MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 29TH JANUARY, 2015

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

Dear Health & Well-Being Board Members,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
7.	CCG- IMPLEMENTATION OF CO-COMMISSIONING	1 - 14
12.	MINUTES OF THE HEALTH AND WELL-BEING FINANCIAL PLANNING GROUP	15 - 34

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AGENDA ITEM 7

	Health and Well-Being Committee **29th January 2015**
Title	**Primary Care Co-Commissioning**
Report of	Maria O'Dwyer Director of Integrated Commissioning Margaret Chirgwin – Primary Care Strategy Programme Lead Barnet CCG
Wards	All
Date added to Forward Plan	December 2014
Status	Public
Enclosures	Appendix 1: NHS Letter from NHSE to Local Authority CEOs and HWBB Chairs -Update on Primary Care Co-Commissioning 18th Dec Appendix 2: London Councils to London Borough Leaders Health and Social Care Portfolio Holders and HWBB Chairs
Officer Contact Details	Maria O'Dwyer maria.odwyer@barnetccg.nhs.uk Margaret Chirgwin Margaret.chirgwin@barnetccg.nhs.uk

Summary

In late September an NSH England (NHSE) document released provided further information on Co-Commissioning, additional guidance was issued on 14th of November. Clinical Commissioning Groups (CCGs) are requested to put forward proposals by end of January 2015 for Joint Commissioning and earlier if Delegated Commissioning was the preferred option. Following internal and public discussion Barnet CCG Governing body in the December 2014 Committee meeting agreed to support in principle the proposal to join with other North Central London (NCL) CCGs and put in a **Joint Commissioning** proposal. The Guidance requires the CCG to review and confirm membership support including support for the necessary changes to the **CCG constitution** and a commitment to proceed towards joint commissioning arrangements and the setting up of a joint committee. From Jan –Feb 2015 the CCG will be committed to engage across NCL to engage with practices, HWBBs Healthwatch and Patients.

The proposed plan is that a Joint Committee would come into existence in shadow form in April 2015 and run in shadow until 1st October 2015 initially as Level 1 "greater involvement"

arrangements. From October it will start to operate formally as a Joint Committee under level 2 joint arrangements. This provides more time for constitutional changes to be put in place by March 2015. The terms of reference and membership of this Committee is currently under discussion.

This paper seeks the support and engagement of Barnet HWBB on it's in principle decision to develop a proposal to take Joint Co-Commissioning forward at the end of Jan 2015. The Board is requested to discuss how the HWBB will participate in a Joint Committee across NCL .The Board is also requested to consider the role of Public Health in this discussion, and feedback any views/considerations to the NCL lead for Primary Care (Chief Officer for Islington).

Recommendation

1. **The Health and Wellbeing Board is requested to note and support Barnet CCG's decision to develop a proposal to jointly co-commission with the other 4 NCL CCGs**
2. **Consider and discuss how the Health and Wellbeing Board will participate in Joint Co-Commissioning Committee across NCL**
3. **Consider the role of Public Health in Joint Co- Commissioning and feed any views /considerations into to NCL ongoing discussions**

1. WHY THIS REPORT IS NEEDED

1.1 Health and Social Care Act 2012 introduced substantial changes to the way the NHS in England is organised, in particular it created CCGs. It defined the responsibilities which did not include responsibility for the primary care contracts (GP, Pharmacists, Opticians and Dentists) which were previously managed by the PCT. However, on 1st October 2014 changes were made to the Act to allow CCGs to take on joint responsibility with NHS England (NHSE) for these contracts thus moving us back towards most of the responsibilities that the PCT held.

1.2 Initially Co-Commissioning is about the contracts NHSE holds with General Practice but in later years is likely to include the contracts with Opticians, Pharmacists and Dentists. So Barnet CCG, with our NCL CCG partners, are considering taking on joint responsibility with NHSE for:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

1.3 It will not include individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).

1.4 **The Options**

Model Zero: Do not get involved at all. However we do not think that this is really an option.

Or one of three options:

1.5 In June 2014 the 5 North Central London (NCL) CCGs put in a proposal to Jointly Commission with NHSE.

1.6 Following a discussion at the Committee and amongst the other NCL CCGs we believe that the best option for the CCG is to join again with the other NCL CCGs and put in a **Joint Commissioning** proposal.

Summary of Co-commissioning functions under each option

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

1.7 **Key Issues for Practices as Providers**

1.7.1 In many ways very little should change from a practice or patient point of view – the same NHSE staff as at present will do the daily management of contract.

1.7.2 However, there should be an improvement of the management of enhanced schemes with more local clinical involvement in their development and implementation. The CCG will be integral to decision making about things such as establishing new GP practices and the approval of Practice building developments, thus ensuring a sustainable General Practice provision for our population. These decisions will be taken across all five NCL CCGs in partnership with NHS England.

1.8 **Key Issues for the CCG and Practices as Members of the CCG**

1.8.1 Whatever option Barnet CCG takes on there are unlikely to be any new resources allocated to the CCG to do the work of managing the contracts and supporting practices with issues related to their primary care contracts – sharing the support work across the 5 CCGs will be more efficient and therefore we believe this is a better option than if we did any form of Co-Commissioning alone.

1.8.2 As CCG Governing Body is made up of mainly GPs the change in commissioning arrangements may give rise to further questions in relation to conflict of interest, however Barnet CCG are cognisant of this conflict and have processes in place to monitor such issues currently. Managing conflict of interest issues across the 5 CCGs will lend itself to reduce actual and perceived conflicts. There is further NHSE Guidance on how to manage this in the background papers.

1.9 **Constitutional Changes**

1.9.1 Changes to the CCG's constitution will be required and in order for the CCG to proceed with Co-Commissioning we will need agreement from GPs – the first change will be to add a few paragraphs to take on joint responsibility for the agreed areas (the first box above) and create the necessary Joint Commissioning Committee with NHSE and the other four CCGs. The second required change is to add the Terms of Reference for this committee as an annex to the constitution. Annex C and D (see background papers) give suggested wording. The CCGs as above will work on these to agree the final wording taking all CCGs views into account.

2. REASONS FOR RECOMMENDATIONS

2.1 Option 2 is being recommended because this is the one that the 5 NCL CCGs are all willing to sign up to at this time. It was felt that there was not enough information in November/December 2014 on Option 3 which is ultimately where the NCL CCGs would like to be but only when there is clear understanding of the risks involved and how these may be managed effectively.

2.2 The NCL CCGs are seeking to only have a Joint Co-Commissioning Committee in Shadow from April 1st 2015 to give enough time to develop full

membership and other stakeholder support for co-commissioning and to move to full joint commissioning and then to full delegated co-commissioning at a pace that ensures risks are minimised and benefits to the population maximised. There is an expectation that HWBB will participate in Joint Co-Commissioning (please see documents from NHS England and London Councils for further information).

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 **Model 0 – not in the NHSE proposal but CCG could decide to focus on our statutory responsibility to improve the quality of primary care and leave NHSE to be responsible for the GMS/PMS/APMS contracts.** Still work to coordinate with other primary care commissioners (PH England, Borough PH, NHSE) but no responsibility beyond improving quality.

3.1.1 This option was not believed to be a possibility and as the present situation has not been working well in particular with lack of information sharing and coordination of effort.

3.2 Co-commissioning as a single CCG or with a different combination of CCGs was considered but dismissed because so much work was undertaken last year to develop a joint proposal and it is unlikely to deliver efficiencies in the system.

3.3 **Model 1 – Greater Involvement – to be locally agreed with the Area Team**

3.3.1 This option was believed to be likely to entail increased level of work for the CCG without the gains of formal involvement in decision making.

3.4 **Model 3 - Delegated Arrangements – proposal due by 9th January**

3.4.1 This option was felt to be one the CCG would want but the lack of sufficient detail and the need for a fully developed proposal by 9th January made this option not feasible at this time in light of understanding impact and risk within the time frame.

4. POST DECISION IMPLEMENTATION

4.1 There is significant work currently underway at the moment to agree across the NCL CCGs the structure and functions of the Joint Co-commissioning Committee and the changes that will be needed to all 5 CCG Constitutions. As soon as the proposed Constitutional changes are available, The CCG will engage with each Member Practice and request that they confirm that they are happy for these changes to be made. We will need a 75% supporting vote to do this but are recommending that this is the only viable option available to the CCG. To date current engagement is supportive.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 This supports the CCG's Primary Care Strategy and the CCGs statutory requirement to ensure the ongoing development of the quality of primary care services provided to the population of Barnet.

5.1.2 This supports all 4 the Health and Well Being Strategy themes because General Practice and primary care more broadly has a role to play in each theme with a particular theme on theme 1 and 4:

1. Preparation for a healthy life – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
2. Wellbeing in the community – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
3. How we live – that is enabling and encouraging healthier lifestyles; and
4. Care when needed – that is providing appropriate care and support to facilitate good outcomes and improve the patient experience.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 This has financial implications for within the NHS (between the CCGs and NHSE) but should have no negative impact on service provision. It is hoped that there will be synergies that mean that more resources will become available for service provision to the Barnet population.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Social Care Act 2012 established health and well-being boards as forums where key leaders from the health and care system work together to improve the health and well-being of local communities. The Health and Well-being Board plays a key role in the local commissioning of health care, social care and public health through developing and overseeing a Joint Strategic Needs Assessment (JSNA) and Health and Well-being Strategy

5.3.2 The terms of reference of the Health and Wellbeing Board , as set out in part 15 of the Constitution, Annex A ; include the tasks of jointly assessing the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies. A further role includes considering all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration. A further duty is to promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

5.3.3 The Recommendations therefore, as set out in this report appear to be in accordance with applicable law and guidance, and what is set out in this report appear to be appropriate recommendations for the HWBB to consider.

5.4 **Risk Management**

5.4.1 The risks of Co-Commissioning are complex in particular around perceptions of and actual conflicts of interest. Managing conflicts of interest: statutory guidance for CCGs was released 18th December 2014 and is attached. Co-commissioning across the 5 NCL CCGs will help to reduce these potential conflict issues. The Guidance will also inform the proposed makeup and functions of the Joint Co-Commissioning Committee.

5.4.2 There is an additional risk in the failure to engage appropriately with member practices to change the constitution

5.5 **Equalities and Diversity**

5.5.1 There is no impact on Equality and Diversity issues.

5.6 **Consultation and Engagement**

5.6.1 There will be a process of engagement with member practices to seek the appropriate support to amend and make the necessary changes to the CCG constitution.

6. BACKGROUND PAPERS

6.1 Proposed next steps towards primary care co-commissioning: an overview Dr Amanda Doyle, Ian Dodge, Ivan Ellul and Julia Simon September 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf

6.2 Next steps towards primary care co-commissioning: Annex C: Model wording for amendments to Clinical Commissioning Groups' constitutions 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-c-mod-wrd-amends.pdf

6.3 Next steps towards primary care co-commissioning: Annex D: Model terms of reference for joint commissioning arrangements including scheme of delegation 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-d-mod-tor-jnt-comms.pdf

6.4 Managing conflicts of interest: statutory guidance for CCGs: NHSE Commissioning Strategy Directorate. First published: March 2013. Update released 18th December 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

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Gateway reference: 02776

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18 December 2014

To Local Authority CEOs and Health and Wellbeing Board Chairs
cc. CCG Clinical Leads

RE: Update on primary care co-commissioning

A. Background and context

NHS England recently invited clinical commissioning groups (CCGs) to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

On 10 November 2014, we published Next steps towards primary care co-commissioning. This document sets out three possible models for primary care co-commissioning (greater involvement, joint commissioning and delegated commissioning) and the next steps towards implementation. The approach has been developed by the joint CCG and NHS England primary care co-commissioning programme oversight group, which includes two local authority representatives: Ged Curran (Chief Executive, Merton Council) and Merran McRae (Chief Executive, Calderdale Council). The group is co-chaired by Dr Amanda Doyle, Co-chair of NHS Clinical Commissioners and Chief Clinical Officer of NHS Blackpool CCG, and Ian Dodge, National Director: Commissioning Strategy, NHS England.

We want to encourage Health and Wellbeing Boards to have a conversation with their local commissioners of primary care, both CCGs and NHS England - and we have made the same recommendation to NHS commissioners. The

effectiveness of co-commissioning arrangements will be reliant upon the development of strong local relationships and effective approaches to collaborative working.

In this context, CCGs have an obligation to consult with each relevant Health and Wellbeing Board in preparing or revising their commissioning plan, as set out in annex A.

B. Invitation to participate in joint and delegated commissioning committees

In both joint and delegated commissioning arrangements, CCGs must issue a standing invitation to the local Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

Where there is more than one local Health and Wellbeing Board for a CCG's area, the CCG should agree with them which should be invited to attend the committee.

Health and Wellbeing Boards are under no obligation to nominate a representative, but we believe there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

If you have any queries or would like to find out more about the primary care co-commissioning programme, please email: england.co-commissioning@nhs.net

With best wishes,

Ian Dodge
National Director: Commissioning Strategy
NHS England

Dr Amanda Doyle
Chief Clinical Officer
NHS Blackpool CCG

Annex A: CCG statutory requirements in relation to CCG commissioning plans and Health and Wellbeing Boards

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012):

- CCGs must give each relevant Health and Wellbeing Board a draft of the plan and consult each such Board on whether the draft takes proper account of each joint health and wellbeing strategy published by it, which relates to the period that the plan relates to (section 14Z13(4)).

- Where a Health and Wellbeing Board is consulted, it must give the CCG its opinion on whether the plan takes proper account of each relevant joint health and wellbeing strategy.

- CCGs must include a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the commissioning plan in the final plan as published (section 14Z13(8)).

- Where a significant revision is made to an existing commissioning plan, CCGs must consult with the Health and Wellbeing Board as per section 14Z13, before finalising the revised plan (section 14Z12). They must also give a copy of the document to each relevant Health and Wellbeing Board.

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From: Cllr Teresa O'Neill

To: London Borough Leaders, Health and Social Care Portfolio Holders and Health & Wellbeing Board Chairs

12th December 2014

Dear colleagues,

Primary Care Co-Commissioning

Discussions at recent London Councils Leaders' Committee and Executive meetings have confirmed that we all recognise the need for local government to find ways of gaining real influence and leadership in health and care transformation. As part of this, NHS England's move to co-commissioning of primary care with Clinical Commissioning Groups (CCGs) is a key opportunity. However, the timescales to influence the arrangements being developed for 2015/16 are tight. So I wanted to flag briefly the latest information and opportunities.

NHS England invited CCGs to express interest in co-commissioning primary care in the summer. Most London CCGs did so, some individually but generally in groups. It appears that in most cases there was very little, if any, discussion about this with local authority partners or Health & Wellbeing Boards.

Mayor Jules Pipe, as Chair of London Councils, wrote to Simon Stevens in September, highlighting local government's interests in primary care and boroughs' strong desire to be partners in new local co-commissioning arrangements. No response has yet been received, but we understand that the letter fed into the shaping up the next stage of the process.

NHS England published guidance to CCGs for the next stage of primary care co-commissioning on 11th November. CCGs have until 9th January 2015 to submit proposals if they want primary care commissioning to be wholly devolved to them or until 30th January if they want to develop joint commissioning arrangements with NHS England. These will then be subjected to a regional moderation and national sign-off by NHS England, so that new arrangements can be implemented from 1st April 2015.

I understand that CCGs' engagement with boroughs or Health & Wellbeing Boards on their developing plans remains very varied, and in too many cases non-existent. For any boroughs struggling to get leverage in these discussions, I wanted to highlight some of the key points from the guidance or other discussions that may be of use, both in this short window when CCGs are determining their arrangements and as these start to operate in practice:

- Specific committees will have to be established to undertake primary care commissioning. The guidance is explicit that a local authority representative from the local Health & Wellbeing Board and a local Healthwatch representative will have a right to join these committees as non-voting attendees.

- Addressing conflicts of interests is a significant issue for CCGs. NHS England will issue specific guidance on this before Christmas. However, the existing guidance is clear that the committees must have a lay and executive majority and a lay chair.

There is, therefore, the potential to explore with CCGs whether boroughs could provide some of this lay membership and/or how membership might overlap with that of the Health & Wellbeing Board.

- One of the main drivers for many London CCGs pursuing sub-regional arrangements for co-commissioning primary care is to share a limited commissioning support resource. Boroughs who feel strongly that primary care commissioning would be better led at local level might want to explore with their CCG the potential for securing sufficient resource by better integrating commissioning functions with local authorities.

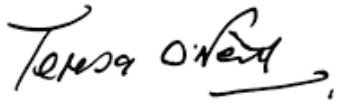
- CCGs are required to include their Health & Wellbeing Board in the preparation of commissioning plans, publish the opinion of the Board with these plans once agreed and Boards can refer plans to NHS England if they do not think they have had appropriate regard to the Joint Health & Wellbeing Strategy. There is no reason or suggestion that these requirements would not apply to any primary care co-commissioning plans.

- Health & Wellbeing Boards have the power to request any information necessary for the performance of their functions from any bodies represented on the Board.

London Councils officers are liaising with borough officers to get a picture of how engagement in primary care co-commissioning is playing out, not least to identify any issues that might need to be raised with NHS England at a London level. They will also explore with NHS England how the clear expectation in the guidance that CCGs will engage local authorities, Health & Wellbeing Boards and local communities in primary care decision making, is taken into consideration in the regional assurance process they undertake.

One other related issue to flag is the Strategic Commissioning Framework for Primary Care Commissioning. This is a proposed specification for primary care in London – ie defining what good should look like - to which all areas should be working, including through co-commissioning. NHS England and CCGs are supposed to be engaging widely on this between now and March. If this not happening in a meaningful way in your area, this should be raised with the CCG directly or London Councils officers who can facilitate the right links.

Best wishes,



Cllr Teresa O'Neill
Leader, London Borough of Bexley
London Councils Portfolio Holder for Health

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AGENDA ITEM 12

	Health and Well-Being Board **29th January 2015**
Title	**Minutes of the Financial Planning Sub-Group**
Report of	Strategic Director for Commissioning
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1- Minutes of the Financial Planning Group – 6th November 2014
Officer Contact Details	Jeffrey Lake jeff.lake@harrow.gov.uk 0208 3593974 Zoë Garbett zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report is a standing item which presents the minutes of the Financial Planning Sub-group and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan.

Recommendations

1. **That the Health and Well-Being Board notes the minutes of the Financial Planning Sub-Groups of 5th November 2014 and 14th January 2015.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health and Well-Being Board on the 26th May 2011 agreed to establish a Financial Planning sub-group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial

planning sub-group meets bi-monthly and is required to report back to the Health and Well-Being Board.

1.2 The Barnet Health and Well-Being Board on the 13th November 2014 agreed to receive the minutes of the Health and Social Care Integration Board as a standard item on the agenda to ensure that adequate attention is given at Board level to the work that providers are doing to support delivery of Barnet's integrated care proposals

1.3 Minutes of the meeting of the Financial Planning sub-group held on the 5th November 2014 are presented in appendix 1 and minutes of the meeting held on the 14th January 2015 are presented in appendix 2.

1.4 In 2014/15, the section 256 allocation for Barnet Council is £5,428,324 to deliver both the main social care services which also have a health benefit, and £1,206,000 for Better Care Fund preparations. The Health and Well-Being Board Financial Planning Sub-Group utilise its delegated powers to approve spend against these budgets during 2014/15, which will support delivery of the vision for integrated care that has been developed for Barnet.

1.5 These budgets will be used to support the delivery of existing initiatives and the development and delivery of new initiatives as well as ensuring appropriate protection for social care services.

1.6 The Board is asked to note that the agenda for the 5th November 2014 meeting focused on a number of areas of integrated commissioning including the five tier model and Better Care Fund plans as well as SEND reforms. A number of decisions were taken at the meeting that the Board should be aware of:

- The group discussed the closure of a branch surgery in East Finchley with issues arising around consultation and impact on patients (such as travel time). The group discussed mitigations to negative impacts such as increasing opening hours at the Muswell Hill surgery, the availability of home visits and transport options. The CCG agreed to meet with and support the practice as well as informing NHS England of discussions and liaising with Healthwatch.
- SEND reform joint operational structure and plan is being developed and would be bought to the group in January 2015.
- Barnet has allocated a Better Care Fund (BCF) advisor who will provide support in resubmitting plans in January 2015 to NHS England. The section 75 agreement for the BCF is delayed due to the current status of the BCF plans being rated as approved with conditions.
- With regards to the 5 Tier Integrated Model the Financial Planning Group will be periodically review the size of the pooled budget to agree any increases to the pool over and above the BCF minimum pooled budget in line with the Frail Elderly Business Case.
- The group agreed the Section 256 template could be submitted to NHS England to ensure draw down of the funds from NHS England to the London Borough of Barnet

1.7 The Board is asked to note that the agenda for the 14th January 2015 meeting focused on the Children and Families Act, CCG co-commissioning, CCG recovery plans and mental health commissioning. A number of decisions were taken at the meeting that the Board should be aware of:

- With regards to the implementation of the closure of East Finchley branch surgery; changes will be implemented from 31st March 2015, doctors will see patients in their homes, other surgeries are able to take on patients and increase opening hours.
- The impact of the Children and Families Act is being considered by the CCG and the full impact is not known yet. A section 75 agreement is being looked at. The group will receive a further update in March.
- CCG are looking at joint commissioning agreements with NHS England with regards to Primary Care Commissioning. Co-commissioning will be in shadow form from April – October 2015 and will be undertaken on a five borough North Central London footprint. The group highlighted there is a need to consider Public Health and engagement. Primary Care priorities will need to be linked with the Health and Well-Being Strategy and a separate report should go forward to the HWBB.
- With regards to the CCG recovery plan, the Local Authority needs to be fully engaged in the development of the CCG delivery plans.
- A consultation is being organised by the CCG around mental health commissioning. Plans will focus on treatment in the community and preventing acute admissions.
- Health and Social Care Integration Board is being reformed and will start to meet regularly.
- The arrangements for the pooled budget for the BCF are being worked on. A separate report will go forward to the HWBB on proposed principles for consideration in January 2015.

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Well-Being Board established the Health and Well-Being Financial Planning Sub-Group to support it to deliver on its Terms of Reference; namely that the Health and Well-Being Board is required:

To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

2.2 Through review of the minutes of the Health and Well-Being Financial Planning Sub-Group, the Health and Well-Being Board can assure itself that the work taking place to ensure that resources are used to best meet the health and social care needs of the population of Barnet is fair, transparent, stretching and timely.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided the Health and Well-Being Board is satisfied by the progress being made by the Financial Planning Sub-Group to take forward its programme of work, the sub-group will progress its work as scheduled in the areas of the Better Care Fund, mental health re-commissioning and implementation of the SEND reforms.

4.2 The Health and Well-Being Board is able to propose future agenda items of forthcoming sub-group meetings that it would like to see prioritised if it is not satisfied with the work that the Sub-Group is taking forward on its behalf.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Integrating care to achieve better outcomes for vulnerable population groups, including older people, those with mental health issues, and children and young people with special needs and disabilities, is a key ambition of Barnet's Health and Well-Being Strategy.

5.1.2 Integrating health and social care offers opportunities to deliver the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and the CCG's Quality, Innovation, Productivity and Prevention Plan (QIPP) and Financial Recovery Plan.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The Health and Wellbeing Financial Planning Sub-Group acts as the senior joint commissioning group for integrated health and social care in Barnet. it has the following functions that relate to the management of local resources:

a) *To oversee the development and implementation of plans for an improved and integrated health and social care system for children, adults with disabilities, frail elderly, those with long term conditions, and people experiencing mental health problems.*
b) *To govern the implementation and delivery of the Better Care Fund including the implementation of the 5 tier model for frail elderly, holding the Joint Commissioning Unit and partners to account for its delivery.*
c) *To approve the work programme of the Joint Commissioning Unit.*
d) *To agree any business cases arising from the Joint Commissioning Unit including in relation to the integrated care model*
e) *To recommend to the Health and Well-Being Board, Council Committees and the CCG Board how budgets should be spent to further integration*

between health and social care.

f) To ensure appropriate governance and management of additional budgets delegated to the Health and Well-Being Board.

5.2.2 Projects and enablement schemes linked to Section 256 funding are reviewed by the Financial Planning sub-group to ensure that the projects have a clear programme of work and that approved business cases are adequately resourced to deliver the agreed outcomes.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Well-Being Board has the following responsibility within its Terms of Reference:

To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet.

5.3.2 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended). This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

5.3.3 Under the Health and Social Care Act 2012, a new s2B is inserted into the National Health Service Act 2006 introducing a duty that each Local Authority must take such steps as it considers appropriate for improving the health of the people in its area. The 2012 Act also amends the Local Government and Public Involvement in Health Act 2007 and requires local authorities in conjunction with their partner CCG to prepare a strategy for meeting the needs of their local population. This strategy must consider the extent to which local needs can be more effectively met by partnering arrangements between CCGs and local authorities, and at 195 of the Health and Social Care Act there is a new duty-- Duty to encourage integrated working:

s195 (1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

s195 (2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose

of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

5.3.4 As yet, there is no express provision in statute or regulations which sets out new integrated health budgets arrangements, and so the s75 power remains.

5.3.5 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

5.4 Risk Management

5.4.1 There is a risk, without aligned financial strategies across health and social care, of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The Financial Planning sub-group has identified this as a key priority risk to mitigate, and the group works to align timescales and leadership of relevant work plans which affect both health and social care.

5.5 Equalities and Diversity

5.5.1 All public sector organisations and their partners are required under s149 of the Equality Act 2010 to have due regard to the need to:

a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

5.5.2 The protected characteristics are:

a) *age;*
b) *disability;*
c) *gender reassignment;*
d) *pregnancy and maternity;*
e) *race;*
f) *religion or belief;*
g) *sex;*
h) *sexual orientation.*

5.5.3 The MTFS has been subject to an equality impact assessment considered by Cabinet, as will the specific plans within the Priorities and Spending Review as these are developed. The QIPP plan has been subject to an equality impact assessment considered by NHS North Central London Board.

5.6 **Consultation and Engagement**

5.6.1 The Financial Planning sub-group will factor in engagement with users and stakeholders to shape its decision-making in support of the Priorities and Spending Review, and Barnet CCG's financial recovery plan.

5.6.2 The Financial Planning sub-group will also seek assurance from group members that there is adequate and timely consultation and engagement planned with providers as the integrated care model is implemented.

6. BACKGROUND PAPERS

6.1 None.

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DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 5th November 2014
North London Business Park
3.00pm – 5.00pm

Present:
(KK) Kate Kennally, Strategic Director for Communities, London Borough of Barnet (LBB)
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(HMG) Hugh McGarel-Groves (Chair), Chief Finance Officer, Barnet CCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(NF) Nicola Francis, Family Services Director, LBB

In attendance:
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB
(RH) Ruth Hodson, Head of Finance, LBB
(MK) Mathew Kendall, Assistant Director- Community and Wellbeing, LBB
(HM) Dr Howard Mulkis, GP Partner, East Finchley GP Practice

Apologies:
(PC) Peter Coles, Interim Chief Operating Officer, Barnet CCG
(JH) John Hooton, Deputy Chief Operating Officer, LBB
(AH) Andrew Harrington, Director of Transformation, Barnet Clinical Commissioning Group (CCG)

	ITEM	ACTION
1.	**Business Proposal for the closure of a branch surgery in East Finchley** Dr Mulkis explained that NHS England had asked the GP practice to gather views from the HWBB about closing one of its branches. The practice has 2 branches, and that the proposal is to close the smaller one at East Finchley. The main surgery in Muswell Hill has more facilities and staff whereas the East Finchley practice has much more limited service provision, leading to difficulties in maintaining the site. The building at East Finchley is also leased rather than owned. Dr Mulkis explained that the practice would be able to provide a better service for patients if all staff/ services were based at one sight. The group asked Dr Mulkis who would take responsibility for informing patients about their options if the closure goes ahead. The group pointed out that older people might not want to travel to the Muswell Hill branch. Dr Mulkis explained that NHS England had asked the practice to write to their patients to explain the plans. There had been 71 responses from patients. He explained that most patients had expressed sadness but understanding about the proposals. Dr Mulkis explained that if patients are housebound and want to remain at the practice, the practice will have to ensure that all patients can stay with the practice and can receive home visits. Dr Mulkis said he was not clear on capacity at other surgeries to take on local patients.	

	The group asked if staffing would remain the same if the proposals went ahead. Dr Mulkis explained that one partner is going to retire next year. The practice is looking to have extra part time help if the proposals go forward. MO'D noted that the practice is part of the north GP practice network in Barnet, and that the business proposals looked to be going in the right direction in terms of ensuring effectiveness in service delivery. **MOD agreed to set up a meeting with the practice to review the plans and identify how the CCG could support them. MO'D also agreed that the CCG should talk to NHSE about any fall out/ difficulties arising from the proposals.** KK asked how GPs would mitigate any adverse impacts of the proposals on practice patients/ what benefits there are for patients of the change. Dr Mulkis explained that they will continue to offer home visits for patients in the whole practice area. He suggested there might be more requests for home visits if the East Finchley surgery closed, but he said that the practice didn't think would be a huge additional burden to support frail elderly residents coming from East Finchley if the practice there closes. Dr Mulkis also explained that NHS England will insist that the practice at Muswell Hill is open 8am-630pm on weekdays if the changes go ahead. The practice is not open for these hours at present. This will be a benefit for patients, and if the proposals went ahead Dr Mulkis said the practice could consider alternative extended opening hour models, which would off-set any negative impacts resulting from longer travel times for some patients. DW suggested that to ensure that patients were better informed about travel support options such as Dial a ride, some of the elderly patients could be linked into the Altogether Better project in East Finchley. MO'D agreed to type up a formal response for NHS England, reflecting the feedback from Financial Planning Group members, and also to alert HealthWatch and Cllr Alison Cornelius (in her role as Chair of Health Overview and Scrutiny) of this discussion, so they know this decision has been considered from a health and wellbeing perspective. HMG suggested the practice might want to produce a script for staff to help explain to patients what the proposals are. He suggested that the practice could share a draft of the script with the communications teams of the CCG/ Council to help tidy up the messaging. MOD agreed to feed back on progress at the next meeting. CM to send a link to the published minutes to the practice.	**MOD** **MOD** **MOD** **CM**
2.	**Minutes of the last meeting** The group noted the draft minutes and noted final changes to these in advance of publication for Health and Well-Being Board.	
3.	**Action Log** The group reviewed the action log and noted the following:	

	Mental health commissioning: Not progressed yet- but MOD/DW aiming to present a paper at January HWBB. Charlotte Benjamin and MOD will develop an action plan, in partnership with DW. This will be bought to the financial planning group in January 2015. **Better Care Fund (BCF):** CCG to confirm if they can contribute to funding the capacity needed to take this work forward in 2014/15 **Adults and Safeguarding Committee Commissioning Plan:** HMG to circulate commissioning intentions letter to each major provider **Redefine the purpose of the Health and Social Care Integration Board:** DW confirmed that proposals were being developed and would be bought back the next Financial Planning Group meeting **HWBB Provider engagement:** the group heard that a letter from Cllr Hart had been sent to the Secretary of State for Health.	**DW/ MOD** **HMG** **HMG** **DW**
4.	**SEND reforms** MOD circulated the paper that went to the CCG Governing Body on 23rd October. MOD fed back that she had not met with Penny Richardson since the last meeting but that Linda Edwards who will be leading this work at the CCG has met with Penny and they are working to produce an action plan by the end of November MOD confirmed that the MOU and joint operational structure/ plan would be ready for the January 2015 meeting KK pointed out to the group that there was a detailed paper going to the November HWBB on how Barnet has met the Commitments of the Disabled Children's Charter. MOD agreed to feed in comments from the CCG to this paper.	**MOD**
7.	**Outcome of the BCF plan assurance process** DW explained that Barnet's plan had been approved subject to conditions. Barnet has been appointed a Better Care Fund advisor, who is very supportive of the current plan and will help the team to include more detail about how to achieve 3.5% savings. DW explained that the advisor wants to ensure wide HWBB Member engagement in the process of revising the current plan. DW and MOD to brief Cllr Hart and Debbie Frost about these intentions The revised plans have to be resubmitted in draft by mid-December (14th), in advance of completion by 9th January 2015. KK suggested that delays to / incomplete delivery of the BCF needed to be put on the financial risk registers for both organisations. She also asked DW and MOD to quantify the time being spent by officers on this process.	**DW/ MOD** **RH/ HMG** **DW/ MOD**

	HMG asked to see the LBB adult and children services risk registers. The group agreed to review risk registers at the next meeting.	**CM to add to agenda**
D W	**5 tier integrated model** DW explained to the group that the current status of Barnet's BCF means that organisations cannot enter into s75 agreements until approved. On this basis, she explained that the team have written a integrated care 'principles document that can be agreed in advance of the plan being approved by NHSE. DW stressed the importance of ensuring that finance colleagues work with Capita colleagues on the technical details of the document. DW explained that guidance on Section 75s and pooled budgets was issued in October, which has been helpful. The team have reviewed the existing overarching s75 and it is pretty much compliant with good practice, but both organisations need to seek legal opinion that the s75 is in fact still fit for purpose. DW explained the staged approach to pooled budgets, and proposed periodic reviews of the size of the pool at this meeting to agree when increases to the pool can be made, and ensure that both the core and influenced budgets in the BCF remain accurate. KK suggested the legal advice was necessary regarding how to treat the existing S75 schedules. KK stressed that this group is the managing body for the pooled budget, and that it needs to create a suitable monitoring regime over the spend, budget and outcomes of the BCF. DW explained the group may need to update the ToR for this group, and will also need to develop a formal process about how to measure benefits. Regarding lead organisational responsibility for the pooled budget, HMG said the CCG will need to check their governance rules about who can lead on budgets on their behalf, and will also need to work out how to manage their block contract spend too. DW called for detailed meetings with finance teams to test out these principles. DW also explained that there is still further work to do on what the BCF is actually funding, and there is a need to improve on placeholder positions in the business case where these exist. KK advised that the draft S75 schedule needs to be ready when Barnet gains full BCF approval (by end January 2015), and that the group needs to be confident that there is money in place to start BCF delivery in April 2015. KK said the finance teams need to look at the administrative burden of managing the BCF, which will require new finance and performance reports. KK suggested	**DW/ MOD** **DW** **HMG** **RH/ HMG** **RH/ HMG**

	this would require dedicated capacity to make this work. KK asked that part of pooled budget meetings with finance colleagues should seek to assure that all of the money is in place to deliver the BCF proposals. DW & MOD agreed to bring back a timetable of activity to the next meeting.	**DW/ MOD**
8.	**2014/14 Section 256 submission** MK introduced the draft completed S256 template. He explained the content of this template has been agreed at this group at previous meetings, and that only the template is different. He explained that the categories in the template are prescribed. He invited comments/ queries from the group and advised group members could email him with these. The group agreed they were happy for the template to be submitted to NHSE but agreed it needed to be signed by DW and HMG.	**All** **DW/ HMG**
10.	**AOB** The group agreed that the other items of business on the agenda had been sufficiently covered in other meetings.	
11.	**Date of the next meeting** **Thursday 14 January 2015 11.00 am to 1.00 pm – Chapman Room, NLBP**	

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DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 14th January 2015
North London Business Park
11.00pm – 1.00pm

Present:
(KK) Kate Kennally, Strategic Director for Commissioning, London Borough of Barnet (LBB)
(DW) Dawn Wakeling, Commissioning Director – Adults and Health, LBB
(HMG) Hugh McGarel-Groves (Chair), Chief Finance Officer, Barnet CCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(NF) Nicola Francis, Family Services Director, LBB

In attendance:
(RH) Ruth Hodson, Head of Finance, LBB
(MK) Mathew Kendall, Assistant Director- Community and Wellbeing, LBB
(JL) Jeffrey Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(PT) Paul Thorogood, Head of Finance, CSG

Apologies:
(RS) Regina Shakespeare, Interim Chief Operating Officer, Barnet CCG
(JH) John Hooton, Deputy Chief Operating Officer, LBB
(AN) Andy Nuckcheddee, Interim Head of Corporate Governance & Quality, Barnet Clinical Commissioning Group (CCG)
(ZG) Zoë Garbett, Policy & Commissioning Advisor, LBB

	ITEM	ACTION
1.	**Welcome / Apologies** DW introduced herself as Chair and welcomed those present.	
2.	**Minutes of the last meeting** MOD didn't feel the Minutes accurately reflected the agreed points of the last meeting surrounding closure of a branch surgery in East Finchley. MOD has followed it up and the key issues are as follows. • Changes will be implemented by 31 March. These will include the redesigning of the appointment system. • Doctors will see patients in their own homes. They will offer a wider range of services e.g. electronic prescription service. • They have consulted the CGG. Other surgeries have agreed to pick up patients • They have agreed to Increase surgery hours. MOD to incorporate points from email report receipt from Primary Care Team	

3.	**Children & Families (C&F) Act Progress Update** MOD confirmed Judy Mace has now started as Head of Joint Children's Commissioning, she has picked up the Children's and Families Act with the team and has started meeting with paediatricians. Judy has already met with Penny Richardson. KK asked whether there is a financial impact on the CCG and if so what is it? MOD confirmed things have progressed since the last meeting. It is not clear yet what the resource impact will be. Although we have had discussions with paediatricians regarding the requirements the impact on financial and people resources is not yet clear. A discussion followed regarding the agreed implementation plan for a task and finishing group. Where were resources coming from as a whole? MOD explained the CCG had a Children's Planning Group Judy has been speaking to Penny Richardson. She is putting processes into place regarding policy and MOU. **Section 75 (s.75)** MOD explained that there had not been sufficient time given to how it would be managed. MOD explained joint papers were back from the local authority and CCG to support actions. – **Target date April**. KK emphasised the need to ensure underpinning structures are in place. She considered s.75 to be the enablers to this decision and stressed the importance of establishing a decision making process. NF explained that it hadn't been a priority – it would pick up once we had the new service manager. MOD – Update due for the next meeting in March.	**MOD/JM**

4.	**Co-Commissioning** MOD explained that the paper shows where we are. She pointed out the importance of a considered approach to how the five CCGs would manage primary care contracts and how we could implement joint commissioning arrangements. MOD pointed out that a key issue would be managing conflict of interest. Terms of reference are being set up and a joint letter is going out to GPs today re planned changes i.e. co-commissioning and changes to the constitution. Co commissioning will be in shadow form from April – October 2015. It will reflect Level 1 engagement and full joint co-commissioning will come into being from October 2015. MOD confirmed that work had stated regarding engagement with patients, LMC and as of today with the HWBB. PT asked whether the changes affected other professionals or primarily GPs. MOD confirmed it was only GPs in the first instance it doesn't include other professionals i.e. dentists etc. as yet. A discussion around Engagement and Public Health followed. JL explained that they were beginning to recognise that capacity with the five CCGS needed to be coordinated. They were developing a conversation at borough level. He has spoken to Matt Powls re primary care . MOD added that David Riddle is working with Alison Blair Chief Officer Islington and this was a conversation that needed to take place. A conversation around the recent NHSE letter followed and the involvement of the HWBB. MOD explained the issue was around planning in advance which is limited and as this is an iterative process. MOD agreed she would have a follow up conversation with Alison Blair who is leading process for NCL. KK explained the HWBB report needed to address issues raised in the letter. It should include HWBB's decisions/roles it set out the HWBB's strategy to reflect the co-commissioning plans. DW said Zoe would help this process when she returned. MOD explained that the decision would be made by NHSE. KK suggested that Primary Care priorities needed to be linked with the HWBB. MOD asked JL if he had a view how we might take this forward inclusive of a view in regard to HWBB and Public Health involvement in co-commissioning. **JL and MOD to have a follow up discussion.**	**MOD** **MOD/JL**
5.	**CCG Recovery Plan** HMG explained that he was not in a position to share the contents of the plan. It had only been sent out to NHSE last week and BCCG would be meeting with them on Friday. Robert Larkman has been reviewing the CCG from a governance point of view and Jonathan Wise has completed a report and BCCG has decided to fully reflect his report in the recovery plan. It was anticipated that BCCG would breakeven in the next 5 years. DW asked what the breakeven figure was.	

	HMG explained that BCCG had an accumulative deficit and the recovery plan had to evidence the repayment of the deficit. BCCG has had an extra allocation which is the main reason it was on target to break even in 5 years. KK asked whether BCCG were in "special measures" HMG confirmed they were not. There were difficulties surrounding Barnet Chase Farm which was why Barnet was put under [special] conditions. KK explained that a recovery plan was different from a delivery plan. How do we work together to shape a delivery plan? It was a case of transactional savings verses transformational savings. We need to prepare business cases to identify planning work. We should start the next financial year with a single view. MOD explained BCCG had been in recovery for some time and were in the transformational stage but there was still work to do. KK asked for clarification as to how the group was being used to achieve alignment of the plans and what processes are going to be in place before the Board. MOD confirmed that Matthew Powls was leading on planning and suggested a meeting could be arranged with KK re delivery plan and how we are taking this forward. **KK and Matthew Powl to meet.**	**KK**
6.	**Mental Health Commissioning Action Plan/TDA** DW confirmed the group were supposed to come back with a plan but there is as yet no timetable for review. MOD explained MHT was committed to working with stakeholders. KK asked whether there would be an increase in mental health investment in Barnet. HMG explained that engagement groups were to be set up. NHSE have said BCGG must reduce their deficit so there may not be the capacity to invest in mental health. DW added that the general impression was that none of the CCGs would be in a position to increase mental health investment. MOD added that the key was to work towards managing more people in the community become it becomes acute. Aim to move it to community rather than Trust.	
7.	**Health & Social Care Integration Board Proposals** There hasn't been a Board meeting since May. The Board intends to formally reform and meet quarterly. DW and MOD to considered if this is regular enough as a lot of the work was being fed though steering groups.. MOD explained that cases regarding VBC were to be tested. Work is ongoing re VBC and pilot integrated team plus developing evaluation.	**DW/ MOD**
8.	**Feedback on closure of East Finchley GP Surgery** Refer to Item 2	

9.	**Organisational Risk Registers** A discussion followed regarding the risk share and the BCF in relation to the £23m figure. The discussion that followed centred around the level of risk and the broader pooled budget. HMG agreed for the purpose of ongoing pooled budget it is a figure we are working with now and we are following the guideline which dictate we must pool for the BCF and have a risk share, although nature of this can be agreed locally. KK understood that there could be a pooled budget with each party bearing its own risk – as per existing s75s.	
10.	**Timetable on BCF Implementation/Risk Sharing** A brief discussion followed about paper being presented to HWBB outlining the key conditions around risk share which require further discussion and timetable.	**ALL**
11.	**AOB**	

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