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Committee Agenda

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 10th October, 2019**
Time:	**4.00 pm**
Venue:	**The Small Hall, Chelsea Old Town Hall, King's Road, London SW3 5EE**

Members:

Councillor Heather Acton (Chairman)	Cabinet Member for Family Services and Public Health
Councillor Nafsika Butler-Thalassis	Minority Group
Houda Al-Sharifi	WCC - Interim Director of Public Healt
Olivia Clymer	Healthwatch Westminster
Robyn Doran	Central and North West London NHS Foundation Trust
Bernie Flaherty	Bi-borough Adult Social Care
Anna Bokobza	
Philippa Johnson	Central London Community Healthcare NHS Trust
Dr Naomi Katz	West London Clinical Commissioning Group
Detective Inspector Iain Keating	Metropolitan Police
Hilary Nightingale	Westminster Community Network
Dr Neville Purssell	Central London Clinical Commissioning Group
Darren Tully	London Fire Brigade
Jennifer Travassos	Housing and Regeneration

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

If you require any further information, please contact the Committee Clerk, Gareth Ebenezer – Governance Administrator.

Tel: 7641 2341; Email: tfieldsend@westminster.gov.uk Gareth.Ebenezer@rbkc.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. WELCOME TO THE MEETING

The Chair to welcome everyone to the meeting.

2. MEMBERSHIP

To report any changes to the Membership of the meeting.

3. DECLARATIONS OF INTEREST

To receive declarations by Members and Officers of the existence and nature of any pecuniary interests or any other significant interest in matters on this agenda.

4. MINUTES AND ACTIONS ARISING **(Pages 5 - 14)**

i) The City of Westminster Health and Wellbeing Board to approve the Minutes of its sovereign meeting held on 3 July 2019.

ii) The Royal Borough of Kensington & Chelsea and City of Westminster Health and Wellbeing Boards to agree the Minutes of the concurrent meeting held on 3 July 2019.

PART A - HEALTH AND WELLBEING BOARD PRIORITIES

5. PRIORITY UPDATES

Sarah Newman, Interim Executive Director of Bi-Borough Children's Services, and **Houda Al-Sharifi**, Bi-Borough Interim Director of Public Health, to present a verbal update on Taking a Public Health approach to Serious Youth Violence.

Anne Pollock, Principal Policy Officer, to present a verbal update on the Dementia Strategy.

PART B – OTHER IMPORTANT ITEMS SPONSORED BY THE BOARD

6.	**JOINT RBKC AND WESTMINSTER HWBB SPEAKER PROTOCOL** To consider a protocol for public speaking at Board meetings (**Senel Arkut**).	**(Pages 15 - 18)**
7.	**PRIMARY CARE NETWORK (PCN) ALIGNMENT** **Joe McGale** (West London CCG) and a representative from Central London CCG to present an update on the PCN Alignment.	**(Pages 19 - 48)**
PART C – MONITORING – STATUTORY ITEMS / OTHER		
8.	**BETTER CARE FUND UPDATE** **Senel Arkut** to present an overview of the recent BCF submission, which was sent to NHSE ahead of the deadline of 27 September.	**(Pages 49 - 56)**
9.	**ANY OTHER BUSINESS** The Board to consider any other business which the Chair considers urgent.	

Stuart Love
Chief Executive,
Westminster City Council

Barry Quirk
Chief Executive,
RB Kensington & Chelsea

2 October 2019

CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Wednesday 3rd July, 2019**, Lord Mayor's Parlour, 19th Floor, Westminster City Hall, 64 Victoria Street, London, SW1E 6QP.

Members Present:

Councillor Heather Acton (WCC - Cabinet Member for Family Services and Public Health)
Councillor Jim Glen (WCC – Deputy Cabinet Member for Family Services and Public Health)
Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)
Councillor Selina Short (WCC – Family and People Services Policy & Scrutiny Member)
Councillor Peter Freeman (WCC – Family and People Services Policy & Scrutiny Member)
Dr Neville Purssell (Chair of the Central London CCG)
Jules Martin (Executive Director – Central London CCG)
Wayne Haywood (Programme Manager – Better Care Fund)
Toby Hyde (Imperial College NHS Trust)
Louise Proctor (Managing Director of the West London CCG)
Neil Hales (Central London CCG)
Robyn Doran (Central and North West London NHS Foundation Trust)
Senel Arkut (Bi-Borough - Head of Health Partnerships and Development)
Houda Al-Sharifi (Interim Director of Bi-Borough Public Health)
Sarah Newman (WCC – Director of Family Services)
Jennifer Travassos (WCC – Head of Prevention)
Sarah Crouch (Bi-Borough Public Health)
Hilary Nightingale (Westminster Community Network)
Dominic Conlin (Chelsea & Westminster Hospital NHS Trust)

1 MEMBERSHIP

1.1 Apologies for absence were received from, Lesley Watts (Chelsea & Westminster Hospital NHS Foundation Trust), Dr Naomi Katz (West London CCG), Angela Spence (Kensington & Chelsea Social Council), Sue Harris (Executive Director Environment & Communities), Iain Cassidy (OpenAge), Sebastian Adjei-Addoh (Metropolitan Police), Bernie Flaherty (Bi-Borough Executive Director of Adult Social Care), Melissa Caslake (Bi-Borough

Executive Director of Children's Services) and Dr Andrew Steeden (Chair of West London CCG).

2 DECLARATIONS OF INTEREST

2.1 No declarations were made.

3 WESTMINSTER'S HOMELESSNESS STRATEGY 2019-2024

3.1 Jennifer Travassos (Head of Prevention) presented a paper setting out proposals for Westminster's draft Homelessness Strategy. It was explained that the Strategy had a greater focus on preventative work undertaken at an earlier stage with those people who might be at risk of homelessness.

3.2 The Board was interested to note the main causes of homelessness in Westminster which included eviction by family or friends (44%), loss of private rented tenancy and relationship breakdowns. It was highlighted that relationship breakdown was the cause of 16% of applications in 2018/19 of which 67% of these cases involved domestic violence. The evidence also showed that certain groups and communities were more at risk of homelessness. These high-risk groups included women, households with children, lone parents and Black and Middle Eastern households. It was emphasised that the number of single people requiring assistance had been growing since the introduction of the Homelessness Reduction Act. The Board was also interested to learn of the clear relationship that had been identified between areas of deprivation in Westminster and homelessness.

3.3 The work being undertaken by the Council to prevent homelessness was detailed. A target to develop at least 1,850 new affordable homes by 2023 had been set. Social housing was allocated to homeless households and they were also prioritised for intermediate housing. The Housing Solutions Service had been retendered in 2017 in response to the Homelessness Reduction Act and this had created a partnership which brought together expertise from both the public and voluntary sectors. Homeless households were also offered private rented housing as an alternative to long waits in temporary accommodation. Due to the high cost of private rented housing locally these were often located outside Westminster, however those with the highest social and welfare needs were prioritised for local accommodation. It was noted that the Council had invested £30million in a scheme, called Real Lettings, to provide good quality private rented housing with follow on support from St Mungo's.

3.4 The Board noted the proposals for Westminster's Homelessness Strategy and that the public consultation would conclude by mid-September 2019. Once the consultation had ended it was confirmed that the Strategy would be circulated to the Board for feedback. The Board advised that once the consultation had been completed it would then determine what role it would undertake in helping implement the Strategy.

The Meeting ended at 4.05 pm.

CHAIRMAN: _____ **DATE** _____

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MINUTES

CITY OF WESTMINSTER

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a concurrent meeting of Westminster City Council's and the Royal Borough of Kensington & Chelsea's **Health & Wellbeing Boards** held on 3 July 2019 at 4pm in the Lord Mayor's Parlour, 19th Floor, Westminster City Hall, 64 Victoria Street, London, SW1E 6QP.

Present:

Councillor Heather Acton (WCC - Cabinet Member for Family Services and Public Health)
Councillor Sarah Addenbrooke (RBKC – Lead Member for Adult Social Care and Public Health)
Councillor David Lindsay (RBKC - Lead Member for Family and Children's Services)
Councillor Jim Glen (WCC – Deputy Cabinet Member for Family Services and Public Health)
Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)
Councillor Selina Short (WCC – Family and People Services Policy & Scrutiny Member)
Councillor Peter Freeman (WCC – Family and People Services Policy & Scrutiny Member)
Dr Neville Purssell (Chair of the Central London CCG)
Jules Martin (Executive Director – Central London CCG)
Angeleca Silversides (Healthwatch RBKC)
Wayne Haywood (Programme Manager – Better Care Fund)
Toby Hyde (Imperial College NHS Trust)
Philippa Johnson (Central London Community Healthcare NHS Trust)
Louise Proctor (Managing Director of the West London CCG)
Neil Hales (Central London CCG)
Robyn Doran (Central and North West London NHS Foundation Trust)
Houda Al-Sharifi (Interim Director of Bi-Borough Public Health)
Senel Arkut (Bi-Borough - Head of Health Partnerships and Development)
Ian Heggs (Director of Schools Commissioning and Education)
Steve Comber (Head of Local Offer and SEN Outreach)
Jennifer Travassos (WCC – Head of Prevention)
Sarah Newman (Director of Family Services)

Sarah Crouch (Bi-Borough Public Health)
Stuart Priestley (RBKC – Chief Community Safety Officer)
Hilary Nightingale (Westminster Community Network)
Dominic Conlin (Chelsea & Westminster Hospital NHS Trust)
Asif Rahman (Redthread)
John Poyton (Redthread)
PC Mark Kent (Metropolitan Police)

1. WELCOME TO THE MEETING

1.1 Councillor Heather Acton welcomed everyone to the meeting and confirmed that as the concurrent Board meeting was being held within Westminster she would Chair the meeting in line with the agreed memorandum of understanding.

2. MEMBERSHIP

2.1 Apologies for absence were received from, Lesley Watts (Chelsea & Westminster Hospital NHS Foundation Trust), Dr Naomi Katz (West London CCG), Angela Spence (Kensington & Chelsea Social Council), Sue Harris (Executive Director Environment & Communities), Iain Cassidy (OpenAge), Sebastian Adjei-Addoh (Metropolitan Police), Bernie Flaherty (Bi-Borough Executive Director of Adult Social Care), Melissa Caslake (Bi-Borough Executive Director of Children's Services) and Dr Andrew Steeden (Chair of West London CCG).

3. DECLARATIONS OF INTEREST

3.1 Angeleca Silversides declared that she was a Director and Trustee for an organisation that provided Special Educational Needs and Disabilities (SEND) services.

4. MINUTES

RESOLVED:

4.1 That the minutes of the Royal Borough of Kensington & Chelsea and Westminster City Council joint Health & Wellbeing Board meeting held on 9 May 2019 be agreed as a correct record of proceedings.

4.2 The minutes of the Royal Borough of Kensington & Chelsea meeting held on 9 May 2019 be agreed as a correct record of proceedings.

5. TAKING A PUBLIC HEALTH APPROACH TO SERIOUS YOUTH VIOLENCE

5.1 Sarah Newman (Director of Family Services) and Sarah Crouch (Interim Bi-Borough Director Deputy Director of Public Health) provided the Board with an overview of activity occurring across Westminster and Kensington and

Chelsea to tackle serious youth violence (SYV). It was explained that SYV was a term used to capture significant violent crime committed by youths up to the age of 25. It was recognised that the factors leading to youth violence were multi-faceted and had the potential to lead to a range of mental health problems and disorders.

5.2 The Board was concerned to note that knife crime had increased by 52% in Westminster and 24% in Kensington and Chelsea in the last year. Despite this the actual number of incidences involving violence and knife crime committed by under 18 youth offenders had decreased over the last three years. The risk factors relating to the likelihood of a person becoming a victim or perpetrator of violence were detailed. In response it was highlighted how a public health approach to SYV was being undertaken which looked at the root causes and the wider and contextual influences of health and crime. It was recognised that prevention and early intervention were key as well as working with a wide range of partners as part of a long-term, integrated multi-agency approach rather than taking a procedural justice response which dealt with the consequences. The three main issues which the Board was asked to consider related to:

i) Leadership – ensuring there was a clear, defined and whole system action plan and accountability;
ii) Data – to define and monitor the magnitude, characteristics and drivers of youth violence in Westminster and RBKC and a commitment to data sharing where relevant; and
iii) Support Services and Prevention – to look strategically at mental health provision across the system and ensure it met needs in this context.

5.3 The Board held a detailed discussion over the issues of youth violence which included potential gaps in the data regarding information on whether offenders and victims were local residents or not. In response it was noted that the Westminster SYV Task Group was looking at an outcomes framework to identify such data as it was acknowledged that some of the data around victims and offenders was not yet in a form which allowed it to be fully investigated.

5.4 Asif Rahman and John Poyton from Redthread, a youth work charity, were invited to address the Board. They discussed the work undertaken with partners to address serious youth violence at an early stage and highlighted the issues encountered. It was recognised that young people often did not interact with GPs and as a result different models of practices were being investigated to improve levels of interaction. The Board then held discussions over how the work commenced could potentially feed into that undertaken by the Primary Care Networks and Family Hubs. It was suggested that the potential to use youth provision funds to establish drop-in centres at Family Hubs or Youth Centres be investigated in order to engage young people and ensure any provision benefitted from a joined up, consistent approach.

5.5 The Board noted the initiatives being undertaken to combat serious youth violence and was pleased to provide support and assistance as required. It was suggested that further work be undertaken to share data amongst

partners and welcomed the opportunity to receive a future update on youth violence related to the 19-24 aged cohort. It was suggested that the outcomes framework being developed by the Westminster SYV Task Group be circulated to the Board to allow the member organisations an opportunity to assess how they could contribute to addressing the issues discussed.

6 CCGs – THE CASE FOR CHANGE

6.1 Dr Neville Purssell (Central London CCG) and Dr Louise Proctor (North West London CCG) presented the Board with a paper providing information on the case for establishing a single CCG across North West London. The NHS England 10 Year Long Term Plan had been published in early 2019 which outlined a number of goals including the development of Integrated Care Systems (ICS) and more local Integrated Care Partnerships (ICP) which would be underpinned by Primary Care Networks (PCN). It was envisaged that each ICS would consist of just a single CCG replacing the eight North West London currently had in place. It was suggested that the changes would address the financial and care provision challenges faced by making the decision-making and administration processes as effective and efficient as possible. It was advised that the change would support consistency and equity in methods of engagement and simplify system wide financial planning.

6.2 The importance of local authorities as key partners was stressed, especially in helping to determine local priorities and strengthening local accountability. It was envisaged that the role of the Health and Wellbeing Board of providing a strategic steer for effective local delivery of health and care outcomes would continue and the importance of the local authorities in scrutinising health services would continue under any reform of commissioning structures. It was explained that Westminster's and Kensington and Chelsea's Boards would also continue to play a key role in shaping and developing local services.

6.3 Concern was expressed that at this stage there appeared to be a lack of clarity with regards to the proposed governance structure under any potential new arrangements. The Board was informed that currently an engagement process was being undertaken with stakeholders up until 24 July 2019 and the Board was asked to feedback any specific comments to help inform the proposals.

6.4 The Board discussed in detail how the proposals would impact on the role of the voluntary sector, potential changes to patient facing services and how it was envisaged that the ICPs would operate. The Chair advised the Board of the importance of feeding into the engagement process to help inform the proposals to establish a single CCG.

7 SEND STRATEGY SELF EVALUATION

7.1 Ian Heggs (Director of Schools Commissioning and Education) and Steve Comber (Head of Local Offer and SEN Outreach) provided an update to the Board on the work carried out to implement the SEND reforms introduced in the Children and Families Act (CFA) 2014 in addition to a summary of inspection arrangements. The report also introduced the Special Educational

Needs and Disabilities (SEND) Self-Evaluation Frameworks (SEF) for both local areas.

7.2 The positive changes and the challenges that the Council had faced since the introduction of the reforms were detailed. The Board was pleased to note the level of joint working undertaken with partners including the CCGs, school representatives and parents to deliver those reforms.

7.3 An overview of the joint Ofsted and Care Quality Commission (CQC) inspection process was provided which focused on the areas of education, health and social care provisions available for children and young people with SEND. The inspectors would review the journey of progress since the introduction of the CFA and how this had been achieved as a local area partnership. As part of the process the inspectors had to understand the robustness of local self-monitoring processes and policies. The Board was advised that Westminster and RBKC had not yet been inspected since the process was introduced in 2016. It was confirmed that once an inspection had been arranged the Board would be updated accordingly. The Board's attention was then drawn to the SEND local area governance arrangements and how the various partners, including the Board, worked together.

7.4 The Board discussed potential issues regarding the process of children receiving an Education, Health and Care Plan (EHCP) and the level of support provided. It was recognised that there was increasing demand for EHCPs and an increase in the complexity of needs encountered. However, services were being tailored accordingly to meet these challenges and nearly 100% of EHCP assessments were now being undertaken within the 20-week timeframe. Schools and colleges had also developed more accessible websites which clearly communicated the Local Offer of support for children and young people with SEND.

7.5 The Board noted the update and expressed its thanks for all the work undertaken to implement the SEND reforms.

8 BETTER CARE FUND UPDATE

8.1 Senel Arkut (Bi-Borough Director of Health Partnerships) introduced a paper which summarised the outcome (Q4 Return) of the Better Care Fund (BCF) Plan for 2018/19 for both Westminster and Kensington and Chelsea. Details on the jointly developed BCF plans for 2019/20 were also provided. It was explained that the services and resources that form part of the 2019/20 BCF were organised into the following five themes:

i) High quality care in the community, preventing unnecessary hospital admissions and ensuing timely discharge;
ii) Joint work on mental health supported accommodation and homelessness;
iii) Advocacy, carers cervices, advice and guidance and prevention;
iv) Aligning the boroughs and CCG BCF with wider strategic plans; and
v) Use of the iBCF, winter pressures, disabled facilities grant funding as enablers for BCF plans in Westminster and Kensington and Chelsea.

8.2 The Board discussed the plans in detail and noted that delays in issuing the national guidance meant that many Health and Wellbeing Boards would not have formally approved their 2019/20 Plans before they needed to be submitted for assurance. It was expected that for Westminster and Kensington and Chelsea the submission deadline was likely to be before the next Board meeting in October. The Board considered options for approving the 2019/20 BCF and agreed that following endorsement of the Plan from partners, responsibility for sign-off of the 2019/20 BCF would be delegated to the Chairs of the Boards for approval. Following which, the final submission, once approved by NHS England, would be retrospectively tabled at a meeting of the concurrent Board.

RESOLVED:

1) That the headline details of the BCF Q4 return that was submitted to NHS England in April 2019 be noted;

2) That the 2019/20 BCF plans be circulated to partners for endorsement before responsibility for sign-off be delegated to the Chairs of the Health and Wellbeing Boards in order to obtain the necessary assurance from NHS England that plans were in place for the delivery of the 2019/20 BCF Plan;

3) That the final submission, once approved by NHS England, would be aimed to be retrospectively tabled at the concurrent Health and Wellbeing Board scheduled for 10 October 2019; and

4) That the approach in Westminster and Kensington & Chelsea outlined in the report be noted.

9.1 ANY OTHER BUSINESS

9.1 Councillor Acton provided an update on a recent visit to the Dementia House in Watford and suggested that a briefing note be circulated to the Board.

The Meeting ended at 6.10 pm.

CHAIR: _____ **DATE** _____

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	**10 October 2019**
Classification:	**General Release**
Title:	**Joint K&C and Westminster HWBB Speaker Protocol**
Report of:	**Senel Arkut, Bi-B Director of Health Partnerships**
Report Author and Contact Details:	**Tristan Fieldsend, Senior Committees Officer**

1. Executive Summary

1.1 This paper outlines the draft speaker protocol for members of the public who want to attend the joint Kensington & Chelsea and Westminster Health and Wellbeing Board (HWBB).

2. Key Matters for the Board

2.1 Members of the HWBB are asked to review the draft speaker protocol and, subject to any feedback, confirm their approval of the proposals.

3. Background

3.1 In line with Kensington & Chelsea and Westminster's commitment to resident and community engagement, officers have drafted this protocol to enable members of the public to participate in HWBB discussions.

4. Options / Considerations

4.1 HWBB members are asked to review the draft protocol and, subject to any feedback, confirm if they are happy for it to be implemented and published on the councils' websites.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

Tristan Fieldsend, Senior Committees Officer

Email: tfieldsend@westminster.gov.uk

Telephone: 020 7641 2341

APPENDICES:

Joint Kensington & Chelsea and Westminster Draft Speaker Protocol

HEALTH AND WELLBEING BOARD PUBLIC QUESTIONS

Introduction

This protocol explains how you can ask questions at meetings of the Joint Westminster and Kensington & Chelsea Health and Wellbeing Board.

How will I know when a particular matter that is of interest to me is going to be discussed at the Board?

The matters discussed by the Board will be set out on the meeting agendas which are published on the website no later than five clear working days before the date of the meeting and can be accessed via the link below.

https://committees.westminster.gov.uk/ieListMeetings.aspx?CommitteeId=162

Who can speak at Health and Wellbeing Board Meetings?

Please note that due to restictions imposed on public gatherings due to the Covid-19 pandemic, public speaking has been temporarily suspended as future meetings will now be held virtually. Members of the public can still submit questions to the Board using the contact information below and these will be discussed by members at the meeting.

Any person living, working or studying within the boroughs of Westminster or Kensington and Chelsea.

If you wish to speak at the Board you will need to notify us beforehand. Submissions for public questions must be made in writing by the individual, or individual representing an organisation, and outline the question to be raised. The deadline for submitting a question is 72 hours before the meeting starts. Once received, the submission will be considered by the Chair of the Board to ensure that it relates to Health & Wellbeing Board matters and is an appropriate matter for a public question. The Chair has the right to not progress a public question to the Board. If the submission is accepted by the Chair, the member of the public will be invited to address the Board with their question. They will have a maximum of 2 minutes to speak and there will be a maximum of three public speakers per meeting. These time limits will be strictly adhered to and the Chair will have the discretion to halt the Speaker should they begin to stray from the subject matter or make inappropriate or offensive comments.

Once speakers have finished they will be asked to retake their seats in the public gallery and may take no further part in the meeting.

In exceptional circumstances the Chair may allow additional time for questions

What can I say?

Comments do not have to be related to matters listed on the meeting agenda but must be based on Health & Wellbeing Board issues. You can either make a brief statement about something that is of interest to you or ask a question on a subject that relates to the work of the Board.

Speakers must not:

• Make statements of a personal or slanderous nature; or

• Be abusive; or
• Interrupt other Speakers

Can I provide additional information to present at the meeting?

Additional material can be provided for further reference but it should be noted that the public speaking session is not the appropriate forum to seek answers to individual complaints or queries which will need to be pursued elsewhere. Officers can provide further details on how to do this if required.

Who do I contact if I want to ask a question at the Board?

You can submit a question using the following email address:
healthandwellbeing@westminster.gov.uk

or you can contact the Committee Clerk who looks after the Health and Wellbeing Board:

Board meetings at Westminster:

- Telephoning 020 7641 2341

Board meetings at Kensington & Chelsea:

- Telephoning 020 7361 2947

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	Thursday 10th October
Classification:	**General Release**
Title:	West London CCG: Primary Care Network Development
Report of:	Health & Wellbeing Board
Wards Involved:	West London CCG area (Royal Borough of Kensington and Chelsea and Queens Park and Paddington area of Westminster).
Financial Summary:	N/A
Report Author and Contact Details:	Joe McGale, Head of Primary Care Strategy and Development Joe.Mcgale@nhs.net

1. Executive Summary

1.1 This Report provides an update on Primary Care Network (PCN) Development in West London CCG.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are invited to note the update on PCN development.

3. Background

3.1 During 2018/19, West London CCG developed and monitored a bespoke local process in order to support the development of PCNs. This involved delivery of a PCN Development Plan which had the following main objectives;

- Establish PCN membership, leadership and collaborative working
- Engage effectively and support the development of the Integrated Community Team
- To achieve 100% PCN population coverage of Out of Hospital Services (OOHS)
- Identify and create plan for delivery of a PCN “local objective”

3.2 In March 2019 NHS England published guidance regarding a new national contract for PCNs - the Network Contract Directed Enhanced Service (DES) with a go-live date of 1st July 2019. The guidance included a service specification and detailed the process which any group of practices interested in participating would need to follow. This included a Registration Form and Network Agreement which sets out how practices and partners (e.g. NHS Providers, Local Authority, and Voluntary sector) agree to work together.

3.3 In order for PCNs to begin delivering the Network Contract D E S from 1st July an assurance process was undertaken by the CCG to confirm the configuration of practices within each Network. At June’s Primary Care Commissioning Committee, all 5 PCNs were recommended for approval to be submitted to NWL Health and Care Partnership for endorsement. The final confirmed configurations are included for reference as Appendix A.

3.4 Since July, the PCNs have begun delivery of the Network Contract DES. This includes a range of requirements including the provision of appointments outside of core hours (0800-1830 Monday to Friday) for patients across the Network. 2019/20 is predominantly viewed as a preparatory year in order to ensure readiness to deliver new service specifications from April 2020. The new service specifications to be implemented during 2020/21 and 2021/22 are as follows;

- Structured Medications Review and Optimisation;
- Enhanced Health in Care Homes, to implement the vanguard model;
- Anticipatory Care requirements for high need patients typically experiencing several long term conditions, joint with community services;
- Personalised Care, to implement the NHS Comprehensive Model;
- Supporting Early Cancer Diagnosis;
- CVD Prevention and Diagnosis; and
- Tackling Neighbourhood Inequalities.

3.5 Across NWL, local expectations have been established for PCNs which are based upon seven keystones for development;

- Developing relationships and leadership to create a strong ICP
- Understanding our population – and improving the way we care for them
- Continuous Quality Improvement and reducing variation
- Improving the health of NWL population in key priority areas
- Being financially sustainable and resilient
- Optimising our workforce's skills and assets
- Maximising digital opportunities

3.6 Each PCN has been asked to undertake a self-assessment using the NHSE Maturity Matrix (Appendix B) which outlines expectations at both a PCN and System-level in order to establish its development needs for the year ahead.

3.7 Using the outputs from this self-assessment, PCN development plans have been formulated which set-out how transformation funds will be used to make the changes required.

3.8 Each PCN will be expected to identify a Health and Care Partnership priority for service improvement in order to build their development plans from the list below:

- Urgent Care
- Outpatient Care
- Supporting people with frailty
- Diabetes
- Last Phase of Life and Enhanced Health in Care Homes
- Cardio Vascular disease and Respiratory disease
- Personalisation
- Mental Health
- Cancer
- Children's Health
- Muskoskeletal Health

3.9 PCNs will increasingly need to work with other non-GP providers, as part of collaborative primary care networks, in order to offer their local populations more personalised, coordinated health and social care.

4. Options / Considerations

4.1 The Health and Wellbeing Board is asked to consider how effective service integration across primary and community services can most effectively be achieved across PCN footprints in the future.

4.2 The Health and Wellbeing Board is asked to consider how PCNs can be supported in their development.

5. Legal Implications

5.1 No legal implications as a result of this paper.

6. Financial Implications

6.1 No financial implications as a result of this paper.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Joe McGale, Head of Primary Care Strategy and Development, West London CCG

Email: joe.mcgale@nhs.net

Telephone: 020 3350 4073

APPENDICES:

Appendix A: WLCCG PCN Configurations

Appendix B: PCN Maturity Matrix 2019-20

BACKGROUND PAPERS:

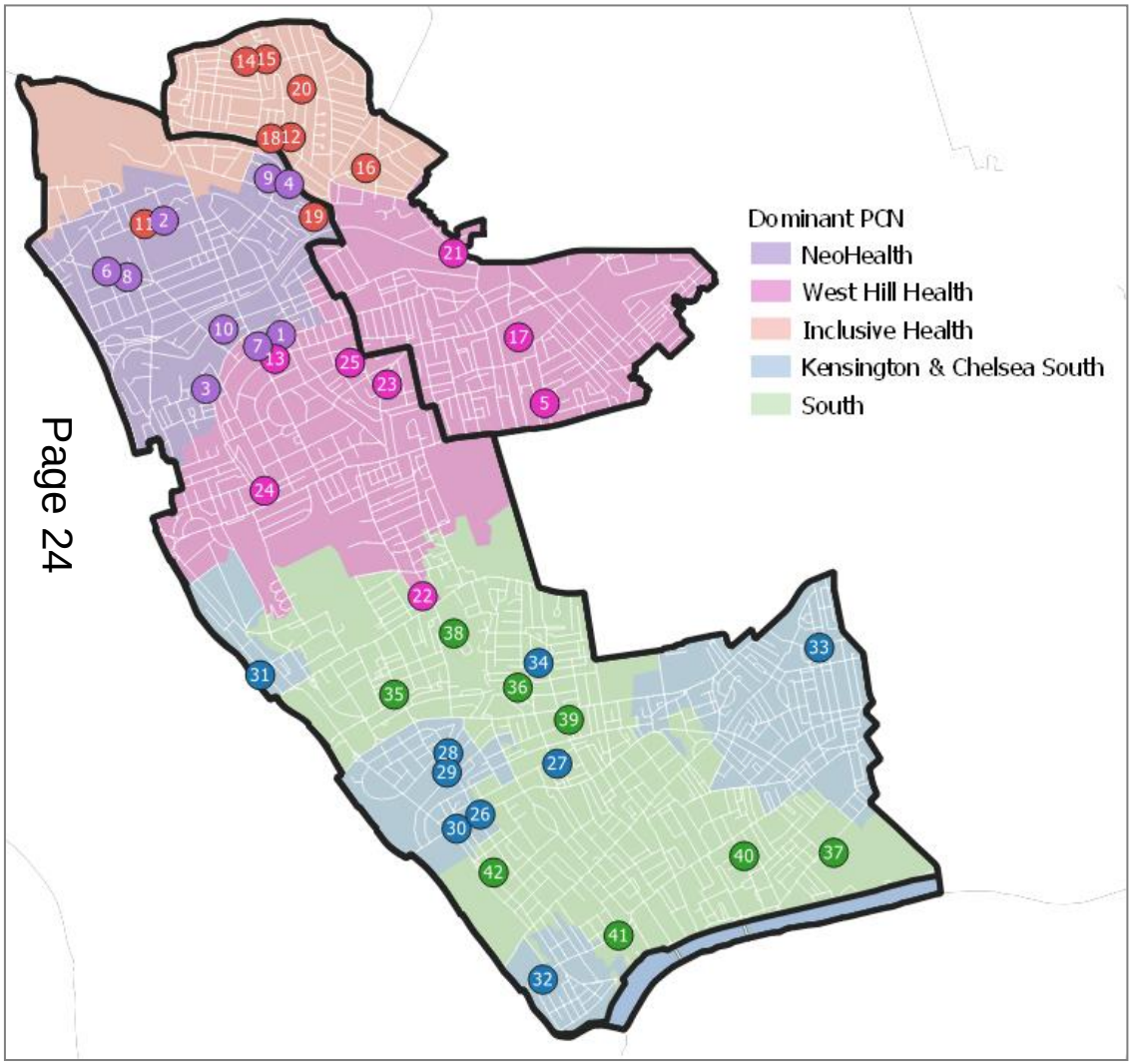
Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (NHS England, 2019)
https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

NHS
West London
Clinical Commissioning Group

Approved Primary Care Network Maps

July 2019

Network Map



Primary Care Network	Map Label	Code	Practice Name
NeoHealth	1	E87067	Colville Health Centre
	2	E87733	The Exmoor Surgery
	3	E87706	Foreland Medical Centre
	4	E87024	The Golborne Medical Centre (Ramasamy)
	6	E87003	North Kensington Medical Centre
	7	E87065	Notting Hill Medical Centre
	8	Y00507	St Quintin Health Centre
	9	E87742	The Golborne Medical Centre (Dathi)
	10	E87050	Beacon Medical Centre
Inclusive Health	11	Y01011	Barlby Surgery (AT Medics)
	12	Y02842	Half Penny Steps Health Centre
	14	E87735	Queens Park Health Centre (Lai Chung Fong)
	15	E87755	Queens Park Health Centre (Ahmed)
	16	E87038	The Elgin Clinic
	18	E87751	Harrow Road Surgery (Dr Srikrishnamurthy)
	19	E87026	The Meanwhile Gardens Medical Centre
	20	E87021	Shirland Road Medical Centre
West Hill Health	5	E87722	Lancaster Gate Medical Centre
	13	Y00200	Portobello Medical Centre
	17	E87009	The Garway Medical Practice
	21	E87637	Grand Union Health Centre
	22	E87016	Holland Park Surgery
	23	E87061	The Pembridge Villas Surgery
	24	E87029	The Portland Road Practice
	25	E87007	Westbourne Grove Medical Centre
Kensington & Chelsea South	26	E87746	Brompton Medical Centre
	27	E87048	Chelsea Medical Services (Dr Joshi)
	28	Y03441	Earls Court Health and Wellbeing Centre
	29	E87047	Earls Court Medical Centre
	30	E87750	Earls Court Surgery
	31	E87720	Kensington Park Medical Centre
	32	E87063	King's Road Medical Centre (AT Medics)
	33	E87738	Knightsbridge Medical Centre
	34	E87702	Kynance Practice
South	35	E87701	The Abingdon Medical Practice
	36	E87043	Emperor's Gate Health Centre
	37	E87711	Royal Hospital Chelsea
	38	E87715	Scarsdale Medical Centre
	39	E87013	Stanhope Mews Surgery
	40	E87665	The Chelsea Practice
	41	E87762	The Good Practice
	42	E87004	Redcliffe Surgery

Network Details

PCN Name	No. of Practices	Aggregated Patient List (Raw: 1st January 2019)	Named Clinical Director
NeoHealth	9	38,152	Dr Rachael Garner
Inclusive Health	8	33,449	Dr Akber Ali
West-Hill Health	8	66,890	Dr Simon Ramsden & Dr Naomi Katz
Kensington and Chelsea South	9	59,474	Dr Puvana Rajakulendran
South	8	55,791	Dr Fiona Butler

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Primary Care Network Maturity Matrix

August 2019

Primary Care Network Maturity Matrix

What is the PCN Maturity Matrix?

The Primary Care Network (PCN) Maturity Matrix outlines components that underpin the successful development of networks. It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for their neighbourhoods.

The matrix was built through learning from the initial wave of Integrated Care Systems who commenced early work on the design and development of PCNs during 2017/18. It has since been refreshed in light of the NHS Long Term Plan and the GP Contract Framework. A number of systems have developed their own version of the maturity matrices to meet local need.

Purpose of the Maturity Matrix

The PCN maturity matrix is not a binary checklist or a performance management tool. It is designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care. Using the matrix as a basis for these discussions will allow networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development and consider how they can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.

- Make plans for further development that help networks to continue to expand integrated care and approaches to population health, and that can best meet the health and care needs of the population served by the network.

- Identify support needs using the PCN Development Support Prospectus as a guide for framing support plans

A development journey for PCNs

Across England, PCNs will be at varied stages of development. A number of networks will be building on already established integrated ways of working and emerging population-health based new care models, with GP practices, other primary care providers, community services, secondary care, mental health, local authorities, the voluntary sector, local people and communities already collaborating on existing transformation schemes and initiatives. It is important the momentum of these existing ways of working is retained where that is already adding value for patients, staff and the wider population

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan sets out a trajectory for how networks can build over time, for example with the planned introduction of the contract service specifications. The matrix is designed to complement that framework and to set out the wider supportive development journey in how networks can grow their capabilities to support local priorities. It will help STPs and ICSs to work with providers within networks to enable those journeys in a way that also reflects the priorities systems identify in their 5 year delivery strategies. As for the prospectus support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications.

General practices are central to the successful development of PCNs but the matrix is intended to support a holistic multi-agency view of the development of networks. 'Neighbourhoods' are the cornerstone of integrated care, served by groups of GP practices working with NHS community services, social care, mental health, other providers, voluntary organisations, local people and communities to deliver more coordinated and proactive services. It is important that development discussions framed around the matrix are able to bring together the insights and expertise of a range of local stakeholders who will be working together to provide improvements in integrated care.

How to use the matrix

Components of the matrix

The matrix is set out as a table of components for the development of PCNs and is organised as follows:

- There are four columns showing a development journey over time – organised into 'Foundation', Step 1, Step 2 and Step 3
- The columns are subdivided in to components that PCNs may find it helpful to consider as part of their development journey and components that ICSs and STPs will also want to consider as part of the wider supporting infrastructure that enables network development
- There are five rows which organise the components into the following
    - Leadership, planning and partnerships
    - Use of data and population health management
    - Integrating care
    - Managing resources
    - Working in partnership with people and communities

A basis for development discussions

Experience from the initial community of Integrated Care Systems shows that the matrix was most effectively used when it provided the basis for local development discussions. Practices within a network came together with their CCGs and other local organisations – for example local authorities and community services – for a shared discussion on current progress and future plans for integrated care and networks. The output of these discussions was typically a shared set of priorities and actions for how the network would evolve. There is no 'one size fits all' approach on how best to organise and hold these discussions. System primary care leaders, CCG primary care directors and PCN clinical directors should come together to agree an approach that works best locally – which could, for example, inform the development of system and place level priorities and actions to support networks. The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

The matrix should be used pragmatically and flexibly, with networks viewing PCN development as a multi-year journey, and one that can build on progress that has already been made in improving and transformation care and services for patients and populations. **Initial discussions may want to reference the maturity matrix and focus on the following questions: Where are you now? Where do you want to be in a year? How will you get there and what do you need? Within this discussion networks will need to think about the time needed, the capacity required, the support needed to build sustainable skills and confidence to deliver.** This will enable PCNs to identify where the network wants to focus its development activity during the remainder of 19/20 and subsequent years. Network development should be a continuous improvement process, which enables plans to grow and mature, and therefore systems and their networks should consider holding further periodic reviews using the matrix – for example on an annual or bi-annual basis.

Conversations between providers operating across the network's footprint are crucial for building, trust and confidence and helping develop partnerships. Where any ICSs or STPs are confident that they have already undertaken a level of local development discussions against previous or locally developed versions of the matrix, it is expected those systems will apply a proportionate approach in how any further discussions are taken forward. In these cases, systems should assure themselves through appropriate local governance channels (including in dialogue with PCN Clinical Directors) that there is sufficient existing intelligence on network development to inform support activities during 19/20, including for the deployment of any transformation funding, and there is an understanding of local PCN level priorities that can in turn inform the development of system primary care strategies.

There is also an important role for systems in support the development of PCNs. The maturity matrix draws out how systems can do this across each theme of the matrix, ensuring that PCNs have the infrastructure, resources and relationships to thrive operationally and financially and make an important strategic contribution.

To complement the maturity matrix, there is a simple diagnostic spreadsheet tool that can support systems to understand local PCN maturity, target support and inform any local development plans. The tool enables PCNs to put the matrix 'into action'.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Leadership, planning and partnerships **Prospectus Domains:** Leadership, OD, Change management, CD leadership	For PCNs: • The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this. • Clinical directors are able to access leadership development support. For Systems • Systems are actively supporting GP practices and wider providers to start establishing networks and integrated neighbourhood ways of working and have identified resources (people and funding) to support PCNs on their development journey. • Systems have identified local approaches and teams to support PCN Clinical Directors with the establishment and development of networks and for clinical directors in their new roles.	For PCNs: • The organisations within the PCN have agreed shared development actions and priorities. • Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint. • There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in place/system strategic decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and local authorities. For Systems: • Primary care is enabled to have a seat at the table for system and place strategic planning. • As set out in the LTP, there is a system level strategy for PCN development and transformation funding, with support made available for PCN development. System leaders supports PCN clinical directors to share learning and support development across networks.	For PCNs: • The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working. • The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop. For Systems: • Primary care is enabled to play an active role in strategic and operational decision-making, for example on Urgent and Emergency Care. Mechanisms in place to ensure effective representation of all PCNs at the system level. • PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs.	For PCNs: • PCN leaders are fully participating in the decision making at the system and relevant place levels of the ICS/STP. They feel confident and have access to the data they require to make informed decisions. For Systems: • Primary care leaders are decision making members of the ICS and place level leadership, working in tandem with partner health and care organisations to allocate resources and deliver care.
Use of data and population health management **Prospectus Domain**: Population Health Management	For PCNs: • The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health. For Systems: • Infrastructure is being developed for PHM in PCNs including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support.	For PCNs: • Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon. • Basic population segmentation is in place, with understanding of key groups, their needs and their resource use. This should enable networks to introduce targeted interventions, which may be initially focussed on priority population cohorts • Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions. For Systems: • Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches. • There is some linking of data flows between primary care, community services and secondary care.	For PCNs: • All primary care clinicians can access information to guide decision making, including identifying at risk patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system. • Functioning interoperability within networks, including read/write access to records,. For Systems: • There is a data and digital infrastructure in place to enable a level of interoperability within and across PCNs and other system partners, including wider availability of shared care records • Analytical support, real time patient data and PHM tools are made available for PCNs to help understand high and rising risk patients and population cohorts, and to support care design activities.	For PCNs: • Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts. • Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care For Systems: • Full interoperability is in place across the organisations within PCNs, including shared care records across providers. • System partners work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Integrating care **Prospectus Domain:** Collaborative Working (MDTs)	For PCNs: • The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long Term Plan, GP contract framework and locally agreed system/place priorities. • The PCN is aware of the organisations they need to engage to develop multi-agency approaches to integrated care and are beginning to make initial approaches. For Systems: • Systems support the PCNs to build relationships across physical and mental health service providers and social care partners to facilitate the delivery of Integrated care.	For PCNs: • Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care. • Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans. For Systems: • Systems support the building of relationships across providers of physical and mental health services, and social care partners. • System workforce plans supports the development of integrated neighbourhood teams.	For PCNs: • Early elements of new models of care defined at Step 1 now in place for most population segments, with integrated teams including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place. • The PCN and other providers have in place supportive HR arrangements (e.g. formalised integrated team governance and operational management) that enable multi-agency MDTs to work together effectively. For Systems: • There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place.	For PCNs: • Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients. • There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed. For Systems: • Systems have developed and implemented integrated care models that meet with objectives of the LTP.
Managing resources	For PCNs: • Primary care, in particular general practice, has the headroom to make change • There are people available with the right skills to make change happen. For Systems: • System plan in place to support managing collective financial resources that includes PCNs. • PCN development support funding is being used to address PCN development needs.	For PCNs: • Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services. For Systems: • Systems have put in place arrangements that support PCNs with improvements in the efficiency of primary care delivery and enable PCNs to make optimum use of their resources.	For PCNs: • The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally. For Systems: • Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes.	For PCNs: • The PCN takes collective responsibility for managing the resource flowing to the network. Data is used in clinical and non-clinical interactions to make best use of resources. For Systems: • Systems support PCNs to take collective responsibility for managing the resource flowing to the network and use data in clinical and non-clinical interactions to make best use of resources.
Working in partnership with people and communities **Prospectus Domain:** Asset based community development & social prescribing	For PCNs: • Approach agreed to engaging with local communities. • Local people and communities are informed and there are routes for them contribute to the development of the PCN. For Systems: • Systems are providing PCNs with expertise to support local involvement of people and communities.	For PCNs: • The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets. • The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care. • The PCN has established relationships with local voluntary organisations and their local Healthwatch. For Systems: • Systems have put in place arrangements to support PCNs to develop local asset maps in partnership with their local community to enable models of social prescribing for personalised care.	For PCNs: • The PCN is routinely connecting with and working in partnership with wider community assets in meeting their population's needs. • Insight from local people and communities, voluntary sector is used to inform decision-making. • Community networks are understood and connected to the PCN. For Systems: • Systems are facilitating effective partnerships with local community assets within PCN footprints. • The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities.	For PCNs: • The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network. • Community representatives, and community voice, are embedded into the PCN's working practices, and are an integral part of PCN planning and decision-making. • The PCN has built on existing community assets to connect with the whole community and codesign local services and support. For Systems: • The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level.

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	10th October 2019
Classification:	General Release
Title:	Primary Care Networks
Report of:	Central London Clinical Commissioning Group
Wards Involved:	All Westminster wards, except for those in the Queen's Park / Paddington area
Financial Summary:	None
Report Author and Contact Details:	Holly Eden, Associate Director of Commissioning, Central London Clinical Commissioning Group

1. Executive Summary

1.1 This report provides the Health and Wellbeing Board with an update on:

a) Progress with establishing Primary Care Networks (PCNs) to date within the Central London area

b) The make-up and geography of Central London Clinical Commissioning Group (CCG) PCNs

c) The key next steps for PCNs in 2019-20; and

d) The longer term vision for PCNs as set out in the Long Term Plan and the "Investment and Evolution: A five year framework for GP contract reform".

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are asked to note this report.

3. Background

3.1 On 7th January 2019, NHS England published the NHS Long Term Plan, setting out its priorities for healthcare over the next ten years and showing how the NHS funding settlement will be used. This plan included a significant number of deliverables to be achieved by local health systems as well as five major, practical changes to the NHS service model:

- Boost “out of hospital” care, and dissolve the primary and community health services divide.
- Redesign and reduce pressure on emergency hospital services
- People will get more control over their own health and more personalised care
- Digitally-enabled primary and outpatient care will go mainstream across the NHS
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere

3.2 Following this, on the 31st January 2019, NHS England published “Investment and Evolution: a five-year framework for GP contract reform to implement the Long Term Plan” which sets out an agreement between NHS England, the British Medical Association (BMA) General Practitioners Committee in England to translate the requirements of the NHS Longer Term Plan into a five-year framework for the GP core contract.

3.3 This five-year framework looks to:

- Seek to address workload issues resulting from workforce shortfall
- Bring a permanent solution to indemnity costs and coverage
- Improve the Quality and Outcomes Framework (QOF)
- Introduce automatic entitlement To a new Primary Care Contract
- Help join-up urgent care services
- Enable practices and patients to benefit from digital technologies
- Deliver new services to achieve NHS Long Term Plan commitments
- Give five-year funding clarity and certainty for practices
- Test future contract changes prior to introduction, via a test-bed programme with clusters of Primary Care Networks.

3.4 Central to both the Long Term Plan and the five year framework for GP Contract reform are the development and maturity of Primary Care Networks (PCNs), increasingly formal partnerships of GP practices and other providers around populations of around 30-50k patients. These build directly from the National Association of Primary Care model – Primary Care Homes – which Central London CCG implemented across primary care in 2018. PCNs are intended to become “an essential building block of every Integrated Care System” supported by the new

Network Contract Directed Enhanced Service (DES) which will build the role of the PCNs over the next 5 years.

3.5 The Network Contract DES must be offered to all practices and requires primary care to work together across groups of practices configured into “authorised primary care networks” to deliver a range of services.

3.6 The focus of the Network Contract DES in its first year (2019/20) is to:

- support the establishment of PCNs;
- support the delivery of extended hours services at a network-level, rather than within individual select practices; and
- introduce additional workforce at network-level to support improvements to care and to support integration. The new roles are a Clinical Director, Clinical Pharmacy support and Social Prescribers/link works.

3.7 Additional service requirements and financial resources will be added to the DES each year. The diagram attached at ***Appendix A*** provides a summary of the service requirements expected to be introduced via the DES and when those are anticipated to be made available.

3.8 PCNs were required to be set-up and authorised by commissioners by 1st July 2019, with the extended hour’s service beginning on this date.

3.9 To participate in the Network Contract DES, PCNs were required to confirm:

- the names of the proposed member GP practices;
- the PCN list size - sum of its proposed member GP practices’ registered list as at 1 January 2019;
- a map clearly marking the proposed geographical area covered by the PCN (Network Area);
- That a network Agreement had been completed by the PCN setting out how they would manage the delivery of the DES as a network, and how they would govern their affairs
- Identify the single practice or provider (who must hold a primary medical care contract) that would receive funding on behalf of the PCN; and
- Identify a named accountable Clinical Director.

3.10 Commissioners were required to confirm and approve all Network Areas ensuring that:

- all patients in every GP practice are covered by a PCN; and
- there is 100 per cent geographical coverage.

4. Options / Considerations

4.1 The introduction of the DES is a significant step forward nationally in supporting the Primary Care at Scale agenda. However, the pace of change required by practices to develop and formalise their network arrangements has been significant.

4.2 Central London CCG has been commissioning our local, non-delegated, primary care services through an at-scale primary care contract since April 2018 – called the Partnership in Practice contract. Our commissioning of primary care at-scale has been instrumental in driving forward the implementation of PCNs locally and in supporting improvement in the quality and equality of our service offer in primary care. This has meant that our networks have been able to respond at pace to the requirements of the national Network Contract DES

4.3 Our PCNs were authorised under the DES on the 15th May 2019 and all of the PCNs began delivering the full extended hours specification from 1st July 2019 in-line with the national timetable.

4.4 All four PCNs used a voting process to appoint their Clinical Directors and have set up either a Board or Committee to manage the PCNs affairs. The Boards or Committees include representation from each practice and have responsibility for developing the strategy for the PCN, the PCN's development plan and how the PCN will use the financial resources available to it to deliver those plans. The Boards and Committees will also agree how best to mobilise services commissioned from PCNs via the DES.

CLCCG Primary Care Networks

4.5 On the 15th May, Central London Clinical Commissioning Group authorised four Primary Care Networks, all of whom had completed the national requirements for authorisation. These networks are:

- St Johns Wood and Maida Vale PCN
- Regent Health PCN
- South Westminster PCN
- West End and Marylebone PCN

4.6 A map setting out the Primary Care Networks and constituent practices is attached at *Appendix B.*

St John's Wood and Maida Vale PCN

4.7 The St John's Wood and Maida Vale PCN consists of 7 practices in the St John's Wood and Maida Vale area of Central London. This includes the Randolph Practice which is currently being managed by a caretaker provider, AT Medics, while a full procurement process is undertaken to secure a longer-term provider for the practice.

4.8 The PCN provides care to a patient population of 52,500 patients. The Clinical Director of this PCN is Dr Saul Kaufman, who is a GP at the St John's Wood Medical Practice. The Chair of this PCN is Dr Nick Collinson, a GP at the Wellington Medical Centre.

Regent Health PCN

4.9 The Regent Health PCN consists of 8 practices in the Regents Canal and Paddington area of Central London. The PCN cares for a patient population of 64,000. Due to the size of this network and the potential for population growth, there may come a time when the network would need to consider delivering services through two smaller operational units. The PCN is open to considering this as it develops its Clinical Strategy.

4.10 Regent Health PCN provide services to our most deprived patients and also have a relatively high number of patients with multiple long term conditions, or patients who could be considered frail. Due to the population the network cares for, Regent Health PCN have been leading on the development of our Integrated Community Team model and are currently piloting and testing a new approach to case management and care coordination for patients who are frail and have complex needs.

4.11 The Clinical Director of this PCN is Dr Rishi Chopra, a GP at the Paddington Health Centre. The Chair of this PCN is Siobhan Brown who is the Practice Manager of the Westbourne Green Surgery.

South Westminster PCN

4.12 South Westminster PCN consists of 9 practices in the Pimlico and South Westminster area of Central London. The PCN cares for a patient population of 75,000 patients and includes a generalist population as well as the specialist populations of a university practice, a homeless practices and a school practice. This PCN is also expected to provide care for the patients of the Royal Mews practice – which looks after the staff within Buckingham Palace – which has chosen not to be a member of a PCN. This is due to the fact that it is not financially viable for the practice to take part in the Network DES. While nationally, a practice participation payment is made to practices to support their inclusion in primary care networks this is set on a per patient level, with £1.76 per weighted patient per year paid to take part. This practice has a very small list size and would receive around £500 per year to take part in the DES. Royal Mews and South Westminster PCN are committed to working together to ensure equity of access for the patients of Royal Mews to the Network DES services.

4.13 South Westminster PCN is our largest network as well as our longest established network. The PCN is considering how it might split its delivery of services into two operational units. This would most likely include delivering services to its general population through one model and delivering services to its specialist populations through a different model. This is a mature approach to managing its size whilst still ensuring services are tailored to the unique needs of the specialist populations.

4.14 The Clinical Director of this PCN is Dr Jan Maneira, a GP at the Millbank Medical Centre. The Chair of this PCN is Dr Sheila Neogi, a GP at the Pimlico at the Marven Medical Centre.

West End and Marylebone PCN

4.15 The West End and Marylebone PCN consists of 9 practices in the West End and Marylebone area of Central London. This includes the Soho Square General Practice, which is currently being managed by Living Care, and is subject to a procurement to identify a new longer term provider.

4.16 The PCN cares for a patient population of 44,000 patients. The PCN includes one specialist homeless practice.

4.17 The Clinical Director of this PCN is Dr Andy Goodstone, a GP at the Marylebone Health Centre. The Chair of this PCN is Miles Davis, the Practice Manager at the Great Chapel Street Surgery.

Next steps

4.18 PCNs are focussing on assessing their current maturity as networks and then putting together their development plans. These plans will set out how they will use both the national and local funding available to the PCNs to improve their ways of working and to develop improved services for the patients they serve.

4.19 Attached at *Appendix C* is a short set of slides on PCN maturity.

4.20 The PCNs are also in the process of defining their workforce models for both clinical pharmacy and social prescribing which are the two new roles due to introduced to, or expanding within, primary care in 2019-20

4.21 From October 2019 onwards, the PCNs will begin to develop their plans for mobilising the services due to be commissioning via the national DES contract form 2020-21 onwards. See *Appendix A* for detail

4.22 As set out clearly in the NHS Long Term Plan, Primary Care Networks are the fundamental building block of Integrated Care Partnerships. The expectation is that Out of Hospital community services will increasingly organise their teams around the patient population of each PCN, to make it easier for services to integrate the care they provide across these discrete geographies. At the same time, PCNs will become more mature at analysing the needs of their population, using population health analytical techniques, and designing new approaches to delivering care.

4.23 Over the longer term, as the Integrated Care Partnerships develop, we expect to see services remodelled to meet the needs of the discrete population they serve and that the boundary between “primary” care and “community” care begins to dissolve – for example through the integration of practice nursing and district nursing – reducing fragmentation for patients, and hand-offs between professionals responsible for delivering care.

5. Legal Implications

5.1 None at this stage

6. Financial Implications

6.1 None at this stage

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

A: Diagram showing services to be delivered under the Network Contract Directed Enhanced Service (DES)

B: Map showing Central London Clinical Commissioning Group Primary Care Networks membership and geography

C: Slides on Primary Care Network Maturity

BACKGROUND PAPERS:

Long Term Plan - nhttps://www.longtermplan.nhs.uk/

Investment and Evolution: a five year framework for GP Contract Reform - https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

National Primary Care Commissioning Requirements

NHS
Central London
Clinical Commissioning Group

"Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, includes seven new specifications to be rolled out within the Network DES

1. Structured Medications Review and Optimisation	In full from 2020/21	Inappropriate use of antibiotics	Low priority prescribing	Structured Medication Reviews	Asthma/COP; STOMP; Frailty; Care Home; Complex needs	
2. Enhanced Health in Care Homes	In full from 2020/21	Consistent MDT, including comprehensive weekly visit.	Regular Pharmacist Review	Advice and support Out of Hours	Care Planning, including end of life	Wider wellbeing – oral, hydration and nourishment
3. Anticipatory Care	Ramp up from 2020/21	Targeted support to those with greatest risk and need	Physical and Mental Health	Longer GP consultation and wider MDT	Fully integrated primary and community team	
4. Personalised Care	Ramp up from 2020/21	Shared decision making and patient choice	Personalised care and support planning	Social-prescribing	Supported self-management	Personal budgets
5. Supporting Early Cancer Diagnosis	Ramp-up from 2020/21	Earlier diagnosis at stage 1 and 2	High and timely uptake of screening	Case finding within particular local groups	Supporting all network GPs to use latest evidence	New QOF module
6. CVD Prevention and Diagnosis	Start in 2021/22	High Blood Pressure, raised cholesterol and Atrial Fib	New CVD prevention audit with QI module	Testbed – to promote diagnosis	Testbed to manage patients with suboptimal treatment	
7. Tackling Neighbourhood Inequalities	Start in 2021/22	Testbed in PCNs with high-level of inequalities	Little detail understood – likely to be best practice based			

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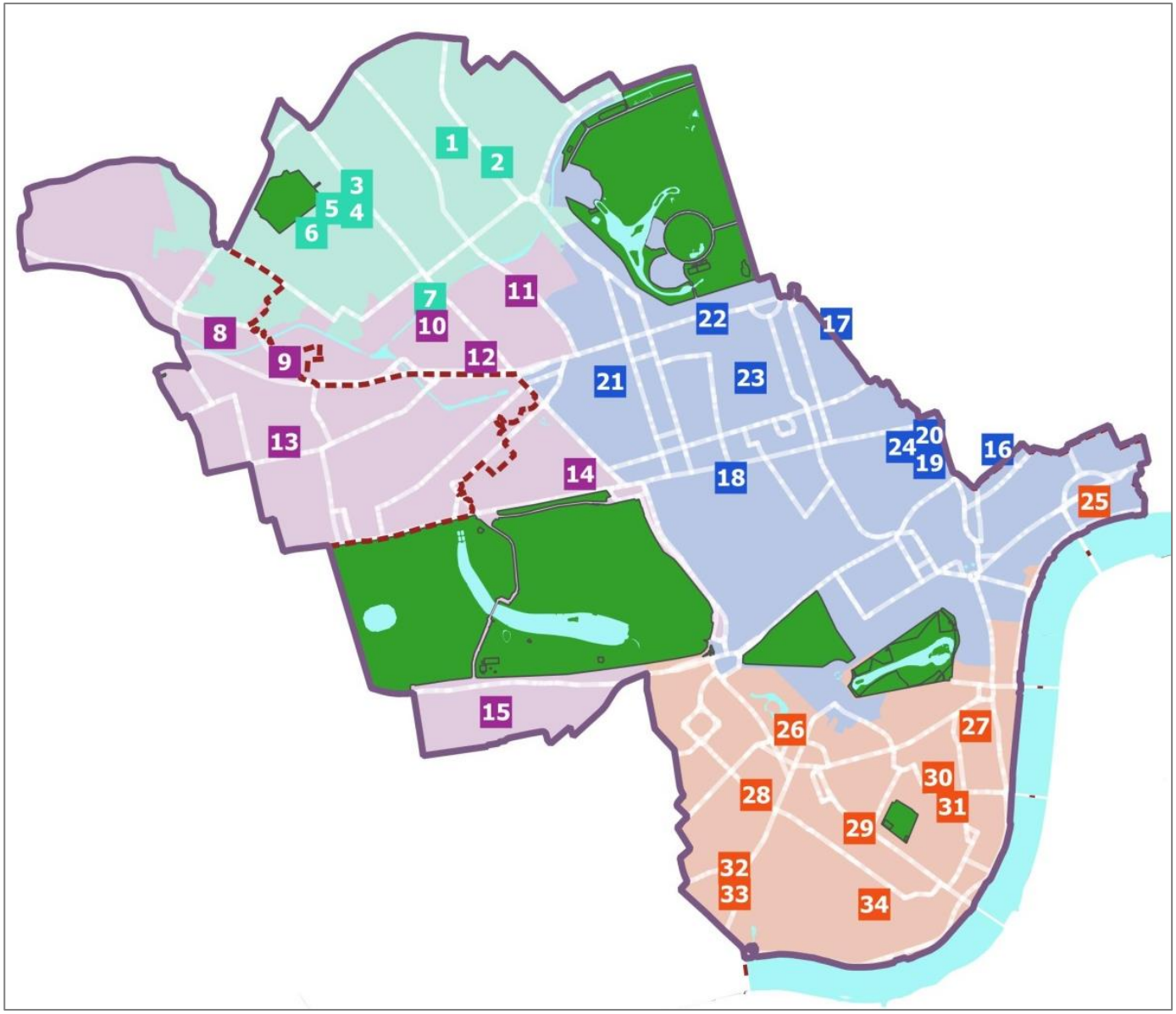
Central London CCG – GP Practices and Primary Care Network (PCN) areas

NHS Central London Clinical Commissioning Group

St John's Wood and Maida Vale		
E87609	St John's Wood Medical Practice	1
E87754	Wellington Health Centre	2
E87663	Third Floor Medical Centre	3
E87756	Lanark Medical Centre	4
E87046	The Randolph Surgery	5
E87010	Maida Vale Medical Centre	6
E87006	Little Venice Medical Centre	7
Regents Canal and Paddington		
E87741	Woodfield Road Surgery	8
Y00902	The Westbourne Green Surgery	9
E87052	Crompton Medical Centre	10
E87011	Lisson Grove Health Centre	11
E87008	Paddington Green Health Centre	12
E87681	The Newton Medical Centre	13
E87037	The Connaught Square Practice	14
E87677	Imperial College Health Centre	15
West End and Marylebone		
E87045	Covent Garden Medical Centre	16
E87066	Fitzrovia Medical Centre	17
E87648	The Mayfair Medical Centre	18
E87069	Soho Square Surgery	19
E87714	Soho Square General Practice	20
E87070	Crawford Street Surgery	21
E87737	Marylebone Health Centre	22
E87745	Cavendish Health Centre	23
E87772	Great Chapel Street	24
South Westminster PCH		
E87768	Kings College Health Centre	25
E87694	Royal Mews	26
E87691	Westminster School	27
E87005	Belgravia Surgery	28
E87002	Victoria Medical Centre	29
E87740	Dr Hickey's	30
E87739	Millbank Medical Centre	31
E87753	Dr Victoria Muir's Practice	32
Y02260	Dr Shakarchi's Practice	33
E87034	Pimlico Health @ the Marven Surgery	34



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What does a mature PCN look like?

NHS
Central London
Clinical Commissioning Group

Clear measures of success, supported by self-evaluation and critical appraisal

A clearly defined, jointly owned shared vision

Leading the system with other providers to delivery your strategies and plans

Strong relationships and trust – members are open and honest about issues which affect the network.

A business plan which articulates how and when the network will grow.

A cost-effective operating model which delivers the best deal for the network.

Regular communication and a single version of the truth

Sharing cost and profit fairly across the network

A medium term clinical strategy with clearly defined care outcomes

What are the steps to maturity

NHS Central London Clinical Commissioning Group

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right Scale		**Practices identify PCN partners** and develop shared plan for realisation	PCNs have **defined future business model** and have early components in place.	**PCN business model** fully operational.
Integrated Working	**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level.	**Analysis on variation** in outcomes and resource use between practices is readily available and acted upon.	Functioning **interoperability within networks**, including read/write access to records, sharing of some staff and estate.	**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.
Targeting Care	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Basic population segmentation** is in place, with understanding of the needs of key groups and their resource use.	All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for proactive interventions, IT enabled access to shared protocols, and real-time information on patient interactions with the system.	**Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well.
Managing Resources	**Time:** Primary care, in particularly general practice, has the headroom to make change	**Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of the system.	Early elements of **new models of care** in place for most population segments, with integrated teams throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review.	**New models of care** in place for all population segments, across system. Evaluation of impact of early implementers used to guide roll-out.
Empowered Primary Care	**Transformation resource:** there are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation	Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.	**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.	PCNs **take collective responsibility for available funding**. Data being used in clinical interactions to make best use of resources.
		Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices	Primary care plays an **active role in system tactical and operational decision-making**, for example on UEC.	**Primary care providers** full decision-making member of ICS leadership, working in tandem with other partners to allocate resources and delivery care.
		Primary care has **a seat at the table** for system strategic decision-making		

Where are we now and where do we need to get to?

NHS Central London Clinical Commissioning Group

	Foundations for transformation 2016-17 - COMPLETED	*Step 1: Underway*	*Step 2: 2019-20*	*2020=2021*
Right Scale	**Plan:** Co-design with local GPs and wider primary care staff, the GP Federation and local providers of the Central London Primary Care Strategy with a clear three stage process to transform the local primary care system – Completed April 2017 **Engagement**: Vision and plan testing with all local practices via "big conversation" events and 1-2-1 partner meetings. Board to Board meetings with the local GP Federation to finalise plan. **Time:** Delivery of 10 HIAs to free up time within general practice to lead the transformation required. Practices support to take part in Productive General Practice Quickstart Programme to develop further headroom. **Transformation Resource**: Restructure of CCGs Primary Care Team to ensure appropriate skills in place to develop primary care-at-scale. Skills placed into early implementer networks. Recruitment of Integrated Care Programme resources to work across local providers to develop integrated care strategy. Investment in external resources to develop delivery plans and support local GP leadership development	**Practices identify PCN partners:** Four Primary Care Networks developed. All local primary care contracts reviewed and integrated into Partnership in Practice. **Analysis on Variation:** Networks are required to review variation and develop plans to ensure equity of provision and service for 100% of population and reduction in unwarranted variation **Basic Population Segmentation:** Proactive care management service requires population segmentation at network level. PCNs use WSIC to undertake segmentation. **Integrated Care Teams:** PCNs develop plans to integrate primary care services at scale to improve quality and access. ICT Pilot **Models of Care** developed for Children and Young People, Working age adults and Older People develop. PCNs to develop one proof of concept pilot each. **Operational Efficiency:** Additional implementation of HIAs and Productive General Practice Quickstart Programme. PCNs begin to share resources. **Seat at the table:** CDs join Westminster Partnership Board	**Defined future business model**: PCNs define business and operating models **Interoperability within networks:** A joint decision making structure across PCNs supported by MoU, defined joint working priorities with shared delivery plans **Information to guide decision making:** Standardised pathways and referral processes. PCN Dashboard in place. WSIC maximised **New models of care: Roll-out of** Integrated Community team (inc community nursing, social care and VCS). Proof of concept pilots tested by each PCN **Sight of resource use and system performance**: PCN Dashboard PCNs use WSIC to monitor resource use of patients under proactive care and the impact on target population groups. **Active role in system decision-making** PCNs in playing a fully active role in system-level discussions. Some PCN CDs act as Clinical Responsible Officer for integration projects	**PCN Business Model:** PCNs have fully defined business model and revise their network agreements to reflect changes. 5 year business plan in place **Fully interoperable IT, workforce and estates:** PCNs have 5 year clinical strategy supported by cross PCN workforce and estates plans,. Shared cross-system case management IT in place. PCNs move towards single record **Systematic Population Health Analysis:** Rising risk dashboard operational. Population health analysis fully embedded in PCN operating model, Peer review to identify and mainstream best practice across PCNs **New Models of Care:** All MoC rolled out across all PCNs **Collective responsibility for funding**: All PCNs control all non-core primary care funding **Primary Care Providers**: PCN Board in place to support "single primary care voice". PCN seen as provider of choice in local system discussions, and is leading development of the Integrated Care Partnership.
Integrated Working				
Targeting Care				
Managing Resources				
Empowered Primary Care				

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	**10th October 2019**
Classification:	**General Release**
Title:	**Final BCF Submission 2019/2020**
Report of:	**Senel Arkut, Bi-Borough Director of Health Partnerships**
Report Author and Contact Details:	**James Partis – BCF Programme Lead (jpartis@westminster.gov.uk)** **David Matthews – Interim BCF Programme Lead for Central & West London CCGs (david.matthews2@nhs.net)**

1. Executive Summary

1.1 This paper sets out the final BCF submission for 2019/20, for retrospective review and sign-off following its submission to NHSE on 27th September 2019.

2. Key Matters for the Board

2.1 The Board is asked to

- Retrospectively sign-off the BCF Submission for Westminster, and Kensington and Chelsea for 2019/20

3. Background

3.1 CCG and local authority officers have worked closely to draft a plan for 2019/20 with clear schedules of joint services, financial commitments, and monitoring

arrangements. The plan agrees with our BCF NHS allocation and has benefited from scrutiny and advice from the NHS BCF Programme Team. The CCG Managing Directors have also been kept up to date with progress.

3.2 The reduced scope of the plan (down from £140million to £60million) supports a more focussed approach to joint working. It does, however, mean that activities previously within the Plan are now sitting outside the BCF framework will need new or augmented governance arrangements going forward so that they are subject to appropriate scrutiny and monitoring.

3.3 We will be putting in place new arrangements for LD and amended governance arrangements for MH services which represent the bulk of these non-BCF services. Also, following joint work through the summer and autumn of 2018, partners agreed on several contracts previously part of BCF Plans would revert to single agency commissioning and those agencies' own internal business as usual governance arrangements.

Financial Overview

3.4 The total value of the plan in Westminster is £38.7m.

The total value of the plan in RBKC is £21.4m.

2019-20 BCF Budget	WCC	RBKC	Total
DFG	£1,523,990	£845,918	£2,369,908
Minimum CCG Contribution	£20,005,126	£13,150,743	£33,155,869
iBCF	£15,806,905	£6,569,857	£22,376, 762
Winter Pressures Grant	£1,323,159	£866,806	£2,189,965
Total	**£38,659,180**	**£21,433,324**	**£60,092,504**

Joint Plan

3.5 Officers from the Bi Borough and CCGs have agreed on the following joint work as priorities for the current financial year:

i. High-quality care in the community, preventing unnecessary hospital admissions, and ensuring timely discharge

ii. Joint work on Mental Health Supported Accommodation and Homelessness

iii. Advocacy, Carers Services, Advice and Guidance and Prevention

iv. Aligning the Boroughs and CCG Better Care Fund with Wider Strategic Plans

v. Use of the iBCF, Winter Pressures, Disabled Facilities Grant funding as enablers for Better Care Fund Plans

3.6 The CCGs and Local Authorities in the Bi Borough have agreed new working principles for the current year to provide a positive context for joint working. These principles will ensure that the value of the investment made by health and social care partners is monitored and assurance provided, or changes made and that no investment or disinvestment decisions will be made without due notice and assessment of the impact on people who use and rely on services.

Governance of Delivery

3.7 Delivery against the 2019/20 Plan will be reported upon Quarterly at HWBB when the Board or its authorised representative will formally be asked to sign-off the Quarterly BCF returns.

3.8 Alongside the local authorities' and CCG's own internal governance arrangements, joint scrutiny and oversight of delivery against the plan is vested in the Joint Operational Finance Group, which meets monthly.

3.9 A forward plan and reporting cycle have been drawn up to support JFOG in its task of reviewing delivery of the BCF Plan to time, cost and quality and providing it with the means to intervene in a timely fashion should things be assessed as 'off track'.

3.10 Reporting, where possible, has been aligned with the NHS England reporting process, and will cover Financials, Contractual Performance, Procurement, and BCF four National Metrics.

Summary and recommendations:

3.11 The Better Care Fund Plan for 2019 2020 has produced agreement on budgets and broad strategic objectives. Work should begin now on plans for 2020 2021 which will further mitigate risks to the Bi Borough authorities and seek to re build more appropriate and collaborative approaches to health and social care in Westminster and Kensington and Chelsea.

3.12 HWB are asked to note the headline details and approve the current year BCF plan and associated budgets.

Appendix 1
WCC – 2019/20 draft BCF Planning template

Appendix 2
RBKC –2019/20 draft BCF Planning template

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

James Partis, BCF Programme Lead

Email: jpartis@westminster.gov.uk

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Kensington and Chelsea

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£845,918	£845,918	£0
Minimum CCG Contribution	£13,150,743	£13,150,743	£0
iBCF	£6,569,857	£6,569,857	£0
Winter Pressures Grant	£866,806	£866,806	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£21,433,324	£21,433,324	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,726,149
Planned spend	£5,340,796

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£5,556,264
Planned spend	£5,842,982

Scheme Types

Assistive Technologies and Equipment	£1,086,520
Care Act Implementation Related Duties	£883,267
Carers Services	£696,330
Community Based Schemes	£2,279,673
DFG Related Schemes	£845,918
Enablers for Integration	£365,958
HICM for Managing Transfer of Care	£319,690
Home Care or Domiciliary Care	£1,465,464
Housing Related Schemes	£2,901,317
Integrated Care Planning and Navigation	£0
Intermediate Care Services	£6,947,347
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£3,341,840
Prevention / Early Intervention	£0
Residential Placements	£300,000
Other	£0
Total	£21,433,324

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Established
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Mature
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Established
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	252.2374462

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.899390244

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Westminster

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,523,990	£1,523,990	£0
Minimum CCG Contribution	£20,005,126	£20,005,126	£0
iBCF	£15,806,905	£15,806,905	£0
Winter Pressures Grant	£1,323,159	£1,323,159	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£38,659,180	£38,659,180	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,695,808
Planned spend	£8,032,349

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£8,445,632
Planned spend	£8,457,019

Scheme Types

Assistive Technologies and Equipment	£1,947,749
Care Act Implementation Related Duties	£1,633,159
Carers Services	£403,850
Community Based Schemes	£960,425
DFG Related Schemes	£1,523,990
Enablers for Integration	£859,000
HICM for Managing Transfer of Care	£327,947
Home Care or Domiciliary Care	£34,850
Housing Related Schemes	£3,349,912
Integrated Care Planning and Navigation	£0
Intermediate Care Services	£9,796,514
Personalised Budgeting and Commissioning	£728,555
Personalised Care at Home	£4,259,000
Prevention / Early Intervention	£0
Residential Placements	£12,834,229
Other	£0
Total	£38,659,180

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Established
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Mature
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Established
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	314.0951632

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.900568182

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes