehab Beds	Community Health		CCG			NHS Community Provider	Additional CCG Contribution		828
B1 Patient/Service User Experience	Community Health		CCG			NHS Community Provider	Additional CCG Contribution		148
B2 Personal Health and Care Budgets	Community Health		CCG			Local Authority	Additional CCG Contribution		30
C1/3 Nurs/Care Home Cont/Joint Comm	Community Health		CCG			Private Sector	Additional CCG Contribution		33
C1/3 Nurs/Care Home Cont/Joint Comm	Community Health		CCG			Private Sector	Additional CCG Contribution	200	200
C2 Jointly Commissioned Services	Community Health		CCG			Local Authority	Additional CCG Contribution		3,287
C2 Jointly Commissioned Services	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		7,795
C2 Jointly Commissioned Services	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	883	610
C2 Jointly Commissioned Services	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	10,734	11,617
C2 Jointly Commissioned Services	Community Health		Local Authority			Local Authority	Local Authority Social Services		45,433
C2 Jointly Commissioned Services	Community Health		CCG			NHS Community Provider	Additional CCG Contribution		203
C2 Jointly Commissioned Services	Community Health		Local Authority			NHS Community Provider	Local Authority Social Services	813	230
D1 Information Technology	Other	Programme services	CCG			CCG	Additional CCG Contribution		180
D1 Information Technology	Other	Programme services	CCG			CCG	Additional CCG Contribution		59
D3 Care Act Implementation	Social Care		CCG			Local Authority	Additional CCG Contribution		517
D3 Care Act Implementation	Social Care		CCG			Local Authority	Additional CCG Contribution		41
D4 BCF Implementation / Monitoring	Other	Programme services	CCG			CCG	Additional CCG Contribution		91
Joint Contracts > £500k	Community Health		Local Authority			Local Authority	Local Authority Social Services		1,052
Total								**19,023**	**80,155**

Health and Wellbeing Board Financial Benefits Plan

Hammersmith and Fulham

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled “Aggregated benefit of schemes for X”, completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the “aggregated benefit” line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		A1 Community Independence Service	NHS Commissioner	(1)	1,281,109	(1,281,109)	5% YOY reduction in NEL admissions	Monitoring of NEL admission activity
Reduction in non-elective (general + acute only)		A1 Community Independence Service	NHS Commissioner	(1)	160,978	(160,978)	70% uplift on avoided A&E attendances	Monitoring of A&E costs
Reduction in permanent residential admissions		A1 Community Independence Service	Local Authority	(1)	87,440	(87,440)	5% reduction in care home admissions	Monitoring of residential care home costs
Reduction in permanent residential admissions		A1 Community Independence Service	Local Authority	(1)	296,496	(296,496)	5% reduction in total length of stay	Monitoring of nursing home costs
Increased effectiveness of reablement		A1 Community Independence Service	Local Authority	(1)	430,579	(430,579)	Net saving on homecare due to reablement	Increase in reablement service users
Reduction in delayed transfers of care		A2 Community Neuro Rehab Beds	NHS Commissioner	(1)	250,726	(250,726)	Bed day reduction	Monitoring of bed days
Other	Specialist hospital savings	A2 Community Neuro Rehab Beds	NHS Commissioner	(1)	167,513	(167,513)	Bed day reduction	Monitoring of bed days
Other	Maintaining contract rates	C1/3 Nurs/Care Home Cont/Joint Comm	NHS Commissioner	(1)	149,333	(149,333)	Analysis of spot/higher cost placements	Monitoring cost of placements
Other	Maintaining contract rates	C1/3 Nurs/Care Home Cont/Joint Comm	Local Authority	(1)	247,401	(247,401)	Analysis of spot/higher cost placements	Monitoring cost of placements
Other	s75 savings	C2 Jointly Commissioned Services	NHS Commissioner	(1)	145,209	(145,209)	Assumed contracts reviewed / savings %	Monitoring s75 expenditure
Other	Community savings	C2 Jointly Commissioned Services	NHS Commissioner	(1)	155,890	(155,890)	Assumed 2% savings	To be included in contract values
Other	s75 savings	C2 Jointly Commissioned Services	Local Authority	(1)	567,922	(567,922)	Assumed contracts reviewed / savings %	Monitoring s75 expenditure
Total						**(3,940,596)**		

Hammersmith and Fulham

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,688**	**2,928**	**2,999**	**3,007**	**2,623**	**2,841**	**2,892**	**2,838**	**2,789**
	Numerator	4,833	5,264	5,392	5,407	4,722	5,116	5,207	5,111	5,039
	Denominator	179,807	179,807	179,807	179,807	180,049	180,049	180,049	180,049	180,647

Rationale for red/amber ratings

P4P annual change in admissions -741
P4P annual change in admissions (%) -3.5%
P4P annual saving *£1,343,249*

Please enter the average cost of a non-elective admission[1] **£1,812**

Rationale for change from £1,490: Local calculation of emergency admission cost with Market Forces Factors

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Hammersmith and Fulham	% Hammersmith and Fulham resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Brent CCG	7,815	7,663	7,403	7,634	0.3%	0.5%	25	24	23	24
NHS Camden CCG	4,373	4,550	4,601	4,678	0.0%	0.1%	-	-	-	-
NHS Central London (Westminster) CCG	3,530	4,004	3,912	3,893	2.6%	2.4%	90	102	100	100
NHS Ealing CCG	9,339	9,834	9,854	9,868	0.6%	1.2%	58	61	61	61
NHS Hammersmith and Fulham CCG	4,776	5,182	5,325	5,354	91.4%	88.2%	4,365	4,736	4,867	4,893
NHS Hounslow CCG	6,036	7,003	7,050	7,054	0.5%	0.8%	33	38	38	38
NHS West London (K&C & QPP) CCG	4,415	5,085	5,086	4,889	6.0%	6.8%	263	303	303	291
Total						**100%**	**4,833**	**5,264**	**5,392**	**5,407**

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Hammersmith and Fulham

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**835.9**	**670.4**	**612.2**
	Numerator	140	118.5	109.7
	Denominator	16,985	17,669	17,923
	Annual change in admissions		*-22*	*-9*
	Annual change in admissions %		*-15.4%*	*-7.4%*

Rationale for red rating: Baseline numerator should be 117 (revised as a final figure since provisional results). Assume no change in 14/15 then 5% reduction on expected rate for residential and 10% on nursing ('as is' figure includes population growth)

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**92.9**	**89.2**	**89.8**
	Numerator	260	252	253
	Denominator	280	282	282
	Annual change in proportion		*-3.7*	*0.5*
	Annual change in proportion %		*-3.9%*	*0.6%*

Rationale for red rating: Local 13/14 data is considered to be inaccurate (too high) as changes in the law around data sharing between agencies has meant measurement in 13/14 could not be carried out as previously. Therefore, previous trajectory based on meeting top quartile average has been used, bas

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**701.7**	**555.9**	**623.3**	**399.7**	**530.7**	**520.1**	**509.5**	**498.9**	**488.3**	**477.7**	**467.1**	**456.5**
	Numerator	1,020	808	906	585	777	761	746	730	715	699	684	669
	Denominator	145,357	145,357	145,357	146,351	146,351	146,351	146,351	146,342	146,342	146,342	146,342	146,616
								Annual change in admissions	*-306*			*Annual change in admissions*	*-247*
								Annual change in admissions %	*-9.2%*			*Annual change in admissions %*	*-8.2%*

Rationale for red ratings: Seasonality not included in targets, as there is no justification for seasonal variation in D

Patient / Service User Experience Metric

Metric		Baseline July 13-Mar 14	Planned 14/15 (if available)	Planned 15/16
Patients had enough support from local services or organisations to help manage long-term health condition(s) - 'yes definitely' (National GP patient survey). For CCG. Those who say'haven't needed much support' excluded from baseline	*Metric Value*	43.6%	46.0%	48.4%
	Numerator			
	Denominator			
Improvement indicated by:		Increase		

Local Metric

Metric		Baseline Apr 11 - Mar 12	Planned 14/15 (if available)	Planned 15/16
Health-related quality of life for people with long-term conditions (NHS Outcomes Framework 2) - for CCG (according to Operating Plan)	*Metric Value*	74.60	75.14	75.38
	Numerator			
	Denominator			
Improvement indicated by:		Increase		

Hammersmith and Fulham

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

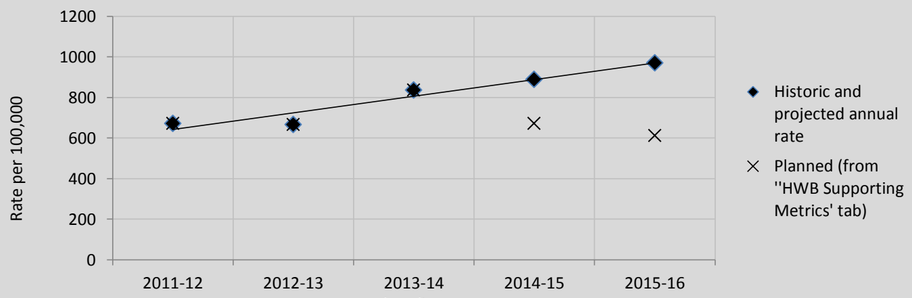
Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	4,598	4,918	4,902	4,833	5,264	5,392	5,407	5,579	5,712	5,846	5,979	6,113

Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*3,102.7*	*3,172.6*	*3,246.7*	*3,320.9*	*3,383.8*
	Numerator	*5,579*	*5,712*	*5,846*	*5,979*	*6,113*
	Denominator	*179,807*	*180,049*	*180,049*	*180,049*	*180,647*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

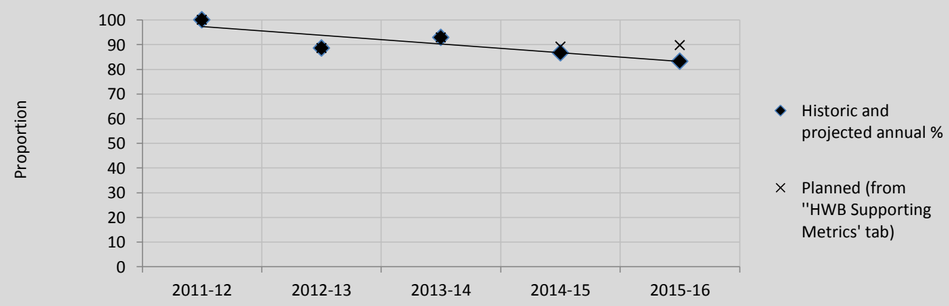
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	672	665	836	*888*	*970*
	Numerator	110	115	140	*157*	*174*
	Denominator	16,525	16,985	16,985	*17,669*	*17,923*



This is based on a simple projection of the metric proportion.

Reablement

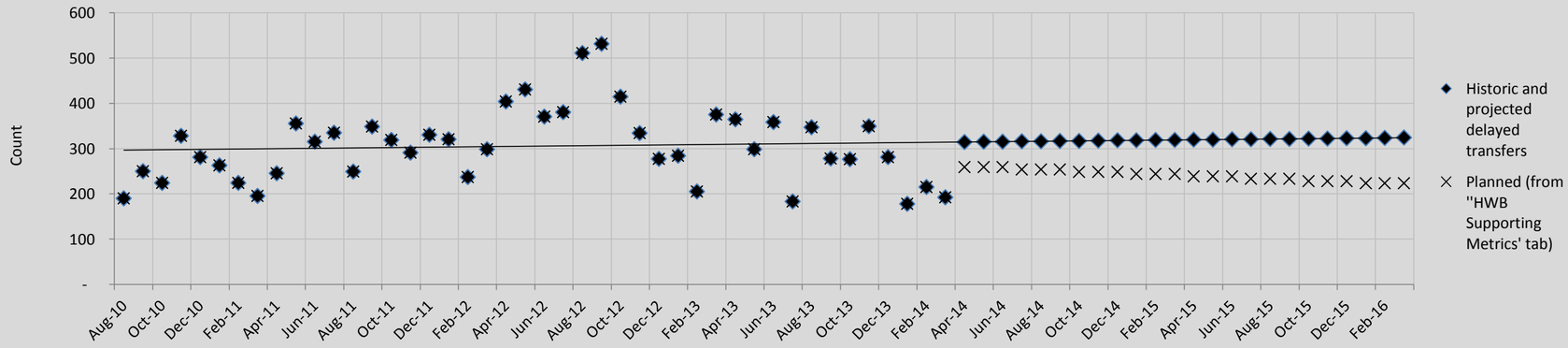
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	100	88.6	92.9	*86.7*	*83.2*
	Numerator	90	140	260	*243*	*233*
	Denominator	90	160	280	*280*	*280*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	190	250	224	328	281	263	224	195	245	355	315	335



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*645.3*	*647.8*	*650.3*	*652.8*	*655.3*	*657.8*	*660.3*	*661.6*
	Numerator	*944*	*948*	*952*	*955*	*959*	*963*	*966*	*970*
	Denominator	*146,351*	*146,351*	*146,351*	*146,342*	*146,342*	*146,342*	*146,342*	*146,616*

* The projected rates are based on annual population projections and therefore will not change linearly

Executive Decision Report

Decision maker(s) at each authority and date of Cabinet meeting, Cabinet Member meeting or (in the case of individual Cabinet Member decisions) the earliest date the decision will be taken	Full Cabinet Date of decision: 3 November 2014 Forward Plan reference: *N/A*	h&f hammersmith & fulham
	Full Cabinet Date of decision 18 September 2014 Forward Plan reference:	THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA
Report title (decision subject)	**REGULATION OF INVESTIGATORY POWERS (RIPA)**	
Reporting of	**Deputy Leader – Councillor Michael Cartwright**	
Reporting officer	Tasnim Shawkat - Bi-Borough Director of Law	
Key decision	Yes	
Access to information classification	**Open Report**	

1. EXECUTIVE SUMMARY

1.1. This report concerns joint working arrangements between the London Borough of Hammersmith & Fulham (LBHF) and the Royal Borough of Kensington and Chelsea (RBKC) for the exercise of functions under the Regulation of Investigatory Powers Act 2000 (RIPA).

2. RECOMMENDATIONS

2.1. That approval be given to a Joint Working Agreement for the exercise of RIPA powers, including sharing officers under section 113 of the Local Government Act 1972.

2.2 That approval be given to a joint policy on the use of surveillance powers including the use of surveillance not regulated by RIPA.

3. REASONS FOR DECISION

3.1 Officers have identified the possibility for more efficient working and a reduction in costs by combining their arrangements for authorising surveillance work and access to communication data. A joint policy with a shared regime of oversight will assist enforcement officers working in Bi-Borough services.

3.2 The Code of Guidance published by the Secretary of State under section 91 of RIPA advises local authority members to review the use of the Act and set the policy.

4. BACKGROUND

4.1. Both authorities occasionally use RIPA to undertake directed surveillance and access communication data in order to detect and prevent crimes such as fraud, rogue trading and social behaviour. Surveillance usually takes the form of officers in plain clothes observing activity, often filming it or taking photographs. The product of such surveillance can be very effective evidence in the prosecution of offenders and can lead to early admissions of guilt saving prosecution costs and court time. These powers have been used to detect various forms of fraud and to prevent the sale of prohibited goods to minors (more details can be found in Appendix 1).

4.2. The Authorities can access communication data from Communication Service Providers (CSP's) e.g. Royal Mail, BT and the mobile phone companies. RIPA does not allow for the interception of communications, it enables the Council to seek information about who someone has phoned not what they say. This includes information, itemised phone bills, periods of subscription and billing addresses. CSP's will only respond to requests for information via designated contacts that must have undertaken and passed a Home Office approved course. Both Councils use the NAFN (National anti-fraud network) service. Hammersmith and Fulham have only used this power twice since 2012 and this related to an investigation into a multi-million pound fraud.

4.3. Covert surveillance and access to communication data inevitably runs the risk that the privacy of persons under investigation as well as other people they associate with may be compromised. The Human Rights Act 1998 requires a public body to have respect for an individual's private and family life in accordance with Article 8 of the European Convention on Human Rights. This is a qualified human right and Article 8(2) provides that the right may be interfered with so long as it is done in accordance with the law and "is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

4.4. The Regulation of Investigatory Powers Act 2000 introduced a process for balancing an individual's rights with the authority's obligations to enforce laws on behalf of the wider community. The Act makes all conduct carried out in accordance with an authorisation granted under the terms of the Act lawful "for all purposes". This is in effect a statutory defence to any claim by a resident that their rights, including human rights such as those under Article 8, have been breached by the authority's surveillance activity. The defence is only available if the surveillance is "necessary" and "proportionate" and has been approved by both a council authorising officer and a magistrate.

4.5. Use of covert surveillance by local authorities is a politically sensitive subject and has received a lot of press attention.

4.6. The number of authorisations approved in the two boroughs since the start of 2012 is set out in Appendix 1. The main use of directed surveillance in the London Borough of Hammersmith & Fulham has been directed at preventing anti-social behaviour.

4.7. In the Royal Borough of Kensington and Chelsea surveillance, techniques have been used to detect fraud such as unlawful use of disabled parking facilities and benefit fraud and in operations to prevent sales of alcohol, tobacco and knives to children.

Judicial Consent

4.8. Since 1st November 2012 a local authority wanting to use covert surveillance, acquire communications data or use human intelligence sources under RIPA are required to obtain an order approving their authorisation from a JP (District Judge or lay magistrate).

Crime Threshold

4.9. The other major change since November 2012 is that local authorities can only authorise covert surveillance under RIPA when investigating criminal offences that are either punishable by at least 6 months' imprisonment or are related to the underage sale of various prohibited items.

5. PROPOSAL AND ISSUES

5.1. RIPA sets out the process of authorising and monitoring surveillance activity and obtaining communication data. The Home Office has prescribed forms for the granting, review, renewal and cancellation of authorisations. The Council's joint policy puts these into effect.

5.2. Complying with RIPA involves a substantial commitment of resources by each Council. Records of each authorisation, its grant, review, renewal and cancellation must be kept for three years and a central register of authorisations and a register of officer training must be

maintained. A Senior Responsible Officer (SRO) must review all RIPA activity and every two years there is an inspection by the Office of Surveillance Commissioners (OSC). For a relatively few operations involving surveillance this does take a disproportionate amount of time. It is hoped that by combining the two authorities' arrangements we will reduce this. The OSC inspector has endorsed greater assimilation of policy and practice between the two Councils and commented that each Council may gain from the experience of the other.

5.3. It is therefore intended that the two Councils adopt the same policy and procedures for the use RIPA and non-RIPA (see 8.7 below) surveillance. The Bi-Borough Chief Solicitor will be the single SRO, five senior officers (three from LBHF and two from RBKC) will be Authorising Officers capable of granting authorisation to officers of either Council. A single central register will be maintained by Legal Services. A Joint Working Agreement enabling this and the sharing of officers under section 113 Local Government Act 1972.

The Authorisation Process

5.4. An investigating officer who wishes to use covert surveillance must apply in writing to one of five Authorising Officers on a form describing the purpose of the investigation, the details of the operation (duration, methods, equipment and so on to be employed), the identities where known of the subject of the application, the information it is desired to obtain, the offence to be prevented or detected, an explanation of why the intrusion is necessary, details of potential collateral intrusion (infringement of the privacy of people other than the intended subject) including precautions taken to avoid collateral intrusion and an explanation of why the surveillance is proportionate to the aims of the operation.

5.5. The Authorising Officer is a senior person of at least Head of Service level, who is not connected with the operation. He or she will consider the application and if satisfied that the requirements of the Act and the Council's policy are met will authorise the surveillance. In doing so the Authorising Officer will record the who, where, what, when and how of the activity, set a date to review the operation and will either him or herself apply to a local JP or instruct the investigating officer to apply.

5.6. None of the authorisations made by either Council has so far been rejected by a JP which is a good indication that the Councils are using the powers responsibly.

Non-RIPA Surveillance

5.7. In certain circumstances, officers may use surveillance techniques where the protection offered by RIPA is not available. For example, on rare occasions it may be appropriate to carry out surveillance on an employee when investigating a disciplinary offence. Case law has established that in such circumstances RIPA authorisation is not

necessary because the Council is acting as an employer that than carrying out a “core” function such as the investigation of a criminal offence.

5.8. The Government introduced the “crime threshold” following concerns that local authorities had been using directed surveillance techniques in less serious investigations, for example to tackle dog fouling or checking an individual resides in a school catchment area. Therefore, it is not possible for Officer to rely on RIPA to carry out surveillance when investigating incidents of anti-social behaviour such as vandalism, and noisy or abusive behaviour. It is accepted that even such ‘low level’ anti-social behaviour, when targeted and persistent, can have a devastating effect on a victim and Officers consider that is some circumstances it will be appropriate to conduct surveillance that does not satisfy the crime threshold requirement of RIPA

5.9. It is lawful to carry out covert surveillance without RIPA approval but Members should be aware that this does come with some risks, for example, evidence may be ruled inadmissible in a trial; there may be a claim for damages for breach of Article 8 rights, a complaint to the Local Government Ombudsman or adverse publicity.

5.10. The proposed joint policy permits non-RIPA surveillance but only when it is approved by a RIPA Authorising Officer. Investigating Officers will be required to demonstrate that their proposed surveillance is lawful and necessary in terms of the qualification in Article 8(2) by carefully considering exactly the same factors of necessity and proportionality which are required under RIPA, The Investigating Officers will be required to complete a form identical in its details to a RIPA application form and to follow a system of review, renewal and cancellation identical to that found in RIPA. The principal difference in process is that a JP’s consent is not obtained. A central record of the surveillance will be maintained by Legal Services.

6. OPTIONS AND ANALYSIS

6.1. The current arrangements for RIPA are working satisfactorily. There have been no claims against either authority for breach of privacy whilst using covert surveillance and the OSC inspector has not found any instances of non-compliance. However, the evolving nature of Bi-borough enforcement activity in corporate services, audit, environmental health and other directorates will be improved by joined up working on RIPA.

6.2. The new joint policy clarifies the use of non-RIPA surveillance but otherwise does not contain any significant change to the Councils’ existing separate enforcement priorities and policies.

7. CONSULTATION

7.1 The Cabinet Member for Community Safety in RBKC and the Cabinet Member for Residents Services and the Lead Member for Crime and Anti-Social Behaviour in LBHF have been consulted and support the recommendations. The joint Policy has also been considered by the Community Safety, Environment and Residents Services Policy and Accountability Committee on 2 September 2014.

7.2 The Officers in both Councils who currently authorise RIPA surveillance have been consulted and they support the recommendation.

8. EQUALITY IMPLICATIONS

8.1 The recommendations do not impact either Council's equality duties.

9. LEGAL IMPLICATIONS

9.1. The legal implications are contained in the body of the report.

10 FINANCIAL AND RESOURCES IMPLICATIONS

10.1 There are no financial implications for this report however, there will be resource and efficiency savings arising from bi borough working. For example in July 2013 the OSC inspector visited Hammersmith on one day and Kensington on the next and saw the same Officers on both days. In future, the OSC will only be required to carry out one inspection of both Authorities saving Officer time and the time of the OSC.

11 RISK MANAGEMENT

11.1 The report proposals promote local accountability and comply with the government's approach on openness and transparency. As such reporting to Committee provides independent assurance for the public on the application of the policy and its compliance across the councils departments. A local authority is required to show that an interference with an individual's right to privacy is justifiable, to the extent that it is both necessary and proportionate and as such it is bound by a risk assessment. Current use of the Act by local councils, and the cost implications, are also closely monitored by campaign groups and have attracted national media interest. Use of the Act contributes to the current entry on the councils Strategic risk and assurance register, risk number 7 Managing Statutory (non-compliance with law and regulations) and risk number 9, (management of fraud)

11.2 Implications verified/completed by: (Michael Sloniowski, Bi-borough Risk Manager Tel: 020 8753 2587)

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

Appendix 1

Number of RIPA Authorisations Granted

LBHF 2014	**RBKC 2014**	**LBHF 2013**	**RBKC 2013**	**LBHF 2012**	**RBKC 2012**
Jan – June 6	**0**	**16**	**4**	**7**	**9**
Covert CCTV cameras and Visual Surveillance to identify perpetrators of ASB, criminal damage and drug dealing(5)		Covert CCTV cameras and Visual Surveillance to identify perpetrators of ASB, criminal damage and drug dealing (12)	test purchase for alcohol x 4	Covert CCTV cameras and Visual Surveillance to identify perpetrators of ASB, criminal damage and drug dealing	Personal injury fraud x2
Investigation into theft from parking meters (1)		Age restricted products test purchasing (1)			Blue badge fraud
		Investigation into theft from parking meters (1)			HB fraud x3
		Communication data: Investigation and prosecution relating to serious fraud (2)			Test purchase x3

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
POPE JOHN EXPANSION (DISPOSAL OF FATIMA CENTRE)	
Report of the Cabinet Member for Children and Education - Councillor Sue Macmillan and the Cabinet Member for Housing - Councillor Lisa Homan	
Open Report	
Classification - For Decision **Key Decision:** Yes	
Wards Affected: Wormholt and White City	
Accountable Executive Director: Andrew Christie – Executive Director of Children's Services	
Report Author: Dave McNamara - Tri-borough Director of Finance & Resources (Children's Services)	**Contact Details:** Tel: 020 8753 2300 E-mail: dave.mcnamara@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The Council has agreed with the Roman Catholic Diocese of Westminster (the Diocese) to expand Pope John School from one to two forms of entry as part of the School Organisation Strategy 2012-13. This requires redevelopment of the Fatima Centre, which adjoins the school and is leased to the Diocese. The Diocese has agreed to acquire the freehold of the Fatima Centre at a cost of £240,000, and in the meantime requests the Council's consent to the demolition and redevelopment of the Fatima Centre.

2. RECOMMENDATIONS

2.1 That the Council agrees to dispose of the Fatima Centre to the Diocese for the provision of school places.

2.2 That, if necessary, the Council as freeholder permits the demolition of the Fatima Centre, in advance of disposal, to enable the construction of an extension to Pope John RC Primary School.

3. REASONS FOR DECISION

3.1 In order to implement the School Organisation Strategy, and facilitate the expansion of Pope John RC Primary School in association with the Diocese, the Council needs to dispose of the Fatima Centre to the Diocese in order to provide the space to accommodate the additional space required for the new school build. Community provision will be re-provided within the new configuration.

4. INTRODUCTION AND BACKGROUND

4.1 Pope John RC Primary School is a one-form entry school located on the White City Estate. Its expansion to a two form entry school is part of the School Organisation Strategy 2012-13. Whilst the school itself was transferred to the Diocese under the School Standards and Framework Act 1998 some years ago, the expansion involves the redevelopment of the adjoining Fatima Centre. The Fatima Centre was originally leased by the GLC to the London Federation of Boys Incorporated for a term of 80 years expiring on 31st July 2044, and later assigned to the Diocese. The ground rent is £40 pa, and the permitted use is as a club for young people provided it does not preclude its use for education, religious, welfare or other approved purposes. There is no provision for demolition and redevelopment in the lease.

4.2 The existing lease of the Fatima Centre ensures that community facilities are provided locally. The new development will include a community hall through which the community benefit will continue.

4.3 The Diocese has already designed the extension to the school and has obtained planning permission. Tenders for the building works have been obtained. Delay will impact on the availability of new places, which are now expected to be provided in September 2015, one year later than originally planned.

5. PROPOSAL AND ISSUES

5.1 The land on which the Centre stands is held within the Housing Revenue Account (HRA). The land is not used for housing purposes, and the community use is protected in the proposals. The building works will be managed by the Diocese and funded by the Council's Basic Need allocation from the DfE. In order to expedite the works prior to completion of the land transfer, it is proposed to grant a licence to demolish with a condition that the Diocese will construct the new school buildings.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 The following options have been considered:

I Extend the existing lease.

The Diocese have stated that the existing lease, with 30 years unexpired, is too short to justify this level of capital expenditure. A lease would also result in the school occupying part of the site on a freehold basis and part as a leasehold. Moreover the proposed use is outside the permitted use, and there is no clause within the lease for demolition and reconstruction.

II Transfer the freehold under the provisions of the School Standards and Framework Act 1998. As the property would be held in trust for the purposes of statutory education provision, future use is restricted to a school and, if the school were to close, the property would revert to the Council.

III To dispose of the freehold outright to the Diocese,

7. CONSULTATION

7.1 Extensive consultation was undertaken before the 2012-13 School Organisation and Investment Strategy was adopted.

8. LEGAL IMPLICATIONS

8.1. The land is at present held within the Housing Revenue Account. Under the General Consent for the Disposal of Land held for the purposes of Part II of the Housing Act 1985 – 2013, A3.1.1 the Council can dispose of land held for housing purposes "for a consideration equal to its market value"

8.2. Also, the Council can dispose of the land, without ministerial consent, provided it obtains the best consideration reasonably obtainable. (Local Government Act 1972, section 123).

8.3. The licence to demolish will need to include reasonable safeguards to protect the Council's position if the Diocese does not proceed with the sale.

Implications verified/completed by: David Walker, Principal Solicitor, david.walker@rbkc.gov.uk 020 7361 2211.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. The expansion of the school is costed at £4.5M. Capital expenditure will be met from the Council's external Basic Need grant.

9.2 The freehold interest in the Fatima Centre was last valued in May 2014 at £240,000, taking into account the existing leasehold interest and 50% of the marriage value.

9.3 The Director for Building and Property Management confirms that this figure represents market value, and Best Consideration in accordance with Section 123 of the Local Government Act 1972".

Financial Implications completed by: Dave McNamara, Director of Finance, telephone 020 8753 3404.
Property implications added by Marcus Perry, Interim Head of Asset Strategy and Portfolio Management 020 8753 2835.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	School Organisation and Investment Strategy 2012-13 (published)	Alan Wharton, 020 7641 2911	Children's Services

Executive Decision Report

Decision maker(s) at each authority and date of Cabinet meeting, Cabinet Member meeting or (in the case of individual Cabinet Member decisions) the earliest date the decision will be taken	Full Cabinet decision Date of decision: 3 November 2014	h&f hammersmith & fulham
	Full Cabinet 30 October 2014 04280/14/K/AB	THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA
Report title (decision subject)	**ESTABLISHMENT OF A BI-BOROUGH ALTERNATIVE PROVISION HUB SCHOOL**	
Reporting of	**Cabinet Member for Children and Education – Councillor Sue Macmillan**	
Reporting officer	Ian Heggs, Tri-borough Director of Schools	
Key decision	Yes	
Access to information classification	**Open Report**	

1. EXECUTIVE SUMMARY

1.1 This report summarises the current alternative provision for children not in mainstream education in Kensington and Chelsea and also in Hammersmith & Fulham, and makes proposals for its development in order to raise standards of delivery and improve pupil outcomes.

1.2 The Tri-borough Director of Children's Services in Kensington and Chelsea, who chairs the Bi-Borough Hub School Programme Board, is of the view that the continued success of the high-performing Tri-Borough Alternative Provision (TBAP) services will be significantly enhanced by the creation of a new or refurbished Bi-Borough Hub School reflecting the criteria set out in this report.

1.3 This approach has been endorsed by the Bi-Borough Hub School Programme Board, which has confirmed its recommendation for the Bi-Borough Hub School

to be established on the site of the current Bridge Academy in Hammersmith and Fulham, funded by a combination of proceeds from the alternative use of the current RBKC Latimer Education Centre site, where the Latimer Alternative Provision Academy is currently based and it is hoped, a successful capital bid to the Education Funding Agency, led by the TBAP Trust. It would have particular benefit to the current Latimer Centre pupils in raising standards and expectations, as The Latimer Centre is currently classified by Ofsted as 'Good', as opposed to The Bridge's 'Outstanding' judgement. The Latimer Centre would be used as a decant facility until the current Bridge Academy site, including the Greswell Centre site currently used by Action on Disability (formerly HAFAD), is appropriately refurbished and remodelled.

1.4 In essence, both authorities would be making significant contributions to ensure the effectiveness of this scheme. To supplement the current Bridge Academy site, LBHF would be making available to the Hub School the Greswell Centre (Action on Disability) site, and RBKC would be contributing a sum equivalent to a valuation of the current Latimer site.

2. RECOMMENDATIONS

2.1 Cabinet is recommended to agree that:

- The principle of a Bi-Borough Hub School be adopted;
- The recommended site option is the Bridge Academy site in Hammersmith and Fulham **(Option 2 in section 6.2)**
- The site currently occupied by Action on Disability (formerly HAFAD) adjacent to the Bridge Academy is included within the Bi-Borough Hub School site,
- 3BM, through its existing contract with LBHF, be commissioned to produce a more detailed, costed programme for the works, developing the design for the new Bi-Borough Hub School sufficiently to give sufficient cost certainty, establishing the decant implications and checking existing proposals against the planning brief prepared for the site under BSF. This would be undertaken at risk by LBHF subject to a limit of £20,000;
- A further report be produced at the conclusion of RIBA Stage 3;
- Consultation begins at the appropriate time with key stakeholders;

subject to:

- Agreement by Cabinet in the Royal Borough of Kensington and Chelsea to make a capital contribution of £6.2m to fund the additional facilities required for its resident pupils
- Any additional capital costs for the scheme being met by the Education Funding Agency, following a bid from the TBAP Trust for AP Academies Capital.

3. REASONS FOR DECISION

3.1 Cabinet approval is requested because:

- The scheme is of a high value;
- It requires substantial capital funding to create the Bi-Borough Hub School on a single site. It requires the physical relocation of all alternative provision principally supporting RBKC students at the Latimer Alternative Provision Academy currently located within RBKC to LBHF;
- It requires The Bridge Academy in LBHF to deliver education to Latimer students on its site, and the building to be remodelled accordingly.
- Failure to approve may result in the TBAP Trust seeking a 125 year lease of both existing sites, as is their right by law as set out in the Academies Act, thus removing the ability of either Council to deal effectively and efficiently with property assets where they retain the freehold or use them to invest in improved alternative provision for the benefit of vulnerable pupils.

4. BACKGROUND

4.1 The TBAP Multi-Academy Trust is a highly effective, overarching organisation established to oversee the delivery of alternative education provision across the tri-borough area. It supports pupils experiencing difficulty in maintaining mainstream school placements, chiefly those who have been excluded from school. Robust academy trust and governance arrangements are now in place. In looking to support the Trust in one of its current key aspirations, the establishment of a Bi-Borough Hub School, the intention is to maximise the opportunity to drive up and maintain high standards, as well as expanding the curriculum offer.

4.2 Tri-Borough Alternative Provision was brought together through a partnership led by the Executive Headteacher of the Bridge AP Academy in Hammersmith and Fulham, who is himself designated a National Leader of Education. The Bridge is a highly successful AP Academy rated by Ofsted as “Outstanding in all areas” in its last inspection. The other three AP Academies within the TBAP Trust are currently judged as ‘Good’.

4.3 Such provision is inherently difficult to offer to such a level of quality, partly because the vast majority of students referred to alternative provision are highly vulnerable and are often in the midst of or working their way through significant trauma or personal or family difficulties. As a result their behaviour can reflect their troubled condition and impede learning and socialisation quite considerably

4.4 The skill sets, experience and training of staff required to implement such approaches are not universal, nor are the leadership qualities required of those responsible for such provision evident in all educational leaders. Furthermore, as

compared with other educational provisions, unit sizes are often small, making broad, balanced curriculum delivery by specialists disproportionately problematic. As difficult to achieve within the resources available in small establishments is the wide variety of relationships necessary with employers, further and higher educational establishments and schools in order to facilitate appropriate, personalised onward routes for students.

4.5 TBAP staff are recognised experts at delivering outstanding outcomes with some of our most challenging young people. Pupils have often been excluded from school and present with extreme behaviours. All pupils have some kind of additional need, and some have very complex social, emotional or educational needs. Pupils can be both verbally and physically challenging on entry but make remarkable progress over time at TBAP Academies. The proportion of pupils who receive the pupil premium is well above average. Two TBAP Academies achieved runner-up status in the National Pupil Premium Awards and attended an awards ceremony hosted by the Deputy Prime Minister In recognition of outstanding work in reducing the achievement gap of their most vulnerable pupils.

5. PROPOSAL AND ISSUES

5.1 **Quality of Provision**

TBAP Academies work with a range of other local providers to offer the support most appropriate to each individual student. The success of the Bridge AP Academy provision is reflected in LBHF by:

- The demonstrable reduction in those Not in Education or Employment ("NEET");
- The reduction in statements and referrals for support for behaviour;
- The reduced need for other SEN provision related to such needs.

5.2 One of the biggest single indicators of successful outcomes is arguably that related to NEETs. The national NEET figure is 6.7% overall. In LBHF, the host of the highly effective Bridge Academy, the position is better than that nationally, at 4.6% (a 13.4% reduction over 4 years), whereas in RBKC the situation is much less favourable at 7.3%. The importance of reducing NEETS cannot be underestimated: some 15/% of long term NEETs are dead within 10 years of leaving school. Appendix A summarises research into the costs of NEETs and cost-effective preventative strategies. The service overall would benefit from greater links with and access to the excellence displayed in LBHF.

5.3 The creation of a high quality, enlarged Bi-Borough Hub School would create an environment much more able to support the raising of achievement and opportunities consistently across the tri-borough area.

5.4 **Provision made in AP Academies**

The four borough-based AP Academies: Latimer (RBKC),The Bridge Academy (LBHF), the Courtyard Primary AP Academy (LBHF) and Beachcroft (WCC), - offer a range of provision for some of the most vulnerable students educated within the boundaries of the tri-borough partnership. The on-site, full-time education for students who have been excluded from mainstream school, are hard to place for a variety of reasons or who have other behavioural, emotional or social difficulties is complemented by such work as part-time placements supporting placements elsewhere, brokering of work-related learning and support for schools and teachers in behaviour management both generally and in specific circumstances. Curricula are broad and balanced and aim to prepare students for reintegration into mainstream life, be it in school, college, work or further training. The TBAP website (www.tbap.org.uk) provides a comprehensive analysis of the services available collectively and in each LA. Commissioned places reflect the requirements of each LA, although the provision is clearly used flexibly to meet the needs of individual children most appropriately.

5.5 Whereas the AP Academies themselves offer direct provision to students, they will frequently commission other providers (FE colleges, work-related learning, voluntary organisations and some of those listed in paragraph 5.8 below) to supplement the offer made. In 2012 some 30 such places were commissioned.

5.6 **Non Hub-based provision ('Spokes') – Commissioning and School Support** Commissioning and School Support provide interventions in tri-borough schools and smaller centres to support the inclusion of learners in schools whose behaviour is causing concern and preventing them achieving. Unless stated, there are no proposals to significantly alter the provision and facilities for the spoke element of the TBAP service.

5.7 Each authority has a range of such provision within it. A summary is provided below:

LA/Provision Name	Type	Age Range	No. Planned Places	Current
LBHF				
Bridge Academy	AP with range of ancillary services	11-16	180 in all	116
Childerley Centre	Day 6 of exclusion provision and managed intervention	11-16	Matched to purchasing.	13*
Courtyard	Primary AP with ancillary services	5-11	16	16
Pupil Inclusion Development Service	In-school support and interventions: mainly LBHF	5-11	2FTE Teachers; 4 Development	34*
RBKC				
Behaviour Intervention Team	Range of in-school interventions/ CPD	5-11	3FTE Teachers	64*
Golborne Education	Day 6 of exclusion provision and managed	11-16	Matched to purchasing.	8*

Centre	intervention			
Latimer Education Centre	AP with range of ancillary services	11-16	44	27
Portobello Centre	Vulnerable pupils and those not in school	11-16	12	08
WCC				
Beachcroft School	AP offer includes Day 6 of exclusion provision and managed intervention; developing primary support	5-16	50 on-site; 20 in related provision	39

*Number recorded in 1 specific week.

5.8 **Academy Status**
All existing PRUs have become AP Academies as part of the Tri-borough Multi-Academy Trust (MAT). Academy conversion has little impact on LA or Dedicated Schools Grant finances (see below). A more direct impact, however, arises from LAs having no liability for repairs and maintenance of Academies (although place costs are always likely to have a relevant cost element included).

5.9 TBAP is submitting an application to set up an AP Academic 6th Form Free School. This school will target academically able pupils in AP who do not achieve their potential GCSE grades. These pupils will join the free school AP Academy and complete A-levels to facilitate progression to good universities. TBAP propose co-location of this post-16 provision l with the bi-borough hub school and would anticipate appropriate levels of capital funding to be made available from the DfE's Free School programme. These proposals are entirely commensurate with the development plans for the provision and, if agreed, would be incorporated into the whole site planning process.

5.10 **TBAP: A Major Training Provider**
From 2013, TBAP, working in partnership with Goldsmiths University of London, has begun to take a leading role in coordinating teacher training. TBAP hosts a number of School Direct places in Maths and English. This new path into teaching enables participants to gain the qualifications and practical skills they need to become teachers and supports teachers within as well as outside of the Tri-Borough Partnership.

5.11 TBAP also offers a range of other professional development opportunities, many of them focused on staff within the tri-borough partnership, thus helping to drive up the quality of work within mainstream, AP and special schools and improving pupil outcomes.

5.12 In April 2014 The Bridge Academy was designated as a national Teaching School. Teaching Schools take a leading role in recruiting and training new entrants to the profession, identifying leadership potential and providing support for other schools. The Bridge AP Academy was one of only 200 "outstanding"

schools in England to be granted this status in the latest designation round. The TBAP Teaching School Alliance (TBAP TSA) will train new teachers in behaviour management and early intervention. In 2015-16 the TBAP TSA expects to train upwards of 25 new teachers. These teachers will then be expertly equipped to deliver outstanding education in our schools. More closely aligning PRU students with this excellence will inevitably improve outcomes.

5.13 **Pupil Place Planning**

It is unlikely that student numbers at the Bridge AP Academy in Hammersmith and Fulham will alter significantly in the coming 3-5 years: whilst funding changes might appear likely to lead to a reduction in places purchased by schools, conversely, perceived need has increased in recent years and is likely to counterbalance that effect. Indeed, recently there has been a marked increase in requests from schools in all three boroughs for managed moves, as well as an increase in requests for KS3 placements.

5.14 However, the need to broaden the service available to support Royal Borough students will lead to an increase in planned places at the Latimer AP Academy, and an increase over current take-up of some 25 students. A significant element of the increase will result from an enhanced purchased service bought by schools. Furthermore, both LBHF and RBKC services need to be mindful of the likely impact of new housing programmes such as that at Earls Court; although the detailed effect of these initiatives cannot yet be quantified it may be important to future-proof current service proposals. However, there is a critical size beyond which such hub provisions cease to become efficient and effective, and it is the view of the service that the proposed hub should not increase its on-site cohort beyond 150, using the benefit of its tri-borough partnership, as at present, to help to manage numbers and young people's needs.

5.15 **Interagency Engagement**

Critical to the lives of many of the troubled young people who are supported in Alternative Provision are agencies such as Child and Adolescent Mental Health Services (CAMHS), other health-related services, Youth and Youth Offending services and social care support. These services are characteristically challenged in respect of their own resourcing, and inevitably target it where it will have the greatest benefit. The larger size of the Bridge Academy has clearly contributed towards its success, as recognised by Ofsted, in attracting support from these agencies, as has a well-developed collaborative ethos. Co-location of these services will lead to faster and more effective early intervention and support for families.

5.16 A Bi-Borough AP Hub School would thus be likely not only to increase the impact of these agencies through further economies of scale; but also share the excellent multi-agency practice currently demonstrable at the Bridge with a wider group of students, further improving their life-chances.

5.17 **Cost and Benefits: Financial**

Pupil funding essentially follows the child and is reflected in planned places, so the location and impact of restructuring of the provision does not necessarily affect budgets other than the DSG, specifically the High Needs Block. However, there is clearly a cost benefit achievable by rationalising sites, and, even if an LA does not directly benefit from that saving, its community will almost certainly benefit from improvements to the service made (see below) and schools will be able to re-use the savings to make further improvements to this or other areas of service. Cash savings that are almost certain to be made will relate to a diminishing need to purchase other, more expensive provision if higher quality, broader-based provision is offered locally. It should also be noted that easing pressure on the High Needs Block of the DSG will reduce the likelihood of the Authority needing to support any expenditure arising from additional needs arising, for example, from implementing the Children and Families Act.

5.18 It is feasible that, through a Bi-Borough Hub School, administrative, site and management costs might reduce over time by in the region of £100,000 per annum in the following areas:

- The size of the administrative function;
- Site cleaning and routine repairs and maintenance;
- The cost of rates in respect of the site released;
- Loss of liability for ongoing backlog maintenance in respect of that site would also ultimately constitute a service saving. Long-term maintenance and improvement of the site released would cease to apply and, in respect of the chosen site, would no longer be an LA liability.

5.19 **Cost and Benefits: Wider Economic and Societal**

A tangible benefit of improved provision to very vulnerable students is their re-inclusion into mainstream life and their on-going engagement with society through further education and employment. Student-focused PRUs support this re-inclusion, and the University of York (see Appendix A) has attempted to quantify the benefits of such inclusion, in terms not only of reductions in claims for benefits and other costs; but also in broader costs to society.

5.20 Sharing the Bridge experience on one site, providing students with an improved and broader curriculum with more individualised support is sure to diminish the likelihood of students becoming NEET. Equally, the economies of scale offered by a larger provision will inevitably further improve the range and scope of the curriculum available, increasing opportunities for personalisation. (The summary of key research findings shown at Appendix B has previously been referenced.)

5.21 **Geographical Locations**

The geographical home locations of the students attending the Bridge and Latimer respectively are available and do not favour one location over the other.

6. OPTIONS AND ANALYSIS

6.1 **Supporting Improvement in Alternative Provision**
Discussion and debate in recent years has led to the conclusion that there are three main options:

(i) To relocate the Bridge provision to the Latimer site and create a Bi-Borough Hub School on that site.
(ii) To relocate the Latimer provision to the Bridge and current Greswell St sites, to develop a Bi-Borough Hub School in Hammersmith and Fulham, refurbishing to 21st century standards.
(iii) To remain in existing facilities and seek to drive up quality through existing partnership arrangements.

6.2 The issues related to the three location options are indicated below. Children's Services officers are of the view that if the Bridge site is selected then full refurbishment should be undertaken in order to deliver accommodation which is fully fit for purpose given the age and nature of the existing building. It is envisaged, subject to a full range of design and site considerations as yet not fully assessed, that the new provision might be occupied by 2018.

Option 1: Bi-Borough Hub School on the Latimer Site in RBKC
The Bridge provision would relocate to the Latimer site to create a Bi-Borough Hub School at the Latimer. The Bridge and HAFAD sites would be sold or used for other purposes and the estimated proceeds of £12.5m if sold used to contribute towards development costs.
The scheme would comprise a new build extension on the site, refurbishment of the existing buildings, new build infill and refurbishment of the outbuildings on site. The proposals would produce on-site provision for a 150 pupil PRU with a maximum capacity of 164 pupil places at a project cost of £17.3m excluding site value. The cost per pupil rate for such a scheme would be £105,000.

The receipt would not fully cover the scheme costs so H&F and RBKC would need to contribute a further £3.6m and £1.2m respectively**.**

This option is not recommended by the two Property Departments as the site disadvantages considerably outweigh the advantages. Furthermore, the project costs of the scheme to each Borough exceed the costs associated with the options considered for the Bi-Borough Hub School at the Bridge in the option below.

Option 2: Bi-Borough Hub School on the Bridge Academy Site in LBHF (Recommended)
The Latimer provision would be relocated to the Bridge Academy site to create a Bi-Borough Hub School in Fulham with a potential capacity of 150 on-site places, including both new build and full refurbishment incorporating the Greswell St site

at a cost of £8.6m. This option produces a cost per pupil rate of £48,000. The Royal Borough's contribution would be to the level of £6.2 million, reflecting the market value of the Latimer site, which would have an alternative use once it is vacated. No decision has been taken about what this alternative use might be at this stage. As £6.2m would not fully cover the costs, theTBAP Trust has confirmed that it will make a bid to the EFA for additional capital resources to fund the budget gap from the AP Academies Capital pot. Informal discussion with the EFA has already begun about this and initial feedback has been positive.

Option 3:-Status Quo

The maximum capacity of the Latimer building is 50 pupils. It is clear, however, that the existing condition and configuration of the property could hinder the TBAP'S efforts to improve the provision further. Doing nothing at the Latimer is thus not considered a viable option. Equally, it would be appropriate to upgrade the Bridge facility anyway in order to meet 21st century educational requirements.

Summary of Benefits and Disadvantages of each Option:

Option	Benefits	Disadvantages
(i) Bi-Borough Hub School on Latimer Site	• Enables curriculum, leadership and management skills to be shared; • Economies of scale achievable and broadening of the curriculum through a larger quantum; • The more centrally located site; • Good transport routes.	• Requires Westway to confirm long term Recreation and Apprenticeship proposals; • Smaller onsite recreation space and complex ownership; • High capital costs and onerous planning and conservation conditions; • Fewer subsequent opportunities to expand provision should that be required in the future.
(ii) Bi-Borough Hub School on Bridge Site	• Enables sharing of curriculum, leadership and management skills; • Larger economies of scale and more broadening of the curriculum; • Larger site, enabling more on-site provision and future expansion opportunities; • Few planning constraints and risks; • Lower capital costs.	• Location less central; • Good transport links by bus, but no tube link nearby
(iii) Maintain status quo	• Few capital costs.	• Raising standards more difficult as lines of communication weaker; • Lack of economies of scale; • Broader curriculum through increase in quantum not feasible.

6.3 **Specification and Site Issues**

A service specification for this new Bi-Borough Provision was prepared by collaboration between Children's Services, Corporate Property and TBAP staff and further developed by Surface to Air Architects. It indicates the outputs that any new or refurbished building would need to deliver.

6.4 There is a risk that if it proves impossible to reach agreement within a reasonable timeframe, the TBAP Multi-Academy Trust will seek 125 year leases of the Latimer and Bridge sites, thus depriving the local authority of the ability to facilitate a new centre in a single location and maximise the financial benefits of its property assets. It is noted that both H&F and RBKC have granted short leases of 7 years 6 months, with provision of break clauses, for The Bridge and the Latimer to the Academy Trust. This has been agreed with the Trust and DfE to provide maximum flexibility for the local authority when the Bi-Borough solution has been identified and agreed. However the Academy Trust is entitled to a 125 year lease on both sites, and the DfE could invoke powers under the Academy Act 2010 to require the local authority to transfer the sites to the TBAP Trust. This would disrupt the local authority's ability to strategically manage its assets or maximise the value of them.

6.5 3BM are reviewing the feasibility study undertaken to scope possible works and providing a report appraising it, taking into account the LBHF planning brief which was developed during the BSF process. Other key items which 3BM are reviewing are as follows:

- Project budget: review of outline project budget against the proposed accommodation schedule. Calculation of target cost per square meter to establish target costings per building elements.

- Phasing and decant analysis

- Planning appraisal and review of historic planning briefs

- Architectural Review

- Programme.

3BM will be convening a project review to understand next steps and clarification of key items and client engagement.

6.6 Action on Disability's (AoD) most recent lease of the Greswell Centre from the Council expired on 31 March 2008, since when it has been holding over under a Tenancy at Will. The Greswell Centre was declared surplus by LBHF's Cabinet on 7th February 2011, subject to an alternative location being found. The Council does not charge AoD rent. In order to free up the Greswell Centre for its planned disposal, it had been agreed to relocate AoD functions to the Lyric Community Hub (for its youth services provision), with the remainder of the service relocating elsewhere in the borough. AoD is favourably disposed towards these moves and work is continuing with them to confirm both a permanent site and the timeline for their move.

6.7 The loss of a capital receipt from the withdrawal of the Greswell Centre from the Disposals Programme has been noted in the latest update of H & F's Capital Programme Monitor.

7. CONSULTATION

7.1 Significant consultation will be required with current and, where known, future users of Alternative Provision and their families in, where relevant, all 3 boroughs (because of interdependencies of provision); with schools, and with neighbours and communities in both areas. A communications plan will be prepared and implemented, incorporating regular updates for interested parties.

7.2 Ward Members for the most affected areas in RBKC and LBHF will be consulted at the earliest opportunity in accordance with the democratic protocols of each borough**.**

8. EQUALITY IMPLICATIONS

8.1. An initial equality impact assessment has been drawn up and is attached as Appendix B. A full equality impact assessment will be completed before a final decision on this proposal is taken.

9. LEGAL IMPLICATIONS

9.1 The legal implications are contained within the report. It should be noted that the two Alternative Provision Academies would be entitled to seek 125 year leases on the existing sites should they so wish.

(Legal comments added by David Walker, Principal Solicitor david.walker@rbkc.gov.uk, 020 7361 2211)

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 **Revenue**

Revenue costs of TBAP Academies are essentially met from a block grant of £8,000 per planned place passported through the EFA, topped up by the High Needs Block and supplemented by the purchasing individual packages in many cases by schools. A summary is provided below of 2014-5 commissioning plans for the 4 key AP Academies, showing the top-ups routinely applied to placements via DSG

Centre	EFA SEN Places	EFA Funding Per Pupil	HNB Top-up	EFA AP Places	EFA AP Fund	DSG Top-up	Other Govt Income (eg PP)	Income Generation	Total Income
Beachcroft	10	£10k	£25k	65	£8k	£11.7k	£12.2k	£12.2k	£1,773k
Bridge	30	£10k	£25k	150	£8k	£9k	£27k	£277.5k	£3,901k
Courtyard	8	£10k	£25k	8	£8k	£21.5k	£0	£0	£528k
Latimer/ Portobello	15	£10k	£25k	50	£8k	£10k*	£13.7k	£0	£1,689k

10.2 **Capital**

Option	Project Cost Estimate (£000)	Comments
Option (i): Bi Borough PRU at the Latimer site	17,300*	Includes new build extension and major refurbishment.
Option (ii): Bi-Borough PRU at the Bridge site	8,600*	Includes major refurbishment and some new build.
Option (iii): Status Quo:	**	Inevitably some refurbishment would be required.

*Excludes decanting costs- to be quantified alongside design development.
**It is difficult to foresee no investment being made in these tired buildings; but this has not been costed to date as this is not considered to be a realistic option.

The proposal is to establish the bi-borough PRU at the Bridge Academy site and is estimated to cost £8.6m. It is proposed that RBKC make a contribution of £6.2 m, equivalent to the estimated market value of the Latimer site.
The £6.2m RBKC contribution could be supplemented and the full sum required achieved if the EFA were to support a successful bid for additional resources.

10.3 Pupil funding essentially follows the child and is reflected in planned places, so the location and impact of restructuring of the provision do not necessarily affect budgets other than the DSG, which is not a centrally-held LA budget. However, there is clearly a cost benefit from rationalising sites, including likely reductions in both management and administration costs and a degree of routine maintenance.

10.4 Even if an LA does not directly benefit from that saving, its community will almost certainly benefit from improvements to the service made and schools will be able to re-use the savings to make further improvements to this or other areas of service. Furthermore, the placement charges are in part funded by a top-up from the High Needs Block, a characteristically constrained budget, and this top-up could be re-negotiated in the light of known savings. Anticipated revenue reductions have been referred to in paragraph 5.19 above.

Ian Heggs
Tri-Borough Director of Schools

Cleared by Finance (officer's initials)	DMc
Cleared by Legal (officer's initials)	DW

Contact officer: Ian Turner Education Capital Projects Manager

077 393 14756

APPENDIX A

The Cost of NEETs: Some Summary Research Findings

1. Direct Costs of those NEET Between Ages 16 and 18

- Estimated as £56,000 per person in public finance (benefits etc);
- Some £104,000 in lost labour market potential;
- NEETs cost £22m per week in Jobseekers' Allowance;
- NEETs also cost £23m as a consequence of their youth crime, in individual cases the cost to the taxpayer of drifting into persistent and serious offending being in excess of £2m each;
- Overall, between £12bn and £32bn in direct costs and £22-77bn in losses to the economy and the individual.

2. Wider Health and Welfare Costs to Individuals and Society

- Young male NEETs are 3 times more likely to suffer depression and 5 times more likely to have a criminal record;
- Young women who significantly underachieve (many of whom are NEET) are 15 times more likely to suffer depression at age 42 and 44% more likely to have a child by age 19;
- Young people who have underachieved are 75% more likely to be smokers by the age of 30;
- NEETs become bored and isolated, and have an increased likelihood of long-term unemployment, ill-health and, if eventually employed, being engaged in low-paid jobs.

3. Effective Approaches Cited

- £4,000 spent on short-term support to a young mother can generate £80,000 in tax contributions and reduce lifetime public service costs by £200,000;
- "Relatively inexpensive" youth support projects produce major public finance savings;
- One of the best strategies involves targeted pre-16 support for those at risk.

Sources:
University of York Social Policy Research;
Audit Commission (used these findings and developed them);
Work Foundation and Private Equity Foundation (used York's findings).

APPENDIX B

Equality Impact Analysis

Overall Information	Details of Full Equality Impact Analysis
Financial Year and Quarter	2015 – 2018
Name and details of policy, strategy, function, project, activity, or programme	Title of EIA: Establishment of Bi-Borough Alternative Provision (AP) Hub School Short summary: In implementing the Tri-Borough AP Strategy, establishing a Hub School on the Bridge site accommodating both LBHF and RBKC AP pupils **Note**
Lead Officers	Name: Ian Heggs Position: Director of Schools Commissioning Email: Ian.Heggs@rbks.gov.uk Ian Turner Education Capital Projects Manager Ian.Turner@rbkc.gov.uk 077 393 14756
Lead Borough	State which officer is co-ordinating the EIA and other associated documentation Ian Turner
Date of completion of final Full EIA	9/010//2014

Section 02	Scoping of Full EIA
Plan for completion	Timing: December 2014 Resources: Within existing Children's Services and Corporate Property Projects Resources.
Analyse the impact of the policy, strategy, function, project, activity, or programme	Analyse the impact of the policy on the protected characteristics (including where people / groups may appear in more than one protected characteristic). You should use this to determine whether the policy will have a positive, neutral or negative impact on equality, giving due regard to relevance and proportionality.

Protected characteristic	Borough Analysis	Impact:

Age	**RBKC and LBHF** This change in itself will have no impact on the age of those to admitted or supported.	Neutral
Disability	**RBKC and LBHF** Whilst the temporary relocation of Bridge pupils to Latimer Road and the final relocation of all to the Bridge site may impact on travelling times to a small degree (the centres are a short distance apart) and for some create a longer journey (but for others a shorter one), the new facilities to be provided at the Bridge will be fully compliant with Equalities Act requirements and offer significantly better and broader opportunities to young people for whom such opportunities are critical to their future education, employment and well being..	Neutral
Gender reassignment	**RBKC and LBHF** The proposal will have no known impact	Neutral
Marriage and Civil Partnership	**RBKC and LBHF** The proposal will have no known impact	Neutral
Pregnancy and maternity	**RBKC and LBHF** The proposal will have no known impact except potentially to improve provision for school-age mothers	Neutral
Race	**RBKC and LBHF** The proposal will have no known impact except to improve provision for the educationally disadvantaged	Neutral
Religion/belief (including non-belief)	**RBKC and LBHF** The proposal will have no known impact	Neutral
Sex	**RBKC and LBHF** The proposal will have no known impact	Neutral
Sexual Orientation	**RBKC and LBHF** The proposal will have no known impact	Neutral

Human Rights or Children's Rights

If your decision has the potential to affect Human Rights or Children's Rights, please contact your Borough Lead for

	advice No reason to assume so

Section 03	**Analysis of relevant data** Examples of data can range from census data to customer satisfaction surveys. Data should involve specialist data and information and where possible, be disaggregated by different equality strands.
Documents and data reviewed	
New research	No new research is required. The University of York research referred to in the main body of the report illustrates the importance of reducing NEETs and addressing access to opportunities issues faced by vulnerable young people, issues addressed by the report's recommendations.

Section 04	**Consultation**
	Complete this section if you have decided to supplement existing data by carrying out additional consultation.
Consultation in each borough	The Governing Bodies of both Academies have been informally consulted, as have staff and both LAs' Cabinet Members.
Analysis of consultation outcomes for each borough	The outcomes of the consultations were in favour of the proposals.

Section 05	Analysis of impact and outcomes
Analysis	The impact on all but those with disabilities will be positive as the proposal will improve young people's access to a broad and individualised range of educational programmes. The final provision will be more suitable for those with disabilities and more able to accommodate more and more efficient visits by specialist support agencies. The locations are a short journey apart, minimising travel issues for the vulnerable.

Section 06	Reducing any adverse impacts and recommendations
Outcome of Analysis	The design of the new build and refurbishment of the existing building at The Bridge will be fully compliant with the latest Equalities Act requirements. A travel plan will assist in advising on support required in travelling to the new site, especially for RBKC pupils, and for LBHF pupils temporarily travelling to the Latimer site.

Section 07	Action Plan
Action Plan	Note: You will only need to use this section if you have identified actions as a result of your analysis Produce a travel plan for both eventualities.

Section 08	
Chief Officers' sign-off	Name: Andrew Christie Position: Director of Family and Children's Services Email: Andrew.Christie@rbkc.gov.uk
Key Decision Report (if relevant)	Date of report to Cabinet: 3/11/2014 (LBHF) Has been agreed in principle by Cabinet Members (09/10/2014 RBKC: 10/10 LBHF) Key equalities issues have been included: Yes
Lead Equality Manager (where involved)	Name: Position: Date advice / guidance given: Email: Telephone No:

	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
FOCUS ON PRACTICE - INNOVATION FUND GRANT	
Report of the Cabinet Member for Children and Education - Councillor Sue Macmillan	
Open Report	
Classification - For Decision **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Andrew Christie, Executive Director of Children's Services	
Report Author: Steve Miley, Director Family Services	**Contact Details:** Tel: 020 8753 2300 E-mail: steve.miley@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Children's services has been successful in being awarded a £4m Innovation Grant from the DfE to transform interventions with families although total match funding of £1m is required (£0.33m for H&F). Hammersmith and Fulham Children's Services allocation will be approximately 38% of the £4m grant funding. The total funding award is for £1.5m to be spent in Year 1 (2014/15) and £2.5m in Year 2 (2015/16

1.2. This report seeks agreement to how that grant is used; the broad proposals are to use this grant to strengthen our clinical practice with specialist therapists, to train social workers in evidence based methodologies and to reduce caseloads to allow for more intensive work with families.

2. RECOMMENDATIONS

2.1. To allocate up to £0.33m from the Invest to Save fund as H&F's match funding to the Innovation Fund Grant.

2.2. That agreement be given to the proposals outlined in the table in paragraph 5.2 of the report as to how this grant should be used.

3. REASONS FOR DECISION

3.1. The size of the grant (being over £100,000) requires Cabinet agreement to the expenditure.

4. INTRODUCTION AND BACKGROUND

4.1. It is recognised that in Family Services, despite a number of initiatives, practitioners continue to be constrained by bureaucratic processes, too much time spent at the computer and too little time spent on effective work with families. The role of case manager for social workers dominates in preference to direct and effective intervention. Too often we see our social workers in the role of watching and waiting with families, referring on to other teams or agencies, while they focus on assessment or planning but have neither the time nor the confidence to undertake the clinical and sophisticated interventions which would be most likely to help the family. We see practitioners who come into the profession with an ambition to make a real difference to children's lives, which is frustrated when they are not able to develop the expertise they need or develop trusted relationships with families.

4.2. A recent analysis of the histories of young people who came into care revealed that that often, families had been known to our departments over a period of years, but there was insufficient evidence of significant change despite repeated episodes of assessment and intervention. The findings from this analysis led us to think about how we might create a service where families are not 're-worked' over and over, but where the intervention is deeper, more intensive and able to help families to engage with our service in a meaningful way in order to make radical and sustained changes in their lives; and deliver significant savings in the process. There are too many repeat referrals, assessments, child protection plans and interventions which do not result in significant change, and which drive unnecessary costs. We need to get it right first time.

4.3. Changing the way we work with families will demand a whole system change. The ambition is to create a more effective children's social care service by developing the key elements as described in the paragraphs below.

4.4. The three key platforms of the new model are to create more **time** for practitioners to work with families, to develop their knowledge, confidence and **expertise** in order that they are more effective in creating change, and importantly, to change the **system conditions** which reinforce and steer practice.

4.5. The new model will enable practitioners to work intensively with families to solve problems and change behaviours, rather than referring out to others. This will involve a gradual reduction of caseloads; our ambition is that practitioners will work with five or six families at any one time, compared to current caseloads of 10-12 families across the Tri-borough.

4.6. By use of evidence based interventions and a more engaging approach, practitioners will develop relationships with families that enable them to build on their strengths. To enable this to happen, there will be delivery of comprehensive skills development programme incorporating: systemic practice; Signs of Safety approaches; Motivational Interviewing; and parenting programmes.

4.7. We plan to create built in learning mechanisms within the organisation, comprising a framework of observation, feedback and coaching to change practitioner behaviour and consolidate training.

4.8. The programme includes a tracking element enabling a more proactive approach with families, identifying those who would benefit from sustained help at key stages, for example, secondary school transfer, in order to reduce the number of teenage entrants to care.

4.9. There will be a career pathway for social workers who wish to remain in practice, whilst rising up the hierarchy and developing their expertise. As in other professions, doctors for example, we would expect to see practitioners in senior positions who are still working directly with families. In our current structure, social workers can only be promoted by giving up practice and becoming managers, who then only see families sporadically.

4.10. We want to see a proportionate time spent on paperwork and case recording and concise analytical reports and we have begun a pilot to reduce the requirements for detailed record keeping of every event, activity and conversation that take place with families and other professionals.

4.11. In each borough there will be a Head of Clinical Practice post, who supervises systemic family therapists working alongside social workers and other professionals. The postholder will teach, coach and also model systemic approaches through direct work with families.

5. PROPOSAL AND ISSUES

5.1. It is proposed the funding from the DfE will be used to fund start up and transition costs with ongoing expenditure covered by the projected savings. The DfE have agreed to fund full year costs in Year 1 and part year costs in Year 2. The additional costs for Year 2 will be provided from Tri-borough budgets using existing staff and redirection of current funding streams, for example, for training. The costs of the programme are

outlined in the table below.

5.2. Subsequent funding post year 2 will be through services delivered as a result of the programme; should the savings not be as great as expected then the programme will be scaled back accordingly.

MAXIMUM COST OF THE PROGRAMME	2014/15	2015/16
Project management	£41k	£70k
Training	£200k	£460k
External observation on quality of engagement and impact of training	£20k	£30k
Heads of Clinical Practice (3 posts)	£81k	£210k
Family therapists or psychologists (24 posts)	£400k	£1,080k
Tracking programme team (15 posts)	£309k	£530k
Career pathway for social workers	£100k	£200k
Transitional social work staff (24 posts)	£267k	£960k
Total funding request	**£1,418k**	**£3,540k**

The two key areas for saving expected from the programme are:

5.3. Key change 1: Stronger and more intensive relationships between social workers and families, and use of more effective interventions in all parts of the system will reduce the number of repeat referrals. This will lead to a predicted reduction in the referral rate from 20% to 10% (of cases closed in the previous 12 months). The Tri-borough receives an average of 4,000 referrals every year so if the programme is successful this will lead to a reduction in re-referrals of 460 per annum, with a knock-on effect of fewer assessments, fewer Child Protection Conferences, fewer Child Protection Plans, and reduced demand on early help and social care services.

5.4. Key change 2: More effective interventions at the assessment, Child Protection Plan and children in need stages will reduce the percentage of children being taken into care by 20% (60 per annum).

5.5. These predicted changes in volume equate to the savings outlined in the table below. The largest portion of the savings is from a reduction in placement costs. The smaller portion of the projected cost saving is a reduction in staff costs.

SAVINGS	2015/16	2016/17	2017/18	2018/19	2019/20
Placement cost savings	£0.68m	£1.35m	£2.03m	£2.70m	£2.70m
Staff cost savings	-	£0.25m	£0.70m	£1.50m	£1.50m
Total savings	**£0.68m**	**£1.60m**	**£2.73m**	**£4.20m**	**£4.20m**

5.6. The grant was awarded on the basis of these proposals and the sustainability of the project as outlined in the bid papers attached as an appendix.

6. CONSULTATION

6.1. Discussions with social workers and with families regarding their experience of receiving services informed these proposals.

7. EQUALITY IMPLICATIONS

7.1. It is not considered that the adjustments to budgets as a result of this grant will have an impact on one or more protected group so an EIA is not required.

8. LEGAL IMPLICATIONS

8.1. The ability of Children Services to reorganise and transform interventions with families is within their general power of competence [s1(1) of the Localism Act] and is consistent with the general function to deliver children services in accordance with the Local Authority Social Services Act 1970. There are no other direct legal implications of the Report.

8.2. Implications verified/completed by: (Jade Monroe, Senior Solicitor 0208 753 2695)

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. The Bid to the Innovation Fund sets out as above the potential send plan for Tri Borough Focus on Practice for the period to March 2015. Hammersmith and Fulham Children's Services allocation will be approximately 38% of the £4m grant funding. The application of £0.33m from the Invest to Save fund is the match-funding required to secure the Innovation Fund Grant and optimises the chances of delivering the department's financial plan over 2015-18.

9.2. The workforce strategy is currently being finalised and recruitment planned over the coming months. The financial profile and monitoring of the forecast will be via the Focus on Practice Board who will agree and manage the budget.

9.3. The forecast spend will be monitored and reported through the monthly departmental revenue monitoring report which will also be scrutinised by the Senior Leadership Team.

9.4. The savings above are currently estimates based on potential reductions in referrals and the number of children becoming looked after. Impacts on the number of referrals and LAC will be closely monitored as part of the project.

9.5. Implications verified/completed by: Caroline Osborne, Tri Borough Head of Finance, Family Services. Ext 1423.

10. RISK MANAGEMENT

10.1. The report recommendations contribute positively to the management of key risk number 6, Standards and Delivery of Care, on the Council's Tri-borough risk register. The Bi-borough Risk Manager agrees that if the programme is successful this will lead to a reduction in re-referrals of, with a knock-on effect of fewer assessments, fewer Child Protection Conferences, fewer Child Protection Plans, and reduced demand on early help and social care services.

10.2. Implications completed by Michael Sloniowski Bi-borough Risk Manager ext. 2587.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1. *Not applicable*.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None.	Steve Miley	Children's services

LIST OF APPENDICES:

Appendix 1 Innovation Fund Bid

Tri-borough Innovation Programme Bid

Tri-borough local authorities and the Spring Consortium

July 2014

The case for change

- In the context of having to make 25% cuts in 2015-18, we have no choice but to do things differently.
- The model of social work practice developed over 20 years has seen the domination of case manager role in preference to direct and effective intervention. There is too much watching, waiting and referring out to other agencies to do the work with the family.
- We see front line practitioners who are not confident in their expertise, or given enough time or the means to develop trusted relationships with families. There is a stemming of practice expertise at a low level in the hierarchy, the only promotion route is a management route.
- Families have not got the support they have needed. Child outcomes have not therefore been as good as they could have been.
- There are too many repeat referrals, assessments, child protection plans and interventions which do not result in significant change, and which drive unnecessary costs. We need to get it right first time.
- There has been a growth in 'add on' projects and initiatives to test out models of practice, but little whole system change.

The proposed model of practice

- The three key elements of the new model are to create **time** for practitioners to work with families, to develop their knowledge, confidence and **expertise** in order that they are more effective in creating change, and lastly but importantly, to change the **system conditions** which reinforce and steer practice.
- Practitioners will work intensively with families to solve problems and change behaviours, rather than referring out to others.
- By use of evidence based interventions and a more engaging approach, practitioners will develop relationships with families that enable them to build on their strengths. To enable this to happen, there will be delivery of training, clinical supervision, and management and technology consistent with the new approach.
- The workforce will move from one which is dominated by micro management and process accountability to one where practice, not management, is the highest status, and is actively undertaken at all levels in the hierarchy.
- There will be built in learning mechanisms within the organisation, specifically, with the support of Professor Donald Forrester and his team, a framework of observation, feedback and coaching to change practitioner behaviour and consolidate training.
- We will work more proactively with families, identifying those who would benefit from sustained help at key stages, for example, secondary school transfer, in order to reduce the number of teenage entrants to care.
- At all stages we will continue our existing good practice in managing risk and keeping children and young people safe from harm.

Testing hypotheses for the Wider System

We propose to deliver this practice change at scale and pace across our 3 boroughs, and in doing so to create and share learning that is highly relevant to colleagues elsewhere. By not only making the change, but reflecting on and learning from HOW to make the change, we will develop our ability to serve as an equivalent to a 'teaching authority ' beyond the end of the programme.

We can change the behaviour and skills of the workforce, sustainably	What makes training effective and leads to impact on practice & outcomes? Coaching, consolidation? How important is the practitioner's starting point? What % of practitioners can really make the jump to being at least good or better under the new expectations? Evaluation team under Prof. Forrester will measure baselines, & monitor attitudes & practice in almost real time, providing short feedback loops to drive continual reflection allowing us to iterate on and flex the model
Intervention is most effective when the SW practitioner delivers everything themselves	What specialist skills do we want and need social workers (and wider teams) to have? What referrals might be needed and when? Is there a 'best' option for the working relationship between SW teams and the wider system (DV, D&A, MH etc). Is embedding clinicians the best way of influencing practice to be more systemic?
We can change how families view SW teams, create much more positive forms of engagement	Is it possible to change the expectations of families? How can this be done? Is it realistic to expect all practitioners on SW teams to have the relational skills necessary to do this?
There is an ideal timeframe for intervention	How much time is needed to change behaviour irreversibly? Do defined periods of intervention help (ie putting a limit on how long the intervention relationships should be)? How important is clarity of expectation? What about wider issues (eg housing, poverty, worklessness)? How do we ensure we don't build dependency?
We can describe and deliver effective step-down support for families	What offers work best, and enable families to avail themselves of what is on offer in the wider system, including Early Help? What role might there be for community or peer support? Do families who have experienced a positive engagement with our new SW teams engage better with the wider system too as a result?
Attending to system conditions is critical for success.	It has to be easier for practitioners to do the new thing than continue old practices which are familiar and comfortable: change will only be achieved and sustained if supported at every stage by permitting circumstances. What does this look like, in terms of leadership? Management? Technology? Administrative flexibility? Accountability? Culture? Incentives and rewards? Underpinning corporate systems (eg HR)?

Theory of Change

The following slides show a simplified version of our Theory of Change. A complex web of activity will be required to bring about the final outcomes we are looking to achieve:

- Children make improvements in progress measures
- Fewer children come into care
- Cost savings

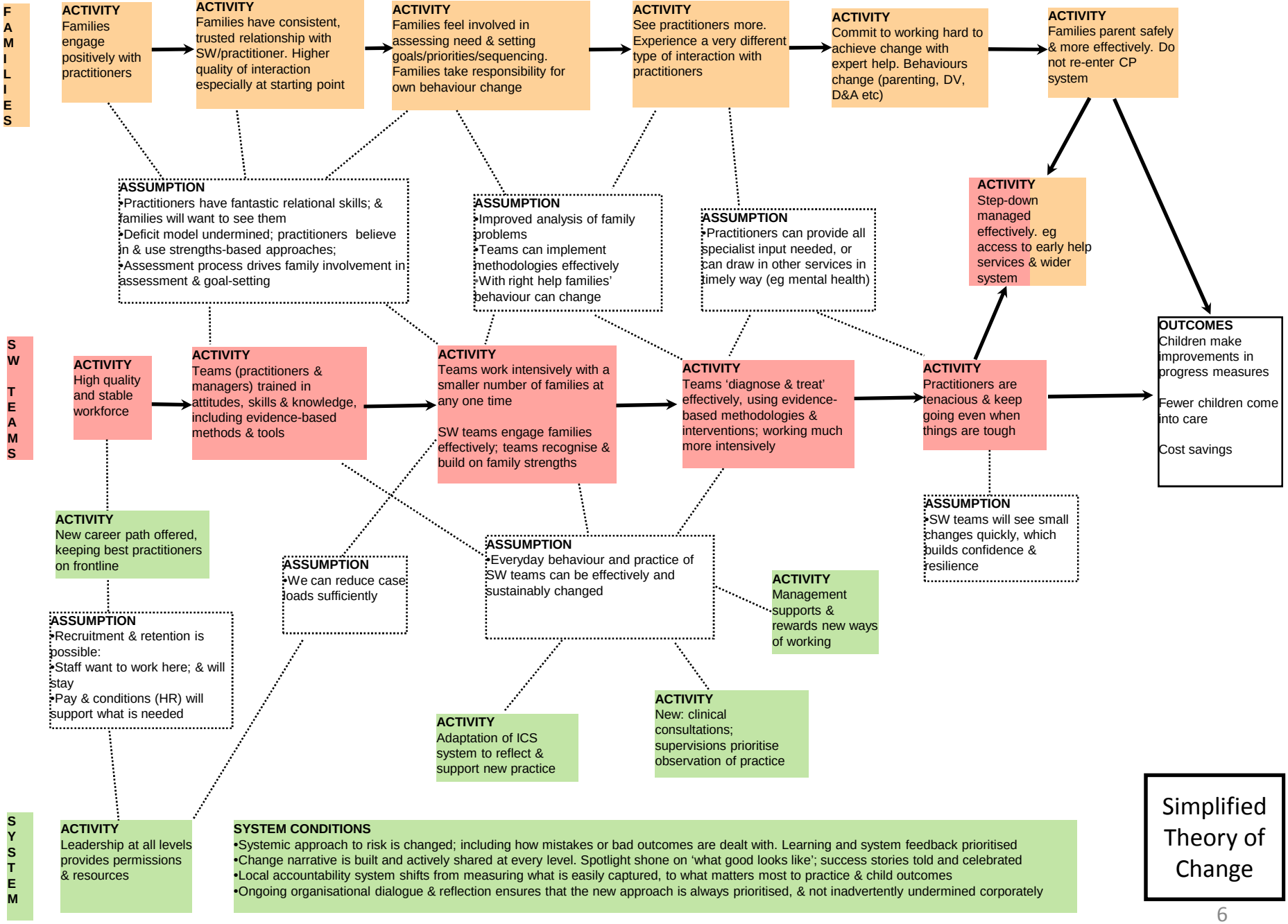
This Theory of Change defines the key building blocks we believe will be required to bring about the longterm outcomes, and makes explicit the underpinning assumptions behind the causal links between the steps in the change pathway. We have identified the changes we need to bring about:

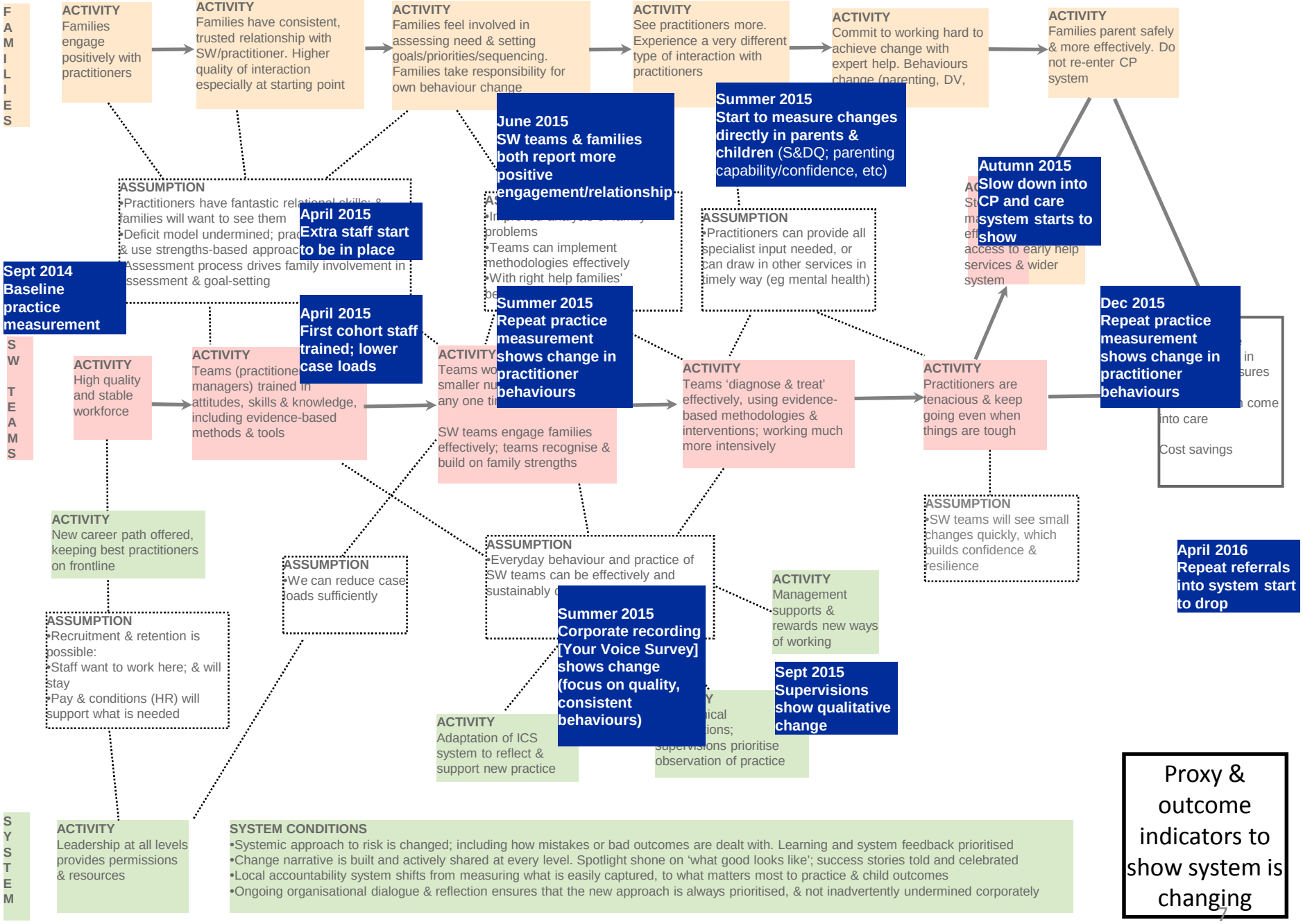
Changes in Families

Changes in SW Teams

Changes in the under-pinning system

The second slide identifies indicators that will show that the system is changing in the way that it needs to, and the dates when we expect to be able to start measurements. We are particularly keen to have proxy measures that will give us confidence that change is happening (for example in families' experiences, in practitioner behaviour), long before outcomes for children and referral numbers start to shift.


FAMILIES
ACTIVITY
Families engage positively with practitioners
ACTIVITY
Families have consistent, trusted relationship with SW/practitioner. Higher quality of interaction especially at starting point
ACTIVITY
Families feel involved in assessing need & setting goals/priorities/sequencing. Families take responsibility for own behaviour change
ACTIVITY
See practitioners more. Experience a very different type of interaction with practitioners
ACTIVITY
Commit to working hard to achieve change with expert help. Behaviours change (parenting, DV, D&A etc)
ACTIVITY
Families parent safely & more effectively. Do not re-enter CP system
ASSUMPTION
•Practitioners have fantastic relational skills; & families will want to see them
•Deficit model undermined; practitioners believe in & use strengths-based approaches;
•Assessment process drives family involvement in assessment & goal-setting
ASSUMPTION
•Improved analysis of family problems
•Teams can implement methodologies effectively
•With right help families' behaviour can change
ASSUMPTION
•Practitioners can provide all specialist input needed, or can draw in other services in timely way (eg mental health)
ACTIVITY
Step-down managed effectively. eg access to early help services & wider system
SW TEAMS
ACTIVITY
High quality and stable workforce
ACTIVITY
Teams (practitioners & managers) trained in attitudes, skills & knowledge, including evidence-based methods & tools
ACTIVITY
Teams work intensively with a smaller number of families at any one time
SW teams engage families effectively; teams recognise & build on family strengths
ACTIVITY
Teams 'diagnose & treat' effectively, using evidence-based methodologies & interventions; working much more intensively
ACTIVITY
Practitioners are tenacious & keep going even when things are tough
OUTCOMES
Children make improvements in progress measures
Fewer children come into care
Cost savings
ACTIVITY
New career path offered, keeping best practitioners on frontline
ASSUMPTION
•We can reduce case loads sufficiently
ASSUMPTION
•Everyday behaviour and practice of SW teams can be effectively and sustainably changed
ACTIVITY
Management supports & rewards new ways of working
ASSUMPTION
•SW teams will see small changes quickly, which builds confidence & resilience
ASSUMPTION
•Recruitment & retention is possible:
•Staff want to work here; & will stay
•Pay & conditions (HR) will support what is needed
ACTIVITY
Adaptation of ICS system to reflect & support new practice
ACTIVITY
New: clinical consultations; supervisions prioritise observation of practice
SYSTEM
ACTIVITY
Leadership at all levels provides permissions & resources
SYSTEM CONDITIONS
•Systemic approach to risk is changed; including how mistakes or bad outcomes are dealt with. Learning and system feedback prioritised
•Change narrative is built and actively shared at every level. Spotlight shone on 'what good looks like'; success stories told and celebrated
•Local accountability system shifts from measuring what is easily captured, to what matters most to practice & child outcomes
•Ongoing organisational dialogue & reflection ensures that the new approach is always prioritised, & not inadvertently undermined corporately
Simplified Theory of Change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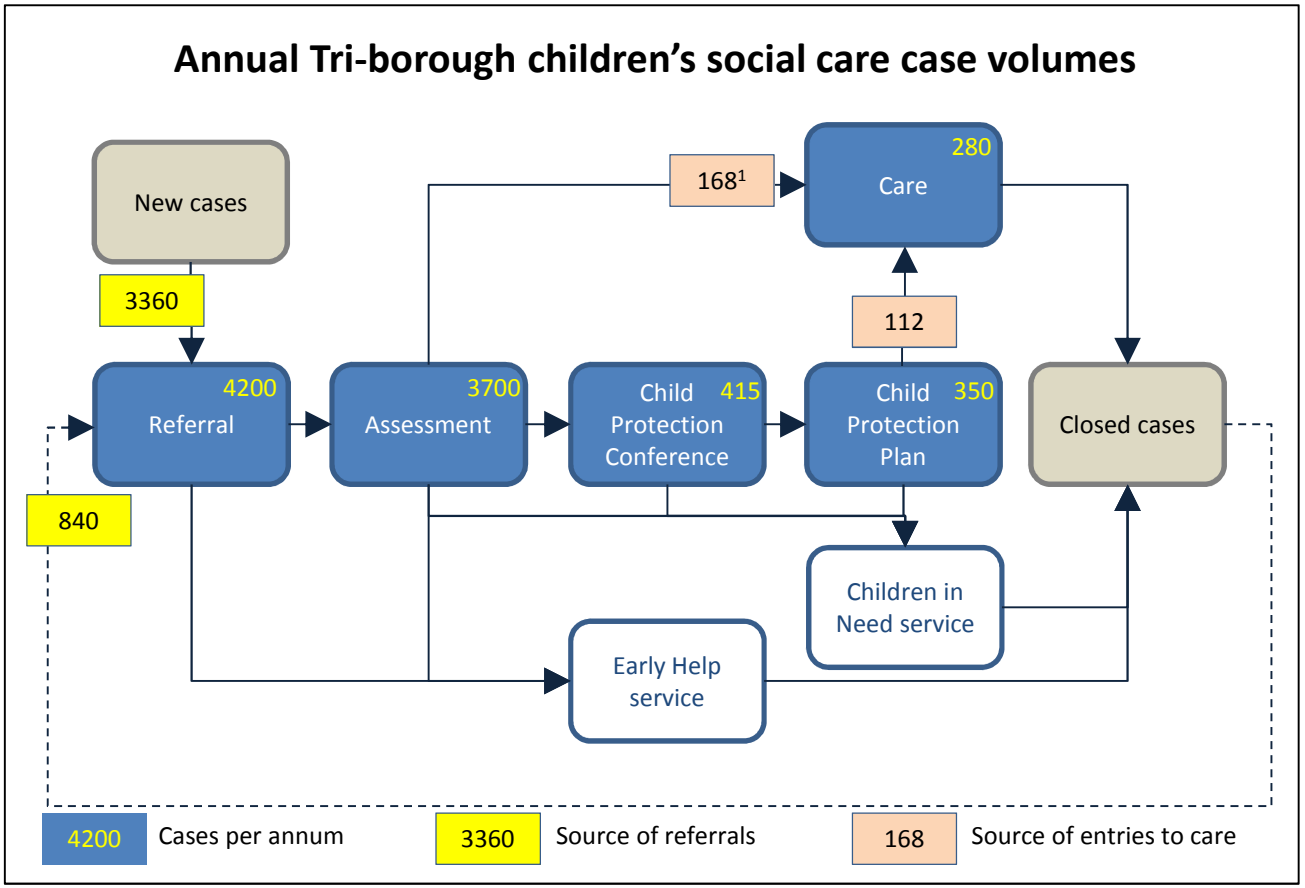
ACTIVITY
See practitioners more. Experience a very different type of interaction with practitioners
ACTIVITY
Commit to working hard to achieve change with expert help. Behaviours change (parenting, DV,
ACTIVITY
Families parent safely & more effectively. Do not re-enter CP system
June 2015
SW teams & families both report more positive engagement/relationship
Summer 2015
Start to measure changes directly in parents & children (S&DQ; parenting capability/confidence, etc)
Autumn 2015
Slow down into CP and care system starts to show
ASSUMPTION
•Practitioners have fantastic rela
families will want to see them
•Deficit model undermined; prac
& use strengths-based approac
Assessment process drives family involvement in
ssessment & goal-setting
April 2015
Extra staff start to be in place
problems
•Teams can implement methodologies effectively
•With right help families'
ASSUMPTION
•Practitioners can provide all specialist input needed, or can draw in other services in timely way (eg mental health)
access to early help services & wider system
Sept 2014
Baseline practice measurement
April 2015
First cohort staff trained; lower case loads
Summer 2015
Repeat practice measurement shows change in practitioner behaviours
Dec 2015
Repeat practice measurement shows change in practitioner behaviours
SW TEAMS
ACTIVITY
High quality and stable workforce
ACTIVITY
Teams (practitione
managers) trained in
attitudes, skills & knowledge, including evidence-based methods & tools
ACTIVITY
Teams wo
smaller nu
any one ti
SW teams engage families effectively; teams recognise & build on family strengths
ACTIVITY
Teams 'diagnose & treat' effectively, using evidence-based methodologies & interventions; working much more intensively
ACTIVITY
Practitioners are tenacious & keep going even when things are tough
in
sures
come
into care
Cost savings
ACTIVITY
New career path offered, keeping best practitioners on frontline
ASSUMPTION
•SW teams will see small changes quickly, which builds confidence & resilience
April 2016
Repeat referrals into system start to drop
ASSUMPTION
•We can reduce case loads sufficiently
ASSUMPTION
Everyday behaviour and practice of SW teams can be effectively and sustainably
ACTIVITY
Management supports & rewards new ways of working
ASSUMPTION
•Recruitment & retention is possible:
•Staff want to work here; & will stay
•Pay & conditions (HR) will support what is needed
Summer 2015
Corporate recording [Your Voice Survey] shows change (focus on quality, consistent behaviours)
Sept 2015
Supervisions show qualitative change
ACTIVITY
Adaptation of ICS system to reflect & support new practice
ical
ions;
visions prioritise observation of practice
SYSTEM
ACTIVITY
Leadership at all levels provides permissions & resources
SYSTEM CONDITIONS
•Systemic approach to risk is changed; including how mistakes or bad outcomes are dealt with. Learning and system feedback prioritised
•Change narrative is built and actively shared at every level. Spotlight shone on 'what good looks like'; success stories told and celebrated
•Local accountability system shifts from measuring what is easily captured, to what matters most to practice & child outcomes
•Ongoing organisational dialogue & reflection ensures that the new approach is always prioritised, & not inadvertently undermined corporately
Proxy & outcome indicators to show system is changing

Current flow of children through the Tri-borough social care system

The diagram below provides a simplified model of the children's social care system and is used in the slides that follow to illustrate the impact of the Tri-borough's proposed children's social care changes. All figures displayed represent numbers of children.

Key features of the Tri-borough's current children's social care volumes include:

- 4200 annual referrals to children's social care, of which 20% are repeat referrals related to families who have previously received children's social care support in the previous 12 months[2].
- 3700 annual statutory care assessments, resulting in 415 Child Protection Conferences , following which 350 families receive a Child Protection Plan.
- 280 annual entries into care, of which 112 involve children who have previously received a Child Protection Plan but for whom the planned interventions were ineffective in preventing the need for the child to be taken into care (32% of all Child Protection Plans).



The Tri-borough system also features step-down (and occasionally step-up) Children in Need and Early Help services, provided by a combination of internal social care work staff and external services commissioned by the Tri-borough from other providers.

[1] For simplicity these 168 entries to care are shown in the diagram as being made from the assessment stage. In reality some of these cases are made directly at the referral stage, and some others are made from the Children in Need service.

[2] In addition, there are also many children and families referred to social care who have received social care more than 12 months previously. Data on the number of such cases is not available. In the diagram, these cases will be included in the 3360 "new" cases.

Changes to flow of children through the Tri-borough social care system

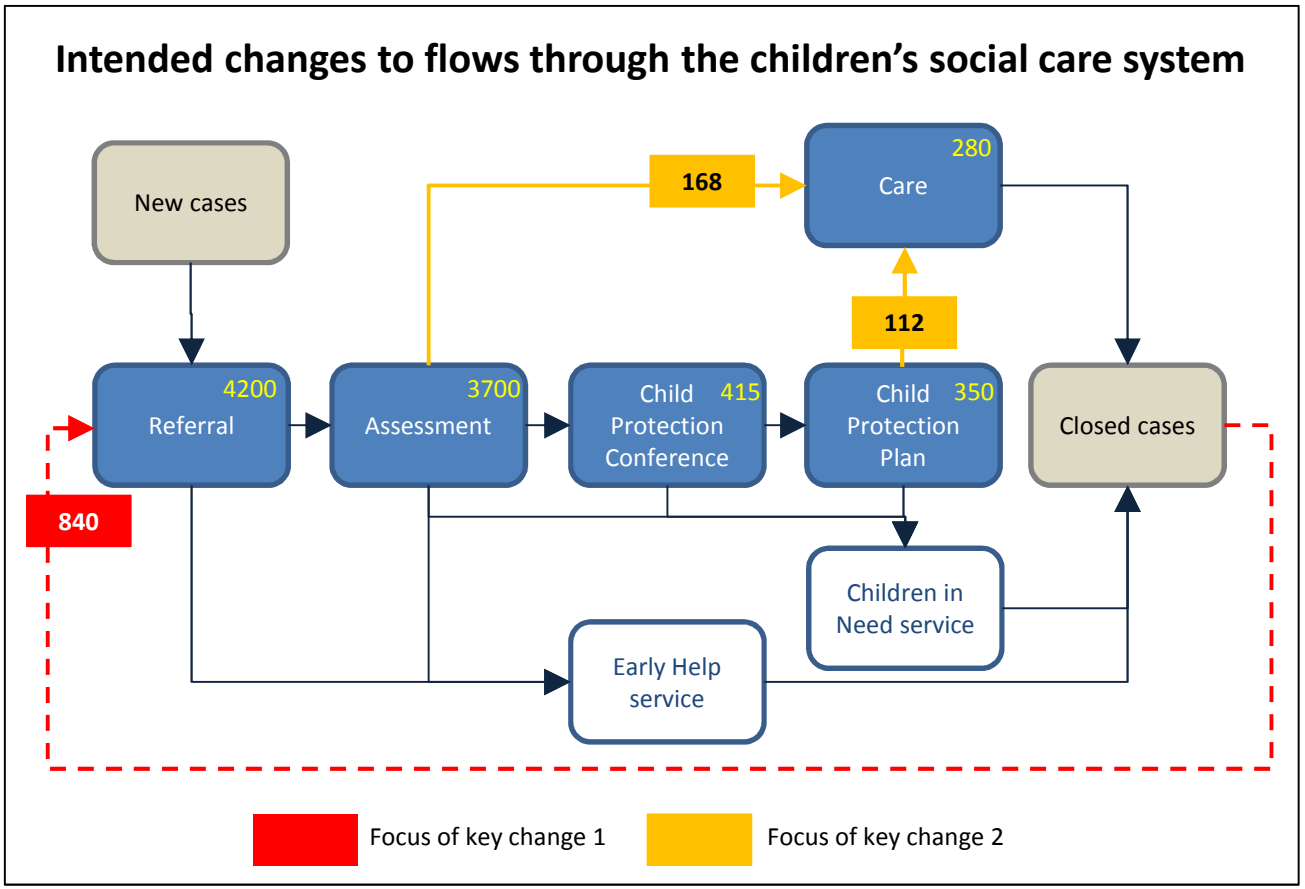
The proposed new Tri-borough children's social care services model will result in two key changes to the flows of children around the system. These are described below, with the assumed magnitude of the change also outlined.

Key change 1: Stronger and more intensive relationships between social workers and families, and use of more effective interventions in all parts of the system (including Early Help and Children in Need services) will reduce the number of repeat referrals.

Assumed size of change: Reduction in the referral rate from 20% to 10% of all closed cases.

Key change 2: More effective interventions at the assessment, Child Protection Plan (CPP) and Children in Need stages will reduce the percentage of children being taken into care

Assumed size of change:
(i) A 10% reduction (from 4.8% to 4.3% of assessments) in the percentage of children entering care without a CPP.
(ii) A 25% reduction (from 32% to 24% of CPPs) in the percentage of children with CPPs subsequently entering care.



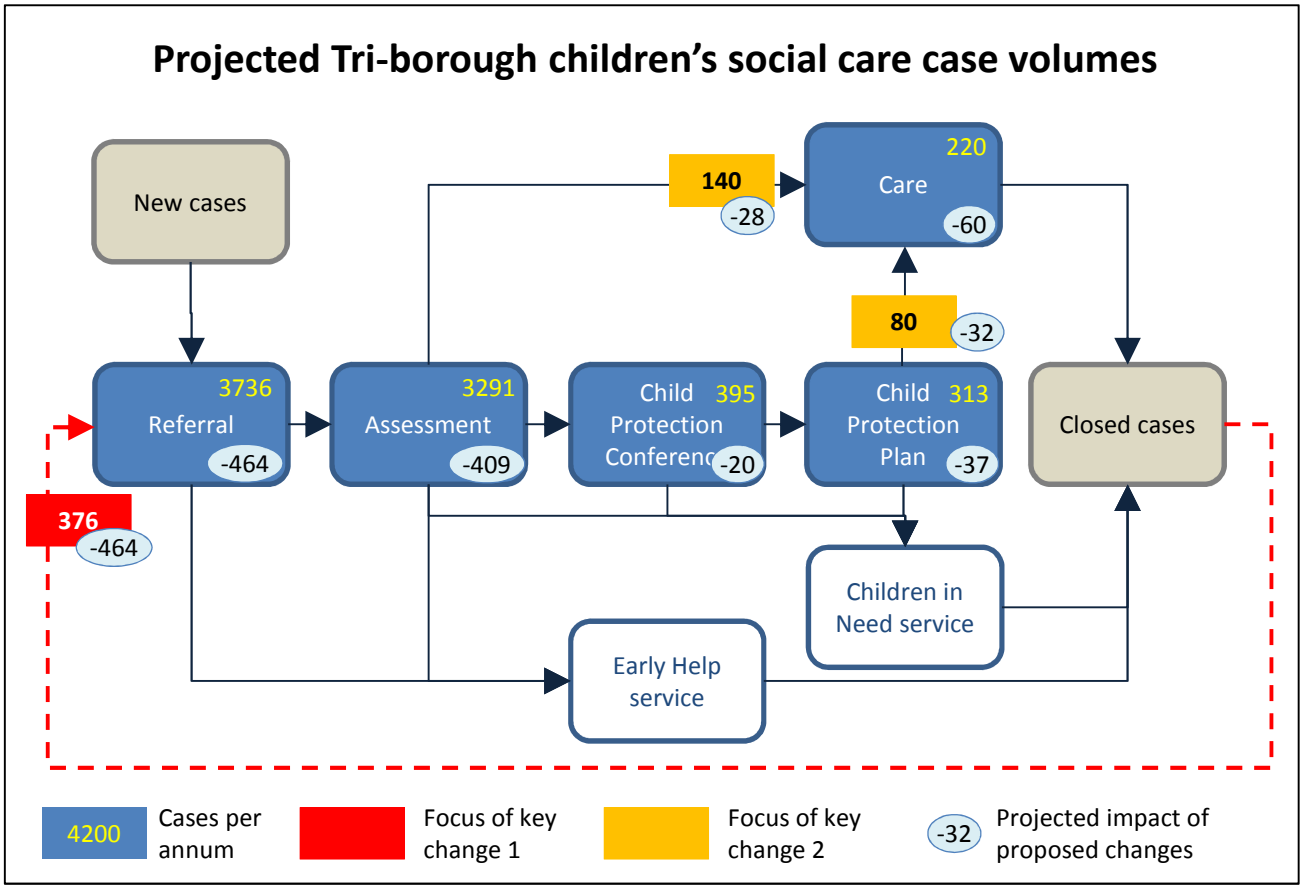
The following page examines the impact of these changes in more detail , and Annex 2 examines sensitivity to the assumptions outlined in the paragraphs above.

Future flow of children through the Tri-borough social care system

The diagram below highlights the projected changes to flows through the Tri-borough children's social care system, based on the key changes detailed on the previous page and the outlined assumptions associated with each.

The main impacts on flows are:

- A reduction in re-referrals of 464 per annum, with a knock-on effect of fewer assessments, fewer Child Protection Conferences, fewer Child Protection Plans, and reduced demand on the Early Help and Children in Need services.
- A reduction in the number of children entering care of 60 per annum (with a small increase in volumes of Child Protection Conferences and Child Protection Plans as an alternative to direct entry to care from the assessment stage).



The size of impacts highlighted above are dependent on the assumptions associated with the changes to the system . Annex 2 examines sensitivity to those assumptions.

Innovation Programme financial support

We are requesting £1.4m in 2014/15 and £3.5m in 2015/16 to fund the additional expenditure that is not covered by the use of existing resources. This financial support will enable us to:

- Implement the model in a much shorter timeframe than we would otherwise be able to do ourselves with existing financial constraints.
- Demonstrate the impact of our proposed model at a system level and share lessons learned with other Local Authorities embarking on similar changes

The table opposite gives a breakdown of the funding request. Each item in that table is explained in more detail on the following page, with outline implications of not receiving funding for each item.

Variances to our previous proposal

In developing our proposal further we have made the following changes to the financial support being requested:

1. Reduced amounts for new posts in 2014/15 for two reasons:
   - People will be in new posts for a shorter portion of 2014/15 than we previously planned due to a later start date
   - A staggered recruitment to the family therapist and transitional social worker posts is planned, with three major rounds of recruitment over a period of 6 months
2. An increase in training costs to reflect more detailed analysis of training needs that we have now undertaken (we noted in the previous proposal the figure at that time was a rough estimate)
3. Addition of £50k cost of external researchers to observe and rate the quality of engagement with families before, and after training.
4. A more accurate estimate for the tracking programme team costs
5. A reduction in some 2015/16 amounts where these will be able to be part-funded from existing Tri-borough budgets

The table opposite summarises these variances. Annex 3 provides more detail.

Financial support request

	2014/15	2015/16
Project management	£41k	£70k
Training	£200k	£460k
External observation on quality of engagement and impact of training	£20k	£30k
Heads of Clinical Practice (3 posts)	£81k	£210k
Family therapists or psychologists (24 posts)	£400k	£1,080k
Tracking programme team (15 posts)	£309k	£530k
Career pathway for social workers	£100k	£200k
Transitional social work staff (24 posts)	£267k	£960k
Total funding request	**£1,418k**	**£3,540k**

Tri-borough will itself fully fund backfill of training, management input to the project, changes to IT system and training programme development.

Variances to previous proposal

	2014/15	2015/16
Previous proposal	£1,800k	£3,460k
Revised 2014/15 recruitment profile	(£621k)	-
Revised training estimate	£100k	£400k
External observation on quality of engagement and impact of training	£20k	£30k
Revised tracking programme team costs	£119k	£150k
Amounts part-funded by Tri-borough	-	(£500k)
Revised funding request	**£1,418k**	**£3,540k**

Innovation Programme financial support

The table below describes the expenditure for which funding is requested , and outlines the likely alternative course of action that the Tri-borough will take if each item is not funded by the Innovation Programme

	Description	Funding request	Alternative to Innovation Programme funding
Project management	The project management job profile would include teaching and coaching of staff	£111k	Without project management capacity, senior managers would manage the project on top of day jobs. The change programme would be considerably slower.
Training	Training of staff in evidence based interventions and systemic approaches	£660k	Some training would take place but at a much smaller scale and would inevitably lead to pockets of training rather than whole system change
External researchers	External researchers to regularly observe and rate the quality of engagement with families before, during and after practitioners have engaged in training.	£50k	Consolidation of learning is crucial in embedding skill and knowledge development of staff. Without this element of the programme there is a risk that the training would be less effective and that staff would revert to previous practice.
Heads of Clinical Practice (3 posts)	K&C have appointed to this post and the first year of costs are covered in one borough	£291k	Without additional capacity and expertise provided by lead clinical practice posts, systemic practice would be adopted at a superficial level and only partly embedded.
Family therapists or psychologists (24 posts)	Joint funding arrangements with health commissioners may reduce this amount. We would want to employ a number of these staff permanently and will work with our CAMHS colleagues to re-commission existing contracts	£1,480k	In a similar vein to the point above, without the expertise provided by family therapists, the change in practice, would still be positive, but the difference would be less radical and systemic practice much harder to embed as a routine way of working with families.
Tracking programme team (15 posts)	Case tracking practitioners will proactively identify and follow targeted cohorts of children and provide ongoing analysis	£839k	Without the funding for this team, our business analysis team would take on the tracking function but not as their core business. We would model proactive intervention with a small pilot group in one borough.
Career pathway for social workers	10 senior posts per borough at an additional cost of £30k per post. This will taper over three years as current management posts are adapted.	£300k	The career pathway is an essential change to the practice system and we would continue to develop practice posts at a higher level in the hierarchy, but at a much slower pace and in a more piecemeal way, possibly one or two posts per year over a five year period.
Transitional social work staff (24 posts)	An additional 10 social workers in H&F, 8 in Westminster and 6 in K&C to enable a gradual reduction in caseloads over a three year period	£1,227k	The transitional staff are a key element to provide capacity and reduce risk during the change programme. They are also a key component in reducing caseloads. Without transitional capacity we would continue to reduce caseloads but at a much slower rate, and in response to reduced demand after three years.
Total		**£4,958k**	

Financial sustainability

The sustainability of the new model depends on it directly contributing to (or enabling) 25% cost reductions that Tri-borough must make over that timeframe. In that context, Tri-borough's proposal for Innovation Programme support projected annual recurring cost savings of £4.2m (2018/19 onwards).

Projected recurring cost savings (original proposal)

	2015/16	2016/17	2017/18	2018/19	2019/20
Placement cost savings	£0.68m	£1.35m	£2.03m	£2.70m	£2.70m
Staff cost savings	-	£0.25m	£0.70m	£1.50m	£1.50m
Total savings	**£0.68m**	**£1.60m**	**£2.73m**	**£4.20m**	**£4.20m**

The largest portion of the projected cost saving is lower placement costs resulting from fewer children entering care. The projected savings value is based on up to a 20% reduction in the number entering care. The projections on the previous pages highlight how a reduction of this magnitude might be achieved.

The smaller portion of the projected cost saving is a reduction in staff costs. There are various competing factors that will affect the staff costs required by the new model. These are outlined in the table opposite.

Further work is needed to model these factors and to validate the achievability of the projected staff cost savings and test whether the proposed model is sustainable within the financial envelope within which the Tri-borough will need to operate.

Factors affecting projected cost savings

		Why might costs increase?	What might enable cost reductions?
Placement costs			• Fewer children entering care
Staff costs	Social workers	• More time spent per family • Creation of higher cost senior social worker grade	• Fewer repeat referrals
	Other social work staff	• New permanent clinical therapist roles	• More targeted use of edge of care / step down services
	Managerial and supervisory staff	• New head of clinical practice role in each borough	• Possible need for fewer supervisors due to staff being higher-skilled (including the new senior social worker grade)

Wider benefits

A more effective children's social care system that results in better and more timely outcomes for children will also have indirect benefits across the wider public sector (edge of care services, school interventions, health services, youth justice, etc).

What does innovation investment buy?

Rather than running a small-scale 'innovation project', investment will allow us to accelerate significantly the scale (whole system) & pace of change, including:

- Delivery of comprehensive skills and development programme for 600 staff over two years instead of five, significantly accelerating the change in frontline practice that we need to see. The existing training budget will be used to supplement these funds as current learning and development programmes are de-commissioned.
- Use of transitional staff to reduce caseloads quickly, in order that more effective work can be undertaken, reducing repeat referrals and the numbers of families being worked with at any one time. Lower caseloads can be maintained as the number of additional staff tapers in year three.
- Paying for additional costs of practitioners at senior levels. The long term funding for these posts will come from reducing the numbers of posts with management responsibilities, currently 150.
- Employing clinical staff at all levels to develop expertise in systemic practice; as expertise embeds, the need for this will decrease. Expected reduced demand on CAMHS will support negotiations for shared funding of clinical posts (early conversations with commissioners are promising).

Investment will also fund powerful systemic learning:

- The whole model depends on achieving behaviour change in practitioners and managers, but evidence from education in England [CUREE study for Teacher Development Trust] suggests barely 1% of training is transforming classroom practice. We will develop a robust, replicable model for successful practitioner behaviour change. Key to this is the embedding real-time observation of practice and coaching into our programme of change of change, enabling us to assess what is working (how much, and why?) and what is not (why?), and the impact of training on different types of practitioner.
- Driving whole systems rather than piecemeal change will enable us to attend properly to the system conditions and permitting circumstances that are so influential on success (or failure). This will be key if new models of practice are to diffuse and embed successfully nationally.

Focus on Practice: Risks & Mitigations

Risk	Mitigation
Child Death: potential that a child dies in circumstances which bring intense media pressure, and questions about whether Focus On Practice has been a contributory factor.	We are not changing our child protection antennae or system; we are adding quality interventions into the system. Existing framework is unchanged and we will continue to keep children safe from harm.
Family Engagement: risk that the frequency with which families engage effectively in our interventions is lower than anticipated.	We will involve families in co-design, to ensure that there is the best possible chance of them choosing to engage positively with the new offer
Inconsistencies in the System: risk that some elements of our system do not sign up to or deliver Focus on Practice in full – for example practitioners may be wholly engaged, but impact will be weakened if their supervisors and managers are not, or practitioners find it a struggle to change deeply embedded ways of working	Programme of observation, coaching and consolidation will enable us to find out quickly if and where problems like this might exist, and to mitigate against them.
Lack of support: risk that political and/or corporate leaders do not understand or maintain support for the programme, most likely due to pressures for delivery of savings, or as a result of high profile CP case.	We have excellent high level commitment to the change programme, which we will seek actively to maintain through continuation of active dialogue at every stage
Recording: risk that we fail to change recording practice and so fail to increase time practitioners spend delivering interventions with families.	Considerable energy already invested in case recording practice, which will be maintained.
Proven interventions: risk that our implementation of four key programmes does not have the impact anticipated despite their evidence base.	We know that picking the right models is necessary but not sufficient for success in terms of outcomes. Commitment to fidelity of implementation, clinical supervision, and the observation of practice and coaching will help maximise impact. But we are clear that behaviour change will not be achieved in every case.
Assumptions on reduced demand and delivery of savings: risk that projections turn out to be miscalculated such that the planned tapering of additional staff capacity becomes harder to achieve, making model unsustainable.	Detailed further modelling including of staffing, flow, throughput, volumes, workload etc to understand how best the model can work within the viable financial envelope.

Conclusion / outcomes for children

- The theory of change and data analysis in the slides above, demonstrate the projected reduction in demand which we would expect to see and which is outlined in the table below.

- By reducing the number of families we work with at any one time, we will manage a gradual reduction in caseloads for practitioners, giving them the time to work intensively and in-depth with families. The additional expertise, use of evidence based methodologies and embedded systemic practice will lead to more effective intervention and improved outcomes for children and their families.

- We believe this whole system change will lead to a radically different relationship between practitioners and the families with whom we work and facilitate change within a risk management context, which will enable more children to grow up safely within their families.

	2014/15	2015/16	2016/17	2017/18	2018/19
Referrals	4,200	4,200	3,990	3,759	3,736
Change from 2014/15		-	*-210*	*-441*	*-464*
Assessments	3,700	3,700	3,515	3,312	3,291
Change from 2014/15		-	*-185*	*-388*	*-409*
Child Protection Conferences	415	422	414	397	395
Change from 2014/15		*+7*	*-1*	*-18*	*-20*
Child Protection Plans	350	356	349	335	333
Change from 2014/15		*+6*	*-1*	*-15*	*-17*
Entered into care	280	261	231	221	220
Change from 2014/15		*-19*	*-49*	*-59*	*-60*

ANNEX 1: Next steps (modelling of flows and cost savings)

Further modelling of flows and cost savings will enable Tri-borough to make detailed transition and staffing plans, validate that the proposed changes are sustainable within the future available financial envelope, and establish clear benefits targets. In particular, the Tri-borough would welcome analytical and financial modelling support from the DfE Innovation Programme's delivery partner with two distinct (but related) areas of focus.

Validation of flow assumptions

The projected impact of Tri-borough's proposed model is dependent on the achievability of the assumed reductions in:

- Repeat referral rate
- Percentage of children at the assessment stage being entered directly into care
- Number of children with a Child Protection Plan subsequently being entered into care

Subject to availability of suitable data, these assumptions can be validated via one or a combination of the following methods:

- Benchmarking across the three boroughs (to identify scale of reductions possible through adoption of local best practices)
- Benchmarking with other Local Authorities (to identify potential scale of reductions through adoption of national best practices)
- Degree of change achieved by other Local Authorities (e.g. Hackney) who have made similar changes to their approach to children's social care
- Dip sampling of historic Triborough cases to identify those where alternative courses of action might be taken under the proposed model

Staffing, costs and savings modelling

More detailed modelling of future staffing, costs and savings will validate that the proposed model can generate the level of saving necessary for Tri-borough's children's social care services to be able to operate within the future likely available budgets.

The core of this modelling will be a five-year staffing model that will enable analysis and forecasting of:

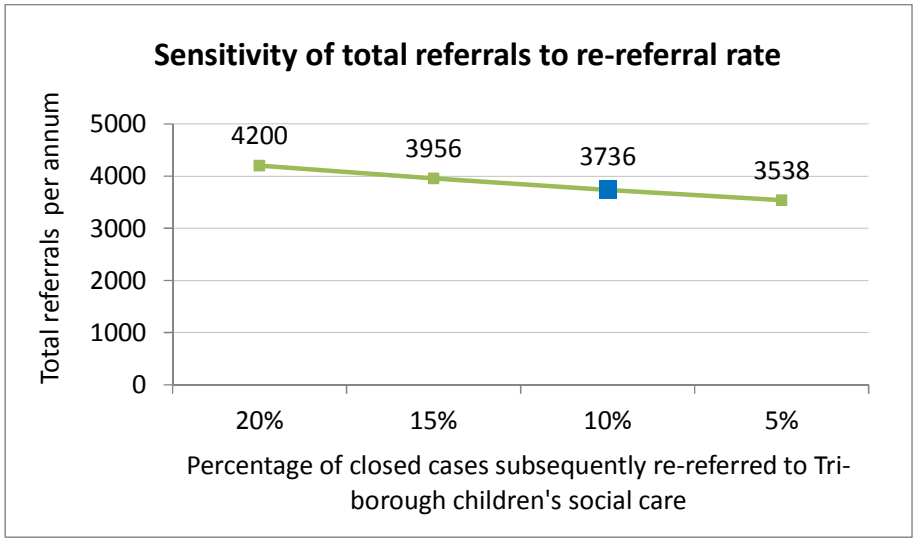
- Social worker staffing levels required to enable smaller caseloads and more intensive relationships with families, whilst taking into account the projected changes in the volumes and flows of children through the system
- Other social care work staffing levels, in particular taking into account new clinical therapists, and the impact of changes in volumes and flows through the system on step-down and edge of care services
- Supervisory staff levels, including the impact of the introduction of a senior social worker role, and career pathway for social workers, and analysis of potential options to increase spans of control and reduce numbers of supervisors

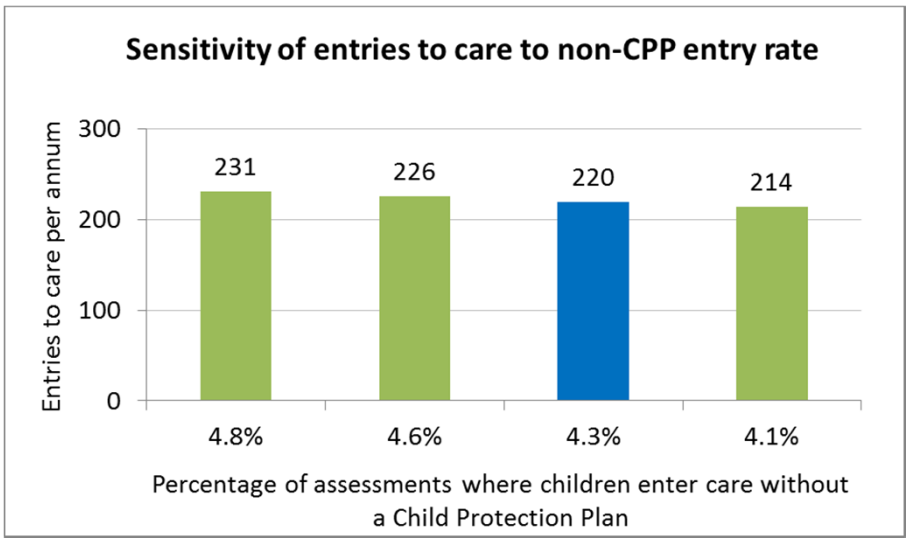
ANNEX 2: Sensitivity analysis

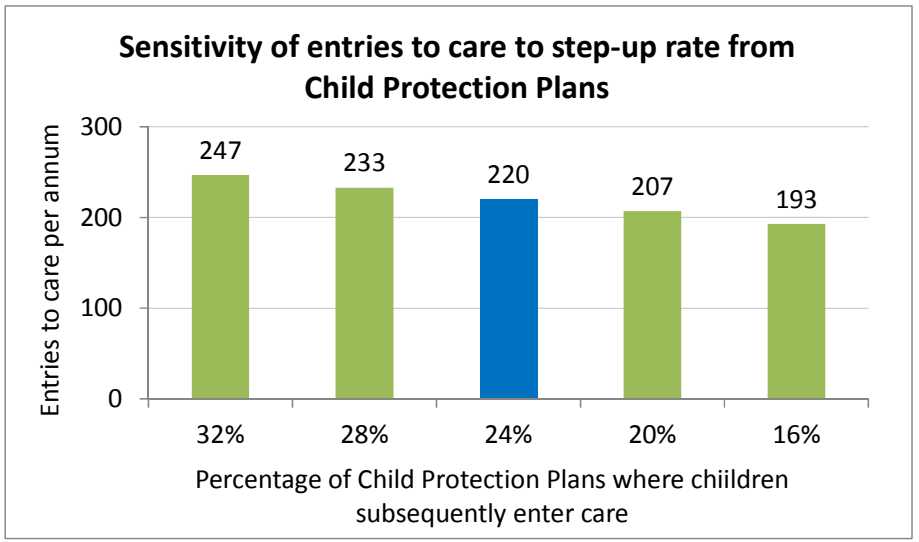
The charts on this page illustrate the sensitivity of volumes and flows of children to three key assumptions with regard to the impact of the proposed changes to Tri-borough's children's social care model:

- A reduction in the re-referral rate from 20% of closed cases to 10% [sensitivity of total referrals illustrated in the upper right graph]
- A reduction in the percentage of times where a child with a Child Protection Plan (CPP) subsequently enters care from 32% of CPPs to 24% [sensitivity of total care entries illustrated in the lower right graph]
- A reduction in the percentage of non-CPP cases where a child is entered into care from 4.8% of assessments to 4.3% [sensitivity of total entries to care illustrated in the lower left graph]

Base case assumptions Sensitivity test assumptions







N.B. In examining sensitivity to each assumption, the other two key assumptions remained constant at their base case projections (e.g. in the top right graph showing sensitivity to re-referral rate, the assumptions for direct entry from assessment and step-up from CPP are fixed at 4.3% and 24%)

ANNEX 3: Innovation Programme financial support

Previous funding request		Add in Tri-borough part funding deducted previously	**Previous cost estimate**			Re-profiling of 2014/15 recruitment	Re-estimate from more detailed/ accurate analysis		**Revised cost estimate**		Part-funding by Tri-borough		**Revised funding request**	
2014/15	*2015/16*	*2014/15*	*2014/15*	*2015/16*		*2014/15*	*2014/15*	*2015/16*	*2014/15*	*2015/16*	*2014/15*	*2015/16*	*2014/15*	*2015/16*
70	70		70	70	**Project management**	(-29)	-	-	41	70	-	-	41	70
100	100		100	100	**Training**	-	100	400	200	500	-	(-40)	200	460
-	-		-	-	**External researchers**	-	20	30	20	30	-	-	20	30
140	210	70	210	210	**Heads of Clinical Practice (3 posts)**	(-59)	-	-	151	210	(-70)	-	81	210
720	1440		720	1440	**Family therapists or psychologists (24 posts)**	(-320)	-	-	400	1440	-	(-360)	400	1440
190	380		190	380	**Tracking programme team (16 posts)**	-	119	150	309	530	-	-	309	530
100	300		100	300	**Career pathway for social workers**	-	-	-	100	300	-	(-100)	100	300
480	960		480	960	**Transitional social work staff (24 posts)**	(-213)	-	-	267	960	-	-	267	960
1,800	**3,460**	70	**1,870**	**3,460**	**Total**	(-621)	239	580	**1,488**	**4,040**	(-70)	(-500)	**1,418**	**3,540**
					Backfill[1]		60	100			(-60)	(-100)		

All figures in £000s

[1] Backfill of training, management input to the project, changes to system pcs and training programme development

NOTICE OF CONSIDERATION OF A KEY DECISION

In accordance with paragraph 9 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the Cabinet hereby gives notice of Key Decisions which it intends to consider at its next meeting and at future meetings. The list may change between the date of publication of this list and the date of future Cabinet meetings.

NOTICE OF THE INTENTION TO CONDUCT BUSINESS IN PRIVATE

The Cabinet also hereby gives notice in accordance with paragraph 5 of the above Regulations that it intends to meet in private after its public meeting to consider Key Decisions which may contain confidential or exempt information. The private meeting of the Cabinet is open only to Members of the Cabinet, other Councillors and Council officers.

Reports relating to key decisions which the Cabinet will take at its private meeting are indicated in the list of Key Decisions below, with the reasons for the decision being made in private. Any person is able to make representations to the Cabinet if he/she believes the decision should instead be made in the public Cabinet meeting. If you want to make such representations, please e-mail Katia Richardson on *katia.richardson@lbhf.gov.uk*. You will then be sent a response in reply to your representations. Both your representations and the Executive's response will be published on the Council's website at least 5 working days before the Cabinet meeting.

KEY DECISIONS PROPOSED TO BE MADE BY CABINET ON 3 NOVEMBER 2014 AND AT FUTURE CABINET MEETINGS UNTIL MARCH 2015

The following is a list of Key Decisions which the Authority proposes to take at the above Cabinet meeting and future meetings. The list may change over the next few weeks. A further notice will be published no less than 5 working days before the date of the Cabinet meeting showing the final list of Key Decisions to be considered at that meeting.

KEY DECISIONS are those which are likely to result in one or more of the following:

- **Any expenditure or savings which are significant (ie. in excess of £100,000) in relation to the Council's budget for the service function to which the decision relates;**
- **Anything affecting communities living or working in an area comprising two or more wards in the borough;**
- **Anything significantly affecting communities within one ward (where practicable);**
- **Anything affecting the budget and policy framework set by the Council.**

The Key Decisions List will be updated and published on the Council's website on a monthly basis.

NB: Key Decisions will generally be taken by the Executive at the Cabinet.

If you have any queries on this Key Decisions List, please contact
***Katia Richardson** on 020 8753 2368 or by e-mail to katia.richardson@lbhf.gov.uk*

Access to Cabinet reports and other relevant documents

Reports and documents relevant to matters to be considered at the Cabinet's public meeting will be available on the Council's website (www.lbhf.org.uk) a minimum of 5 working days before the meeting. Further information, and other relevant documents as they become available, can be obtained from the contact officer shown in column 4 of the list below.

Decisions

All decisions taken by Cabinet may be implemented 5 working days after the relevant Cabinet meeting, unless called in by Councillors.

Making your Views Heard

You can comment on any of the items in this list by contacting the officer shown in column 4. You can also submit a deputation to the Cabinet. Full details of how to do this (and the date by which a deputation must be submitted) will be shown in the Cabinet agenda.

LONDON BOROUGH OF HAMMERSMITH & FULHAM: CABINET 2014/15

Leader:	**Councillor Stephen Cowan**
Deputy Leader:	**Councillor Michael Cartwright**
Cabinet Member for Children and Education:	**Councillor Sue Macmillan**
Cabinet Member for Economic Development and Regeneration:	**Councillor Andrew Jones**
Cabinet Member for Finance:	**Councillor Max Schmid**
Cabinet Member for Health and Adult Social Care:	**Councillor Vivienne Lukey**
Cabinet Member for Housing:	**Councillor Lisa Homan**
Cabinet Member for Social Inclusion:	**Councillor Sue Fennimore**
Cabinet Member for Environment,Transport & Residents Services:	**Councillor Wesley Harcourt**

Key Decisions List No. 25 (published 3 October 2014)

KEY DECISIONS LIST - CABINET ON 3 NOVEMBER 2014

The list also includes decisions proposed to be made by future Cabinet meetings

Where column 3 shows a report as EXEMPT, the report for this proposed decision will be considered at the private Cabinet meeting. Anybody may make representations to the Cabinet to the effect that the report should be considered at the open Cabinet meeting (see above).

* All these decisions may be called in by Councillors; If a decision is called in, it will not be capable of implementation until a final decision is made.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
November				
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Property Asset Data Management - Proposed Call-Off** Seeking approval to a proposed call-off contract. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Maureen McDonald-Khan Tel: 020 8753 4701 maureen.mcdonald-khan@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Transfer of 5 lodges from Environment, Leisure and Residents' Services (ELRS) to Housing (HRA)** Approval is sought to transfer the properties from ELRS to Housing, and thus requiring appropriation from General Fund (GF) to the Housing Revenue Account (HRA). **PART OPEN** **PART PRIVATE** Part of this report is exempt from	Cabinet Member for Housing Ward(s): Palace Riverside; Ravenscourt Park; Sands End Contact officer: Manjit Gahir, Danny Rochford Tel: 020 8753 4886, Manjit.Gahir@lbhf.gov.uk, Danny.Rochford@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
		disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Tri-borough Corporate Services Review Report** This report describes the recommendation and business case to establish a Tri-borough Corporate Service including an Executive Director re-organisation, Tri-borough ICT, Tri-borough Procurement, Tri-borough Legal, Tri-borough Revenues & Benefits and Bi-borough Customer Services function.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Surrender and re-grant of leases at 16 St Stephens Avenue** Surrender and re-grant of leases at 16 St Stephens Avenue **PRIVATE** This report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Housing Ward(s): Shepherds Bush Green Contact officer: Labab Lubab Tel: 020 8753 4203 Labab.Lubab@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure	**Focus on Practice - Innovation Fund Grant** Report seeking agreement to plans outlining the use of the £4m Innovation Fund Grant awarded to	Cabinet Member for Children and Education Ward(s): All Wards	A detailed report for this item will be available at least five working days before the date of the meeting and

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
	more than £100,000	the Tri Borough Family Services	Contact officer: Steve Miley Tel: 020 8753 2300 steve.miley@lbhf.gov.uk	will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Affects 2 or more wards	**Regulation of Investigatory Powers** Recommends joint working arrangements and a joint policy with RBKC for the exercise of functions under the Regulation of Investigatory Powers Act 2000 (RIPA)	Deputy Leader Ward(s): All Wards Contact officer: Janette Mullins janette.mullins@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Affects 2 or more wards	**Corporate Revenue Monitor 2014/15 Month 5** Update on revenue outturn forecast as at end of August 2014.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Establishment of a Bi-Borough alternative provision Hub School** To outline the need for a Bi-Borough Hub School (LBHF/RBKC)and to discuss the property issues associated with that proposal.	Cabinet Member for Children and Education Ward(s): All Wards Contact officer: Ian Heggs Tel: 020 7745 6458 ian.heggs@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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Cabinet	3 Nov 2014 Reason: Affects 2 or more wards	**Enhanced policing report** Report outlining the costs and benefits of maintaining and extending Council funded enhanced policing in LBHF **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Deputy Leader Ward(s): All Wards Contact officer: Pat Cosgrave Tel: 020 8753 2810 Pat.Cosgrave@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Funding To Achieve A More Customer Focused Revenues & Benefits Service** The report requests one-off funding of £290k, for additional resources in order to bring revenues and benefits work up to date. This, in turn, will allow staff to spend more time providing a more supportive service to residents.	Cabinet Member for Finance Ward(s): All Wards Contact officer: John Collins Tel: 020 8753 john.collins@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Tri-Borough Managed Services - Finance And Human Resources (Transactional Services)** The original Managed Services (Finance and HR) Cabinet Paper agreed funding to cover all costs (for both Finance and HR) to implementation. Following a re-set of the go live date, further funding is now being requested to cover these costs. It is proposed that these costs are met from the existing Managed Services reserve.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Caroline Wilkinson Tel: 020 8753 1813 caroline.wilkinson@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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		PART OPEN **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Resubmission of Better Care Fund and Community Independence Fund** Agreement of the resubmission of the Better Care Fund Plan to the Department of Health and to agree the business case for the Community Independence Service.	Cabinet Member for Health and Adult Social Care Ward(s): All Wards Contact officer: Liz Bruce liz.bruce@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
December				
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Extension and re-tender recommendations for Insurance contracts 2015** This report seeks approval to extend five of seven contract lots for insurance for two years in accordance with the contractual terms at last procurement in 2012.These allow the Council, at its sole discretion, to extend the contract terms by a period of up to two years until 31st March 2017. This report seeks approval to re-procure two of seven contract lots for insurance to improve service delivery and assurance.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Andrew Lord Tel: 020 8753 2531 andrew.lord@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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		PART OPEN **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Contract for the supply of temporary agency workers** H&F's contract with Pertemps for the supply of temporary agency workers will expire on 1st October 2015 without the possibility of an extension. Given the importance of maintaining flexibility in resourcing, the overall contract value and the time scale for a tendering process, we are seeking decisions on the objectives, options and timescale for procuring a new contract. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Leader of the Council Ward(s): All Wards Contact officer: Debbie Morris, George Lepine Tel: 0208 753 4975 debbie.morris@lbhf.gov.uk, george.lepine@HFHomes.org.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Future Highway Maintenance Contracts 2015** Options for future highway maintenance contract provisions.	Cabinet Member for Environment,Transport & Residents Services Ward(s): All Wards Contact officer: Arif Mahmud arif.mahmud@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Proposed Outsourcing of Commercial Property Management Function** Lot 1 of New Property Contract. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Marcus Perry Tel: 020 8753 6697 Marcus.Perry@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Permission to tender for Bi-borough printing, scanning and payment processing contracts for Parking Services** A Bi-borough Parking Service was established in April 2014. Linked to the procurement of a shared Parking IT system scheduled for implementation in mid 2015, the boroughs will need to separately retender for services covering the printing of statutory documentation and the scanning and processing of incoming post and payments.	Cabinet Member for Environment,Transport & Residents Services Ward(s): All Wards Contact officer: Matt Caswell Tel: 020 8753 2708 Matt.Caswell@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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		PART OPEN **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	1 Dec 2014 Reason: Affects 2 or more wards	**Draft Hammersmith and Fulham Local Plan – Approval of consultation document** The Core Strategy and Development Management Local Plan are being revised in order to include new policies for the part of the Old Oak area that is within H&F. The opportunity is being taken to combine the 2 separate documents into one document but many existing policies remain largely unchanged.	Cabinet Member for Environment,Transport & Residents Services Ward(s): All Wards Contact officer: Pat Cox Tel: 020 8753 5773 pat.cox@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Speech and Language Therapy Services - Extension of Service Level Agreements (2014-2016)** Requests agreement to extensions to the Service Level Agreement's (SLA's) for speech and language therapy services for 2014 - 2016. The extensions are required to enable a procurement exercise to be completed. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule	Cabinet Member for Children and Education Ward(s): All Wards Contact officer: Alison Farmer Alison.Farmer@rbkc.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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		12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Contract Award for a Bi-Borough Parking Management Information System** Award of a Bi-borough contract for a Parking Management Information System for processing of Penalty Charge Notices, Permits and Suspensions. Note the approval on 7th April to go out to tender included delegation of the Contract award to the lead Cabinet Member in each borough. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Environment,Transport & Residents Services Ward(s): All Wards Contact officer: Matt Caswell Tel: 020 8753 2708 Matt.Caswell@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Exiting three Community Admission Bodies from the Local Government Pension Scheme** H&F Pension Fund has seven Community Admission Bodies. Three no longer have any active members. Regulation 38 of the Local Government Pension Scheme (Administration) Regulations (the Regulations) now requires the Fund to treat these organisations as exiting	Cabinet Member for Finance Ward(s): All Wards Contact officer: George Lepine Tel: 0208 753 4975 george.lepine@HFHomes.org.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
		employers. There are three options for doing this. Each deals differently with their outstanding liabilities and the exit payments required to cover those liabilities. The preferred option for exiting the organisations allows the Fund to fulfil its obligations under the Regulations while recovering some of their deficit to the Fund. The paper recommends that H&F Council should agree to act as guarantor for all three organisations to enable the Pension Fund to exit them on an on-going basis and agree repayment plans with two of the three organisations. The recommendation has financial implications for the Council. It creates a liability which would be another factor to consider at the time of the next triennial review and might, therefore, impact on the council's contribution rate. However, it may be helpful to have in mind here that the Community Admission Bodies accounted for only 0.8% of the deficit when it was last measured at the triennial valuation at 31st March 2013. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		

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Cabinet	1 Dec 2014 Reason: Affects 2 or more wards	**New Approaches to Homelessness and Temporary Accommodation** To set out new initiatives in the field of homelessness and temporary accommodation, including improving linkages with the third sector and the procurement of new forms of temporary accommodation. To set out a strategy to meet MTFS savings in the area of temporary accommodation.	Cabinet Member for Housing Ward(s): All Wards Contact officer: Mike England Tel: 020 8753 5344 mike.england@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Affects 2 or more wards	**Review of Waste Collection Arrangements - TEEP** To seek approval of the 'TEEP' assessment undertaken by officers which suggests that it is not technically, economically or environmentally practicable to collect paper, glass, plastics and metals streams separately from one another and from other waste types. To approve the continuation, therefore, of commingled recycling collections.	Cabinet Member for Environment,Transport & Residents Services Ward(s): All Wards Contact officer: Kathy May Tel: 02073415616 kathy.may@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Special Educational Needs Reform and Burdens Grant** The special educational needs reform and burdens grant are one off un-ringfenced grants and this cabinet report will request permission to spend the grant.	Cabinet Member for Children and Education Ward(s): All Wards Contact officer: Ian Heggs Tel: 020 7745 6458 ian.heggs@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than	**Corporate revenue Monitor 2014/15 Month 6** Updated budget outturn forecast update and requests for budget virements.	Cabinet Member for Finance Ward(s): All Wards	A detailed report for this item will be available at least five working days before the date of the meeting and

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
	£100,000		Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Tri-borough Procurement of Information Technology and Communications services** The report seeks approval for a tri-borough procurement of Information Technology and Communications services, the procurement strategy, the procurement and its funding **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jackie Hudson Tel: 020 8753 2946 Jackie.Hudson@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	1 Dec 2014 Reason: Expenditure more than £100,000	**Public Health Procurement, Contract Award, Extension,Variation Report** Public Health portfolio of contracts moved to the local Authority in April 2013. This report is submitted to resolve some of the financial and legal concerns that have been highlighted since the transition. The Recommendation to approve contracts award/variation for Public Health services	Cabinet Member for Health and Adult Social Care Ward(s): All Wards Contact officer: Liz Bruce liz.bruce@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

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		PART OPEN **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.		
January				
Cabinet	5 Jan 2015 Reason: Expenditure more than £100,000	**Change ICT service desk provider** At the end of the HFBP service contract the Council will need to transition all ICT services to other suppliers. By changing the service desk earlier than contract expiry, H&F will be able to reduce the effort, costs and risk and align to the one team Tri-borough. This paper recommends an early transition from the current service desk provider to the new service desk provider by calling off the Tri-borough framework contract which has the benefit of providing a consistent user experience for staff. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jackie Hudson Tel: 020 8753 2946 Jackie.Hudson@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
		maintaining the exemption outweighs the public interest in disclosing the information.		
Cabinet	5 Jan 2015 Reason: Expenditure more than £100,000	**ASC Information and Signposting Website - People First** Discussions and decision around rolling out the People First ASC information and signposting website to LBHF. Currently operational in RBKC and WCC. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Health and Adult Social Care Ward(s): All Wards Contact officer: Mark Hill Tel: 0208 753 5126 mark.hill2@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet	5 Jan 2015 Reason: Expenditure more than £100,000	**Corporate Revenue Monitor 2014/15 Month 7** Update of Revenue Outturn forecast and approval of virement requests.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet Full Council	5 Jan 2015 28 Jan 2015 Reason: Budg/pol framework	**Council Tax Base and Collection Rate 2015/16** This report contains an estimate of the Council Tax Collection rate and calculates the Council Tax Base for 2015/16	Cabinet Member for Finance Ward(s): All Wards	A detailed report for this item will be available at least five working days before the date of the meeting and will include details

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
			Contact officer: Steve Barrett Tel: 020 8753 1053 Steve.Barrett@lbhf.gov.uk	of any supporting documentation and / or background papers to be considered.
Cabinet Full Council	5 Jan 2015 28 Jan 2015 Reason: Budg/pol framework	**Council Tax Empty Homes Premium** This report outlines the provisions available to charge a council tax premium on properties that have been empty for more than two years	Cabinet Member for Finance Ward(s): All Wards Contact officer: Steve Barrett Tel: 020 8753 1053 Steve.Barrett@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
Cabinet Full Council	5 Jan 2015 28 Jan 2015 Reason: Budg/pol framework	**Hammersmith and Fulham's Council Tax support scheme** The council need to agree a council tax support scheme for 2015/16	Cabinet Member for Finance Ward(s): All Wards Contact officer: Paul Rosenberg Tel: 020 8753 1525 paul.rosenberg@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.
2 March				
Cabinet	2 Mar 2015 Reason: Expenditure more than £100,000	**Corporate Revenue Monitor 2014/15 Month 9** Update of forecast Revenue outturn and agreement of virement requests.	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
30 March				
Cabinet	30 Mar 2015 Reason: Expenditure more than £100,000	**Corporate Revenue monitor 2014/15 Month 10** Update Revenue Outturn forecast and agreement of virement requests	Cabinet Member for Finance Ward(s): All Wards Contact officer: Jane West Tel: 0208 753 1900 jane.west@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

NOTICE OF CONSIDERATION OF ADDITIONAL KEY DECISIONS PROPOSED TO BE MADE BY CABINET ON 3 NOVEMBER 2014 (published on 8 OCTOBER 2014)

In accordance with paragraph 9 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the Cabinet hereby gives notice of Key Decisions which it intends to consider at its next meeting.

NOTICE OF THE INTENTION TO CONDUCT BUSINESS IN PRIVATE

The Cabinet also hereby gives notice in accordance with paragraph 5 of the above Regulations that it intends to meet in private after its public meeting to consider the Key Decision referred to in this Notice which may contain confidential or exempt information. The private meeting of the Cabinet is open only to Members of the Cabinet, other Councillors and Council officers.

Reports relating to this Key Decision which the Cabinet will take at its private meeting are indicated below, with the reasons for the decision being made in private. Any person is able to make representations to the Cabinet if he/she believes the decision should instead be made in the public Cabinet meeting. If you want to make such representations, please e-mail Katia Richardson on katia.richardson@lbhf.gov.uk. You will then be sent a response in reply to your representations. Both your representations and the Executive's response will be published on the Council's website at least 5 working days before the Cabinet meeting.

If you have any queries on this Key Decisions List, please contact
***Katia Richardson** on 020 8753 2368 or by e-mail to katia.richardson@lbhf.gov.uk*

The decisions may be called in by Councillors; If a decision is called in, it will not be capable of implementation until a final decision is made.

Decision to be Made by (Cabinet or Council)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision** **Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.**	**Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents**	**Documents to be submitted to Cabinet *(other relevant documents may be submitted)***
Cabinet	3 Nov 2014 Reason: Expenditure more than £100,000	**Pope John Expansion (Disposal of Fatima Centre)** Disposal of the site of the Fatima Centre to the Roman Catholis Diocese of Westminster to facilitate the expansion of Pope John Primary School.	Cabinet Member for Children and Education, Cabinet Member for Housing Ward(s): Wormholt and White City Contact officer: David Mcnamara David.Mcnamara@lbhf.gov.uk	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.

Decision to be Made by (Cabinet or Council)	Date of Decision-Making Meeting and Reason	Proposed Key Decision Most decisions are made in public unless indicated below, with the reasons for the decision being made in private.	Lead Executive Councillor(s), Wards Affected, and officer to contact for further information or relevant documents	Documents to be submitted to Cabinet *(other relevant documents may be submitted)*
Cabinet	3 Nov 2014	**LGPS Pension Administration Services** This report seeks authorisation to terminate our current contract with Capita early and to appoint a new contractor Surrey County Council to provide the Local Government Pension Administration Service. **PART OPEN** **PART PRIVATE** Part of this report is exempt from disclosure on the grounds that it contains information relating to the financial or business affairs of a particular person (including the authority holding that information) under paragraph 3 of Schedule 12A of the Local Government Act 1972, and in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.	Cabinet Member for Finance	A detailed report for this item will be available at least five working days before the date of the meeting and will include details of any supporting documentation and / or background papers to be considered.