APPENDIX B

Summary of 2016/17 planned BCF Schemes

Ref no.	**Scheme**	**Non recurring** Investment (£000s)	**New delivery cost** (£000s)	**Existing Costs** (£000s)	**Total costs** (£000s)
A1	*Community Independence Services*	2,688	-	17,221	**19,909**
A2	*Community Neuro Rehab Beds*	-	2,117	1,562	**3,679**
A3	*Homecare*	-	1,600	-	**1,600**
	- *Low level health tasks*	-	-	-	**-**
A4	*Integrated Hospital Discharge and 7*	-	-	938	**938**
B1	*Patient/Service User Experience and Care Planning – including self-management and peer support*	-	-	200	**200**
B2	*Personal Health and Care Budgets*	-	30	20	**50**
C1/C3	*Transforming Nursing and Care Home*	-	-	721	**721**
C2	*Review of Jointly Commissioned*	-	-	127,062	**127,062**
D1	*Information Technology*	-	-	201	**201**
D2	*Information Governance*	-	-	-	**0**
D3	*Care Act Implementation*	-	-	1,750	**1,750**
D4	*BCF Programme Implementation and Monitoring*			350	**350**
	Disabled Facility Grant			2,867	**2,867**
	TOTAL	**2,688**	**3,747**	**152,892**	**159,327**

Three Borough (3B) Better Care Fund Schemes – 2016/17

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

Scheme ref no

A1

Group A: Community Independence Service

Original Intention

The Community Independence Service is a rapid response and reablement service for older people. It aims to support people in the community and avoid the need for unplanned hospital admissions.

The service provides fast and responsive care to support patients at risk of admission to hospital and enables hospital inpatients to be transferred in a timely manner to community settings to ensuring a full recovery whilst retaining independence and remain in their own home.

The CIS represents a single model of care, working across the three boroughs to replace a range of often duplicated services. The model encompasses multi-disciplinary integrated health and social care and (nursing, medical, therapies and social care) and operates 7 days a week.

The service is jointly commissioned across health and social care and delivered across the three boroughs.

The service has four core elements:

- Rapid Response
- In-Reach
- Non-Bedded Intermediate Care/Rehabilitation
- Reablement

The target patient cohort includes individuals:

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

Progress and Delivery to date

The CIS is based on our shared belief in delivering joined up care to people when they need it in the community. It will drive clear clinical benefits for patients in a sustainable way across the health and care system as a whole.

The CIS has been recognised nationally for successfully bringing together a range of services and skills to support people in the community by working work across primary, secondary care, community nursing, therapy and social care.

The benefits delivered in 2015-16 are:

- User satisfaction with the CIS service is very high across health and social care.
- GPs rate the service very highly, however, between a quarter and a third do not refer in. This is probably due to a lack of awareness of the service.
- Delivery of a seven day service for In-Reach, Rapid Response Nursing, Rehabilitation and Reablement.
- Improved partnership working between healthcare organisations across the three boroughs, including establishment of a Partnership Board led by Imperial College Healthcare.
- Establishment of a multi-service clinical redesign group to create more cohesive pathways of care across health and care services.
- Operational staff have made inroads to integration using practical approaches like stronger working networks with colleagues, made possible from co-location, sharing IT/ clinical information and through work to streamline processes.
- CIS is dealing with a high level of acuity, particularly the H&F service – probably more so than in the other two CCGs/ LAs. The service offers a genuine alternative to hospital, although high acuity comes at a cost, with double-up care/ large packages increasingly common.

Challenges experienced in 2015-16, with plans for resolution.

- Further integration and effective working has been hampered by delays in implementing an integrated IT system which is due for delivery in July 2016.
- High turnover of staff and use of agency staff is hampering planning for future service development. A fully integrated service on a 21 month contract with clear plans for the future is currently being procured and will help to address some of these issues.
- Intermediate 'step-down' beds are a service gap that could be a safe alternative for medically stable but unwell patients.
- Mental health is also a gap in the service offer, as well as memory assessment services and end of life care which is being addressed in the current procurement.
- High expectations of commissioners and the BCF Programme Board regarding the level and speed of change in the first year has been a challenge for the Lead Health and Social Care Providers.
- The objective of increasing referrals and activity remains a challenge. Feedback suggests that increased activity has been reliant on increasing GP confidence, knowledge and awareness of the service. The introduction of Rapid Response GPs and Consultant Geriatrician cover across the three boroughs will help to improve confidence in the service (as in H&F).

Delivery

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
- GP Federations (West London, Central London and Hammersmith & Fulham)
- Imperial College NHS Healthcare Trust
- Chelsea & Westminster NHS Foundation Trust

Investment Requirements

A1 Community Independence Service (ex BCF08)	
	£'000
Investment	2,688
New Delivery Costs	
Existing Costs	17,221
Total	**19,909**

Changing Context

The development of Accountable Care Partnerships within North West London has shaped the procurement for the delivery of the CIS. The contract has been set for a period of 21 months to align with the North West London ACP timetable.

BCF Scheme Plans 2016/17

The CIS is being recommissioned with a planned start for the new service from 1st July 2016.

In line with NW London wide outcomes, the new provider will be working to deliver the following local outcomes.

- High quality, effective care delivered within available resources (financial, estates and human resources).
- Reduced time (counted as non-elective bed days) our residents are spending in institutional care (acute hospitals, nursing and care homes and long term care).
- Improved patient/customer satisfaction in relation to treatment outcomes.
- Improved Friends/Family/Carer satisfaction in relation to treatment outcomes.
- Financial sustainability of the health and social care system and support the development of an evidence base that informs the future development of the service.
- Add value by increasing links between the CIS and other services, through improved system-wide working that supports further integration across social care, community and primary care as a Whole System.

Scheme ref no.

A2

Community Neuro Rehab Beds

Original Intention

To commission additional rehabilitation capacity across the three boroughs with the objective of providing interventions to restore a patient's optimal functioning (physically, psychologically and socially) to the level they are able or motivated to achieve. This will lead to an anticipated reduction in DTOCs and reduction in LOS for neuro-rehab patients

Progress and Delivery to date

The target cohort are patients who require rehabilitation services to regain a loss of physical, mental or social functionality.

Lack of step down neuro-rehab options means that the system is unable to provide informed and cost effective services when a person is experiencing a wait for specialist neuro-rehab intervention.

This leads to longer lengths of stay in costly specialist centres for some people as they become more debilitated and dependent whilst waiting for specialist services.

In 2015/16, the referral and delivery pathway for bedded and non-bedded community rehabilitation /neuro-rehabilitation services was established with subsequent investment in additional community and bed based capacity (9 additional neuro beds; 5 physical beds and 4 virtual beds) and the extension of the community rehabilitation period up to 12 weeks in the community, including Homecare.

From April 2016 the new neuro-rehabilitation service (15-bedded and 4 virtual beds for community neuro-rehabilitation) commenced, provided by Imperial College Healthcare NHS Trust as the lead provider, with Hillingdon Hospitals NHS Trust and Central London Community Health Trust. The contract will be initially for 3 years, with an option to extend for 2 more years.

Delivery

Commissioners:

- Central London CCG (Lead Commissioner)
- West London CCG
- Hammersmith and Fulham CCG

Providers:

- Imperial College Healthcare NHS Trust (Lead Provider)
- Central London Community Healthcare NHS Trust
- Hillingdon Hospital NHS Trust

Investment requirements

A2 Community Neuro Rehab Beds (ex BCF10)	
	£'000
Investment	
New Delivery Costs	2,117
Existing Costs	1,562
Total	**3,679**

Changing context

Not applicable

BCF Scheme Plans 2016/17

It is estimated that the scheme will deliver an estimated annual efficiency saving of £369k for the tri-borough CCGs for 202016/17 through reduction in DTOCs, which represents 1300 days or 12 days per neuro-rehab patient.

It is anticipated that additional patient benefits will include improved social and economic, health & quality outcomes which will be evaluated over the course of 202016/17 as they emerge with the progression of the scheme.

Scheme ref no.

A3

Scheme name Homecare

Original Intention

To successfully commission, procure and implement a new Homecare service in the three boroughs that will better enable our patients and service users to remain independent in their own homes.

Progress and Delivery to date

The programme aims to deliver a new and improved homecare service across the three local authorities based on:

- Achieving outcomes, rather than "time and task" based provision
- Integration of health and social care tasks over the life of the contract (hybrid working)
- Providers working directly with customers to agree details of care and how outcomes will be achieved
- Ensuring dignity and compassion as core values
- People being helped to feel a part of their local community

A patch based approach to care has been developed across the three boroughs, with one provider delivering all the care in one patch. This allows providers to establish strong connections to existing community assets and offers a greater consistency of care to service users. Contracts for 8 of the 9 patches have been awarded, with the award for the final patch expected for early July 2016.

Delivery

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

Investment requirements

A3 Homecare	
	£'000
Investment	1,600
New Delivery Costs	
Existing Costs	
Total	**1,600**

Changing context

One of the objectives of the model is the integration of health and social care tasks over the life of the contract. There is agreement to pilot the hybrid working model (for care workers to carry out low level health tasks) in Kensington and Chelsea. However, this has been delayed whilst issues with provider performance and service quality are resolved and will impact on the overall mobilisation and implementation timeline for hybrid working.

BCF Scheme Plans 2016/17

Subject to the successful mobilisation of all Homecare providers, key activities for 202016/17 include:

- Provider assurances over training / competency and clinical governance for health tasks
- Pathway redesign to transfer health tasks from CLCH to three Local Authorities
- Establishing a data sharing agreement between CLCH and three Local Authorities
- Establishing a reporting mechanism to monitor health tasks

Scheme ref no.

A4

Scheme name

Integrated Hospital Discharge and 7 Day Working

Original Intention

The scheme aims to implement a single Hospital Discharge function across health and social care. The scheme will build upon 2015/16 work to further embed and scale up the implementation of the integrated discharge function.

Progress and Delivery to date

The two key objectives of the scheme have been delivered in 2015/16:

1. Integration across the three local authorities to provide a single discharge function
    - Implementation of a single hospital discharge team across the three boroughs managing all three boroughs patients who present at hospital
    - Streamlined hospital discharge processes, implemented across the hospital team
    - A new streamlined assessment tool, implemented on Frameworki and used across the hospital team

2. Integration with health partners to fully achieve an effective, efficient and consistent service to residents.
    - Hospital discharge process co-designed with health to work effectively with acute sites
    - Single three boroughs teams providing onsite support to acute sites within the three boroughs
    - Support of key wards (wards with high numbers of discharges) with allocated social workers, working closely with ward staff and supporting the MDT process

The initial pilot showed evidence of improvements within the system:

- 89% of NHS and 79% of Local Authority staff believe the pilot has been effective in improving the patient/carer experience with discharge – a 63-68% improvement on Friends and Family Tests on two wards
- 89% of NHS ward staff and 79% ASC staff believes the new model and approach has significantly improved the overall discharge process
- 63% of NHS staff believe the pilot has reduced the LOS of patients
- Approximately 5-10% decrease in referrals into higher levels of care (e.g. increase in home care support, reablement, placements)
- Some of the wards have shown between 5% and 10% reduction in re-admissions in the same period compared to the previous year

Key challenges of the scheme during 2015/16 include:

- Delays in providing cross organisational access to patient data due to the complexity of the required Information Governance arrangements (with no significant agreements between the organisations previously in place)
- Ongoing staffing challenges to support the transition periods and wider change program (primarily due to shortages of staff in the wider health and care system)

Delivery

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:

- Imperial Healthcare NHS Trust
- Chelsea & Westminster NHS Foundation Trust
- Westminster City Council
- Royal Borough of Kensington and Chelsea London Borough of Hammersmith and Fulham
- Central London Community Healthcare

Further sub-regional working:

We are working with the CCGs and Councils in Ealing, Brent and Hillingdon to roll-out this model across North West London as part of the West London Alliance (WLA) Hospital Discharge programme.

This will integrate ASC hospital based functions across the six 6 boroughs in the wider North West London sub-region. It will enable seamless discharge for patients across the sub-region – no matter which borough they live in and which hospital they attend.

Investment requirements

7 Day Social Work Hospital Discharge (ex BCF01)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	938
Total	**938**

The scheme for 2015/16 achieved its expected outcomes as per the programme plan. The key changes to the scheme include:

- Early implementation of a single Tri-borough adult social care team due to strategic willingness and operational readiness
- Delays in providing access to hospital systems for adult social care staff and access to Frameworki to hospital staff due to complexity issues regarding information governance

BCF Scheme Plans 2016/17

To achieve the plans for 202016/17 and the benefits associated with these plans the programme will focus on the following key success factors:

- Partnership working between Acute trusts and Local Authorities – to further integrate functions including staff and processes
- Further development of commissioning models for discharge – as part of WLA and NWL work with CCGs and Commissioners
- Information Sharing – ensuring staff from different organisations can access the appropriate information and not duplicate work.

The following focus will be required to address the challenges and support the plans for 202016/17:

- Further service development
- Further health and social care organisational development/training
- Additional pump-priming of staff to facilitate change (e.g. Social Workers)

Our aims for 2016/17 include

- Establish one key discharge worker who has accountability for individual cases from discharge to home.
- Improved patient and carer experience through the Friends and Family Test (FFT)
- Early identification of patients/customers who require social care, community health and 3rd sector services
- Improve sharing of staff & resources across LAs and Hospitals – improving skills and capacity
- Embed one hospital discharge process across health and social care from 1st May 2016
- Improve throughput and decrease of acute capacity
    - Reduced DTOC (related to delayed assessments) – deliver a 785 day reduction in DTOC days (H&F – 344, Kensington & Chelsea – 274, Westminster 177)
    - Reduced Bed day costs (related to delayed assessments) - £278K based on £350/day costs (H&F - £120,472, Kensington & Chelsea - £95,877, Westminster - £61,968)
    - Reduced Emergency Re-admissions (early benefits of holistic discharge planning) – 4-5% reduction of total readmissions

Scheme ref no.

B1

Scheme name: Patient/Service User Experience and Care Planning

Original Intention

The original focus of this scheme was on developing two key aspects of care delivery:

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

The intention remains unchanged; however, greater clarity has been developed on the intentions and implementation within the current strategic direction of commissioners. Commissioners have agreed that in order to deliver this project at scale we will engage with the wider Sustainability and Transformation Plan (STP) and align it with our journey towards Accountable Care Partnerships by April 2018, this will ensure that the aims, objectives and outcomes are developed across NW London.

Progress and Delivery to date

In 2015/16, further clarity has been developed on the scope of the scheme making it relevant to the current commissioning strategies and landscape.

Delivery

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

Investment requirements

B1 Patient/Service User Experience and Care Planning (ex BCF02, 06 & 12 combined	
	£'000
Investment	
New Delivery Costs	
Existing Costs	200
Total	**200**

Changing context

The three boroughs' commissioners have independently developed good patient and public engagement and involvement functions, which has resulted in strong engagement and qualitative feedback on patient experience. There have also been developments on the whole systems integrated care programmes which have resulted in extensive engagement and movement towards monitoring and reporting patient experience.

However, within this context the commissioners feel that there is a need to provide an overarching framework within which engagement, involvement and experience is captured and informs commissioning practices. The intention is to deliver this scheme within the context of our STP, so that it can be delivered at scale and also align it with our journey towards developing Accountable Care Partnerships by April 2018.

BCF Scheme Plans 2016/17

The key aims for implementation for 202016/17 include:

- Develop and embed a standardised framework for Patient and Service User Experience to effectively capture, analyse and inform commissioning decisions. It will aim to enable patients and communities to have greater involvement and understanding of their health and wellbeing.
- Develop focused self-management and peer support for Whole Systems and integrated care programmes, enabling a positive impact on patient experience and for the health and care outcomes of service users.

Initial focus for developing self-management and peer support interventions shall be on:

- Whole Systems Integrated Care (WSIC) for frail and elderly patients; and
- Long term enduring mental health conditions.

This scheme will provide Patient/Service User Experience and Care Planning support to:

- Service users, carers and adults with a long term condition, or at risk of a long term condition
- All GP practices within the three borough localities
- Hard to reach communities particularly those in deprived areas
- Enable self-management and Peer Support to be focused on patients over the age of 65 years old and patients with long term enduring mental health conditions

Scheme ref no.

B2

Scheme name

Personal Health and Care Budgets

Original Intention

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.

Progress and Delivery to date

The Personal Health Budget programme for continuing healthcare was rolled out across all care groups in a consistent manner, with evaluation and quality assurance mechanisms developed and monitored during 2015/16.

The programme built on existing arrangements, by developing an integrated approach to the provision of personal care budgets and personal health budgets, including direct payments, so that eligible customers could commission an integrated package of services.

The evidence and best practice gathered enabled the three CCGs to develop a Personal Health Budgets policy for identified service user groups

Delivery

The commissioners and providers involved in delivery of the scheme are:

- 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

Investment requirements

B2 Personal Health & Care Budgets	
	£'000
Investment	
New Delivery Costs	30
Existing Costs	20
Total	**50**

Changing context

The NHS Mandate and NHS Planning Guidance re-affirmed the Government and NHS England's commitment to the roll-out of personal health budgets.

During 15/16 work was undertaken to review emerging best practice and work across the CWHHE collaborative to develop appropriate approaches to delivering PHBs. Work to deliver appropriate initiatives at scale (including internal management arrangements) will be developed through Sustainability and Transformation Plans (STPs) in line with planning guidance.

BCF Scheme Plans 2016/17

Continue to implement Personal Health Care Budgets for Continuing Healthcare across all Children's and Adult Care Groups as required by NHS Operating Plan

Continue to consolidate arrangements for care management and financial management of direct payments of customers with PHBs.

Work through the Integration and Collaboration Board which oversees the development of a wider PHB policy under the Sustainability and Transformation Plan

Gather evidence and best practice from elsewhere which will inform the development of a PHB service offer, which can be delivered at scale.

Integrate Social Care Personal Budgets and Personal Health Budgets for Long Term Conditions through Integrated Care Pathways and Provision

Scheme ref no.

C1

Scheme name

Transforming Nursing and Care Home Contracting

Original Intention

The strategic objectives of this project are:

- To work across health and social care to improve alignment of processes, practices and contracting for funded placements and packages of care to ensure efficiency of process.
- To develop a market strategy for care homes across health and social care to achieve delivery of efficient, high quality placements for local residents underpinned by a sustainable market.

The scheme is to address the approaches to brokerage, commissioning, placement and quality management of care home placements between the LAs and CCGs. These are complex, fragmented and reactive, which impacted the capacity of commissioners to manage a challenging care home market and inhibited the quality of care delivered. This also put pressure on other areas of the care pathway through DTOCs and increased emergency admissions.

The intended outcomes of the scheme are:

- Enhanced service quality through better sharing of information and intelligence, and joint learning between operational teams
- Improved 'soft' market knowledge in operational teams
- A single, best practice, approach to brokerage to be developed if recommended
- Best use of existing joint capacity in services that are stretched
- A clearly defined approach to the future integrated commissioning of residential and nursing care that acknowledges both current pressures and the strategic direction for health and adult social care
- Clarity for CCGs, Local Authorities and providers on the processes and procedures for funded placements and packages of care across all adult health and social care client groups
- Learning from best practice across our current client groups and funding streams to, where possible, align practices and procedures
- Embedding positive joint working relationships through jointly agreed processes, protocols and policies that reflect the holistic needs of our local patients and residents
- Ensuring that across all organisations our increasingly limited resource base is able to work efficiently avoiding duplication or lack of clarity arising from processes or pathways
- Positive experiences for people who need funded placements or packages of care and their families/carers and no delays faced in these processes or from issues resulting from inter-agency working
- Development of a joint market strategy is undertaken as a priority and aligned with wider work around accommodation based care and support across the Local Authorities and CCGs.

Progress and Delivery to date

In 2015/16 a business case was produced based on detailed analysis of the brokerage, commissioning and contracting functions for placements and packages of care for health and adult social care. The recommendations identified in the business case were:

1. Options for co-locating the health placements team and Adult Social Care placements teams are explored to identify a location that best meets the needs of the teams (based on a feasibility study)
2. Options for the brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements being channelled through a single brokerage team are developed which would need to be designed collaboratively to ensure it has the necessary capabilities and capacity
3. Development of a joint market strategy is undertaken as a priority and is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs

There have been difficulties in recruiting to the Delivery Manger role, which has delayed progress on this scheme. It is now intended to appoint on an interim basis to scope the project and then review on-going resource requirements.

Delivery

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

Investment requirements

Investment is required for a delivery manager post initially for 6 months at Band 8b but then with consideration for the on-going implementation of the recommendations.

Changing context

During 2015/16 the CCGs with their Local Authority partners identified the need to review the processes and procedures for funded placements and packages of care across all care groups and funding streams (excluding children) and therefore have added the requirements for this review into this project. This will also enable the CCGs, with partners, to meet the actions identified through its internal audit of placements, and NHSE Deep Dive into Continuing Healthcare.

BCF Scheme Plans 2016/17

In 202016/17 the project will deliver the following objectives:

- Co-location of the health placements team and Adult Social Care placements teams (based on a feasibility study)

- The brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements are channelled through a co-designed single brokerage team

- As a priority, deliver a joint market strategy which is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs

Furthermore, we will review funded placements and packages of care including:

- A single overview of the different processes and procedures for each client group or funding stream related to assessment, decision making and ratification including panel processes. The overview will cover older people, physical disabilities, learning disabilities, mental health and adult social care pathways and panels.

- Common documentation, based on best practice from our existing processes or wider, that is jointly agreed and adopts similar or aligned approaches across the client groups and funding streams:
  - Identification of training needs around the NHS Continuing Healthcare and Funded Nursing Care Framework, Mental Health Act, Care Act and other relevant legal and statutory frameworks to enhance the draft training plan for 202016/17
  - Development of Joint Dispute Resolution Policy and Joint Funding Policy, based where possible on current good practice, that can be used across the client group pathways and processes
  - Development of Joint Operational Policy (if deemed relevant)

Scheme ref no.

C2

Scheme name

Review of Jointly Commissioned Services

Original Intention

The original intention of the scheme in 2015/16 was:

- 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.
- Each CCG and Local Authority 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, in particular Community Equipment.
- 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 and recommend how these services should be commissioned in future.

Progress and Delivery to date

In 2015/16 a savings target of £1,385m was identified against the Joint Commissioning Services as part of the BCF programme.

Proposals were identified to achieve these savings from within existing services, either through reduction in contract value, service redesign/transformation or de/re-commissioning. However, a double count with savings already attributed to Local Authority savings strategies was subsequently identified. A revised savings target of £634k was agreed and these savings were delivered jointly by CCG and LA commissioners.

Delivery

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

Investment requirements

C2 Review of Jointly Commissioned Services (ex BCF07)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	127,062
Total	**127,062**

Changing context

Since the inception of this project there is further need to ensure alignment of our jointly commissioned services to both our overarching BCF objectives and also those of our Sustainability and Transformation Plan (STP).

BCF Scheme Plans 2016/17

In 202016/17, it is recognised that further review of Jointly Commissioned Services is required to ensure alignment with key strategic objectives and in recognising the financial context of all organisations.

It is proposed that the project will deliver:

- Recommendations for each CCG and Local Authority on the schemes currently being jointly commissioned, comprising an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of BCF priorities and STP direction of travel 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

Scheme ref no.

C3

Scheme name

Integrated Commissioning

Original Intention

The original intention of the scheme in 2015/16 was:

- To address the current fragmentation in commissioning across three borough health and social care commissioners. In designing the new commissioning structures, the project will seek to understand, validate and address existing issues.
- 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.

Progress and Delivery to date

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

The key benefits include better value for money and improved efficiency through integrated commissioning. They will have a positive impact on service users and provide an accurate understanding of current risks and issues as well as opportunities for improvement.

In 2015/16, the CCGs and Local Authorities reviewed the issues and structures for Joint Commissioning. However, implementation of the review recommendations have not been progressed pending the outcome of ongoing discussions concerning the future structures and functions of the joint commissioning team, particularly the Mental Health team.

Revised funding contributions for the joint commissioning teams across the six organisations have been agreed and reflected in Section 75 schedules. These were based on the findings of the review concerning the split of health and social care tasks being undertaken by the teams.

Delivery

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

Investment requirements

C1 / C3 Transforming Nursing and Care Home Contracting (ex BCF03) & Integrated Commissioning (ex BCF09)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	721
Total	**721**

Changing context

2015/16 has seen a turnover in staff across the CCGs and Local Authorities, which has delayed the process.

Furthermore, the developments made in CCG and LA Whole Systems Integrated Care programmes have merited renewed consideration of the longer term vision for integrated commissioning and the required structures and functions to deliver this. The ongoing validity of the findings from the previous review need to be considered in light of the longer term vision.

BCF Scheme Plans 2016/17

In 202016/17 the project will review how services are currently commissioned and contracted across the organisations and identify better ways to achieve integrated commissioning and the functions and structures that support this in light of the development of Whole Systems Integrated Care models.

Key project objectives include:

- Develop a shared understanding between LA and CCGs of current issues
- Understand direction of travel for the integrated commissioning vision under WSIC, STP and BCF
- Design and implementation of new integrated commissioning structures

Scheme ref no.

D1

Scheme name

Information Technology

Original Intention

To continue to implement IT solutions to link the three boroughs Adult Social Care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.

Progress and Delivery to date

Preparatory work was undertaken in 2015/16 to improve readiness for our ambition to integrate ASC and GP IT systems. This included developmental work to establish NHS numbers within the ASC Frameworki system and business plan development.

Delivery

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

Investment requirements

D1 IT Integration (ex BCF05)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	201
Total	**201**

Changing context

There is a growing understanding of the importance of integrated systems working from developmental work in other schemes including hospital discharge and CIS. Further managing dual dependencies across health and ASC means time frames for delivery are longer than originally anticipated.

BCF Scheme Plans 2016/17

The key deliverables for 202016/17 are:

- 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
- 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'

Once the options are agreed there will be a need to specify and procure for relevant providers, pilot for a service specification and test and implement the new model.

Scheme ref no.
D2
Scheme name
Information Governance
Original Intention
To continue to implement IG solutions to link three borough social care systems to the GP systems and to ensure that other schemes have robust IG arrangements.
Progress and Delivery to date
An Information Governance and Caldicott Support Manager has been appointed to lead on IG issues and to provide direct support to the Caldicott Guardians for Adult Social Care and Public Health and for Children's Services. An IG Training Strategy is being developed in conjunction with Corporate Information Management leads. An Information Governance Training Needs Analysis has been undertaken and on line training made available across all three boroughs. A number of Information Sharing Agreements have been established, including the WSIC Information Sharing and Hosting Agreement including the overarching North West London Information Sharing Protocol. Access to the WSIC Data Warehouse has been established although data has yet to be transferred. Pooled data from Health and Social Care Providers across North West London will be available to support integrated commissioning and contracting. In order to provide a safer mechanism for sharing data with independent providers of services, the Egress email system has been integrated within the mailboxes of LBHF staff. Plans have been developed to extend availability to staff in RBKC and WCC and a roll out programme has been initiated.

Delivery

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

Investment requirements

N/A

Changing context

As the scheme is mainly designed to underpin and enable other schemes in the BCF programme and is designed to ensure continuous improvement in IG policies, practice and culture, it is not directly affected by strategic or delivery changes. There may be impact on available resources or on timescales as a result of the effect of any strategic or delivery changes on other schemes.

The WSIC Data Warehouse implementation has been affected by a reticence on the part of some GP Practices to sign up to the agreements and to share data. A great deal of effort has been put in to obtaining sign up and steady progress is being made in obtaining a more extensive buy in.

BCF Scheme Plans 2016/17

Work will continue to regularise the submission of data to the WSIC Data Warehouse and the Information Sharing and Hosting Agreement will be kept under review to ensure that any amendments required by any new signatories are appropriately risk assessed and signed off. This will include full participation in the design and development of enhanced sharing arrangements introduced through the adoption of the Patients Know Best integrated sharing system, although it is not yet certain when access and integration will be proposed for Local Authorities.

Information Sharing Agreements are being developed to support the Community Independence Service (A1) and Integrated Hospital Discharge and 7 Day Working (A4) schemes. All new initiatives will be supported and regulated through the use of Privacy Impact Assessments to ensure that IG solutions are designed in to solutions and that Information Sharing Agreements are deployed as appropriate.

Building on the Training Needs Analysis and the IG Training Strategy, there will be an audit of current compliance with the baseline training requirements for IG with a full campaign to ensure that all staff requiring refresher training is supported in accessing and completing the required courses.

The Egress secure Email System will be rolled out across RBKC and WCC in order to improve the resilience of information sharing arrangements with independent providers of services.

Scheme ref no.

D3

Scheme name

Care Act Implementation

Original Intention

To continue to ensure the key statutory requirements of the Care Act 2014 (detailed in the Care Act Impact Analysis) can continue to be delivered following successful implementation from 1st April 2015. This includes continuing consolidation and bedding down of the changes working closely with Health, Housing and other partners.

Progress and Delivery to date

The Care Act Part 1 set out a range of substantial reforms to the way in adult social care (ASC) is provided, impacting on duties and functions provided by ASC services. Processes and practices were reviewed and changed in the lead up to 1st April 2015 and all requirements were successfully delivered including.

- Duties on prevention and wellbeing
- Duties on information and advice (including advice on paying for care)
- Duty on market shaping
- A national minimum threshold for eligibility for care and support services for adults and carers and associated outcomes as the basis for service delivery
- Assessments (including carers assessments)
- Promoting and progressing Whole Systems Integration between social care and health
- Personal budgets and care and support plans
- Safeguarding
- Universal deferred payment agreements

The key challenge was the scale and range of work required to assure compliance including partnership working with health and housing. This is a continuing challenge in terms of consolidating and bedding down the change and understanding the impact.

Delivery

Commissioners:

- Royal Borough of Kensington and Chelsea Westminster City Council
- London Borough of Hammersmith and Fulham

Investment requirements

D3 Care Act Implementation (ex BCF18)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	1,750
Total	**1,750**

Changing context

The Care Act has led to significant increased demand for in-depth carers reviews and there are signs that demand for lower level care is increasing. These demands will need to continue to be met.

Part 2 of the Care Act which was focused on the funding of long term care and including a capped charging system and care accounts was due to go live in April 2016 , this has now been deferred by the Government until 2020. However there is substantial work to do to develop the personalisation of services offered and to increase uptake of Direct Payments.

BCF Scheme Plans 2016/17

- Following successful delivery of the changes the programme was closed in October 2015.
- Portfolio Deliver Steering Group and Portfolio Review Board chaired by the Director of Finance and Resources and the Executive Director, continue to monitor impact and progress delivering the work plan returns to the Department of Health to track impact on demand, activity and costs and continued implementation on a quarterly basis.
- Staff will need to undergo continued training. Legal expertise will continue to be required to deliver some of this training.
- In order to meet the requirements of the Care Act and support its implementation several projects and working groups are continuing that are tied to the wider ASC Transformation Portfolio, particularly the Customer Journey Programme, these are:
    - Front door, information and advice and prevention offer development.
    - Outcomes based assessment, review and support planning.
    - Market management development.
    - Safeguarding and provider failure development.
    - Personalisation and Direct Payments

Scheme ref no.

D4

Scheme name

BCF Programme Implementation and Monitoring

Original Intention

To successfully programme manage the BCF schemes, ensuring each scheme delivers the agreed outcomes on time and to the right standard.

Progress and Delivery to date

The programme management scheme is an enabler to delivering the agreed BCF ambition. This scheme sits at the centre of the three boroughs (3Bs) BCF and acts as the coordination point for all current schemes. This support enables timely coordination and monitoring of the agreed BCF plan and delivery against the total budget of £157.5m.

In 15/16 it is acknowledged that this scheme experienced some challenges with a change in-year from external PMO support to agreed internal support. During this period there was a focus on BCF Project A schemes, particularly the Community Independence Scheme, which is a high priority in order to support delivery of the BCF.

The internal PMO linked to the CIS supported the development and distribution of flash reports that provided monthly updates about progress on each scheme; these were provided to JET and HWB Boards.

In 15/16 delivery of the CIS was particularly challenging in relation to planned and actual activity. This was closely monitored and provided data and analysis to support reprocurement of the service in 2016/17.

The reprocurement of neurorehab and the shift from acute to community resulted in the expected benefits being realised.

Delivery

Commissioners:

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

Investment requirements

D4 BCF Implementation/Monitoring (ex BCF04)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	350
Total	**350**

Changing context

We are currently establishing a revised approach to BCF Programme Implementation and Monitoring, this is to build on our experience in 15/16 and ensure that we have the right support to ensure continued delivery against our BCF ambition in 2016/17.

The BCF has an established SRO and additional management capacity to support delivery, engagement and reporting of the BCF in 2016/17

BCF Scheme Plans 2016/17

The 2016/17 BCF plan is a rollover of the previous year's plan 15/16. All schemes have remained the same and the governance and reporting structure to support the delivery is now embedded in the development, delivery and monitoring of the schemes.

We are continuously reviewing how we can support SROs and implementation leads for the BCF schemes to ensure that we deliver the agreed visions and ambitions related to the BCF. The Sustainability and Transformation Plan (STP) will further support the integration and collaboration and where appropriate we have identified work that can be done at scale via the STP.

Together we have agreed joint resource to work across the BCF to support implementation and monitoring.