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	Health and Well-Being Board **29 January 2015**
Title	**Better Care Fund Update**
Report of	Adults and Health Commissioning Director CCG Director of Integrated Commissioning
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1 – Final BCF Plan Part 1 v1.1 (14 Jan 2015) Appendix 2 – Latest Work Plan BCF Pooled Budget
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Summary

This report presents the Final Better Care Fund (BCF) Plan submitted to NHS England on 9 January 2015 for ratification by the Health and Well-Being Board (HWBB). The plan was agreed by the Chairs of the Board and the Barnet Clinical Commissioning Group (CCG) along with the Chief Executive of the Council prior to submission. The previous version of the BCF Plan was presented to the Health and Well-Being Board on 18 September 2014 and submitted to NHS England on 19 September.

The Council and Barnet CCG have updated the BCF Plan following a request from NHS England to include more details of the schemes of work and their individual impact on reducing non-elective admissions. The additions include further financial and benefits modelling, an additional scheme of work for enabler services and tables that present the impact of the schemes and how each contributes towards achieving target changes in activity and financial benefits for the target cohort and the investment involved.

This report also updates the Board on delivery progress on integrated health and social care services for older people (as detailed in the Business Case for integration presented on 18 September 2014) and the work plan to set up the pooled budget required to determine and manage investment and spend to deliver the schemes of work in the Plan.

This includes an update on the Barnet Integrated Locality Teams project and Pilot Team in place. It also includes findings from a review of the Multi-Disciplinary Teams (MDT) and Care Navigation Service (CNS) elements of the Older People Integrated Care Project and new projects and developments in Tier 1 of our 5 Tier Integrated Care Model.

Recommendations

1) **That the Health and Well-Being Board (HWBB) ratifies the final BCF Plan submitted with the Chairman's agreement, along with the Chair of NHS Barnet CCG and the Council Chief Executive, to NHS England on 9 January 2015.**

2) **That the Health and Well-Being Board (HWBB) notes the next steps described here following approval of the Plan.**

3) **That the HWBB notes and comments on progress on delivering and embedding the 5 Tier Integrated Care Model for older people in Barnet.**

4) **That the HWBB comments on work to date to create a Pooled Budget for the delivery of services in the BCF Plan.**

5) **That the HWBB notes that final approval for the Pooled Budget will be given by the Council's Policy & Resources Committee and by the Barnet CCG Board.**

1. WHY THIS REPORT IS NEEDED

1.1 This report presents the Final Better Care Fund (BCF) Plan submitted to NHS England (NHSE) on 9 January 2015, following the previous Plan presented to HWBB on 18 September 2014 and submitted to NHSE on 19 September 2014.

1.2 This plan was given a rating of 'Approved Subject to Conditions' on 29 October 2014.

1.3 Only one of 11 potential conditions applied. This was a request for more details on how the BCF schemes would reduce Non-Elective Admissions (NEL) by the target of 1,025 between 01 April 2014 and 31 March 2016. Therefore we have updated the BCF Plan and submitted the final version to NHS England on 9 January as requested. Further details are below. Feedback from NHS England is anticipated in February (to be confirmed).

1.4 This report also updates the HWBB on progress to integrate health and social care services (as detailed in the Business Case for integration presented to HWBB on 18 September 2014) and the set up of the Pooled Budget required for implementing the schemes of work in the BCF Plan.

1.5 BCF Plan – NHS England Review

1.5.1 Barnet CCG and LBB Adults & Communities (A&C) met NHS England BCF Advisor Steven Bedser on 4 November 2014 to agree a plan of action for resubmission of the BCF Plan.

1.5.2 NHS England issued an assurance report, detailing the further information required and other updates for consistency and some minor technical corrections.

1.5.3 Barnet submitted an Action Plan to NHSE as required on 14 November 2014 as agreed, which NHS England approved by return.

1.5.4 Officers engaged with Steven by email and telephone regularly and met him again in December 2014 to update him on progress. Steven met the Chairman of the HWBB and Chair of the CCG Board for further discussions. He was fully informed of our work throughout.

1.5.5 Barnet CCG and LBB A&C made the following amendments to the BCF Plan document, listed in the Action Plan:

- Additional modelling of the impact of individual schemes for all metrics, i.e. NEL, reduced permanent admissions to residential and nursing care, increased effectiveness of reablement, reduced delayed transfers of care, increased patient experience and increased proportion of people using social care who receive self-directed support.
- Addition of a fourth scheme of work called Enablers, covering a range of successful operational services that support the other schemes to deliver the target BCF benefits and form part of the delivery of the different tiers in our integrated care model, e.g. later life planning, shared digital care records and other community health services.
- Further detail of the providers for services detailed within each scheme.
- Details of progress to date on establishing a pooled budget for delivering the schemes of work and for sharing any risk and the expected rewards (detailed below).
- Tables in Part 1 that present the impact of the schemes of work planned and how each scheme contributes towards achieving expected changes in activity and financial benefits derived for the level of risk for the target cohort and investment or cost involved, all referenced with Part 2.
- Quality assurance and further development of the care home admissions and patient experience targets.
- Enhanced descriptions of health and social care in Barnet today and the vision for 'Mr Colin Dale' and our integrated care model in future.
- Additional detail on how the Plan aligns with the Barnet Council Local Vision (from its Business Planning framework for 2015/16 to 2019/20).
- Technical assurance of the whole Plan and financial and benefits plans for consistency and extensive minor additions throughout.

1.5.6 The final Plan was approved by the Chairman of the HWBB under delegated authority on 18 December. It was approved by the CCG Board Chair on 6 January 2015 and submitted 9 January 2015.

1.6 Integrated Care in Barnet (5 Tier Model) – Progress

1.6.1 We continue to make significant progress towards integrating health and social care services in Barnet. In place at the time of writing are the following:

- Joint Commissioning Unit for community health, social care, mental health, learning disability, older people and disability services is operational.
- Integrated Learning Disability and Mental Health care services in place.
- Substantial elements of the BCF / 5 Tier Model are in place for Community Based Intensive Services (Tiers 3 and 4) as follows:
- Multi-disciplinary case management system in place (MDT - acute care, mental health, social care, primary care, community health).

- Care Navigator service (CNS) to support people to get the care they need is now operational, with benefits being tracked.
- Risk Stratification is live in all GP practices, enabling them to proactively identify frail older people at high risk of deterioration.
- 7 day a week Rapid Care service in place to respond early to a crisis.
- 7 day a week social work services in place at Barnet General and Royal Free hospitals.
- Pilot Barnet Integrated Locality Team (BILT) in place.

Barnet Integrated Locality Teams

1.6.2 The BILT Pilot is based in the West locality working with seven GP practices that identified higher risk patients using the Risk Stratification tool. The Pilot Team also works with social care users with high packages of care. It comprises social workers, a telecare advisor, district nurses, occupational therapists and physiotherapists. We are also working to involve important roles such as community psychiatric nurses. The team will continue to grow as the Pilot learns from its early experiences and design of care pathways.

1.6.3 The Team is led by a Central London Community Hospitals (CLCH) Locality Manager and LBB Adult Social Care Service Manager. The Team is currently supporting 27 adults. Two have already been discharged following effective interventions. The number of adults supported will grow as the Team and pathways evolve. The Team has experienced positive engagement with third sector organisations, who we aim to include in the final model for wider roll out.

1.6.4 The Pilot runs through 2015, with a full evaluation starting in spring to determine the final design model for the Teams and scope of work. Work will also being to plan extend the approach across the rest of Barnet starting in the autumn. This includes plans to move services like CNS and MDT to be an integral function of the Team.

Evaluation

1.6.5 We recently reviewed the progress to date and outcomes and lessons learnt for two elements of the 5 tier model, namely Multi-Disciplinary Teams (MDT) and Care Navigation Service (CNS).

1.6.6 The review established there is a strong demand for MDT and CNS services. Initial findings indicate that their support can positively impact on spending on health services. Feedback from all MDT members indicated strong support for the value of integrated, collaborative working amongst professionals across different services.

1.6.7 Further analysis and data is required to establish the impact on spending on social care services. However, early analysis suggests that in some cases a reduction in costs may be possible or short to medium-term costs are either flat or do not increase significantly.

1.6.8 The review assessed 32 of the 107 cases supported by MDT in the six month pilot period. It considered the profile of health and social care provided before being the referral to MDT, the support provided as a result of the MDT review and the patient journey and care received for six months afterwards, to see if this contributed to improved outcomes.

1.6.9 The main findings from the review are:

- There were on average 3.5 A&E attendances and outpatient appointments per person in the period prior to the referral. The data shows a significant reduction of both in the six months post intervention. A&E attendances fell by 24% and outpatient appointments fell from 114 appointments in the six months before referral to 26 in the subsequent six months.
- One of the most expensive costs to health care budgets is the cost of days in hospital. Initial findings indicate that inputs from the MDT have resulted in the number of days spend in hospital falling from 571 days in the six months before referral to 128 days in the subsequent six months (a drop of 443 days).
- There were 54 fewer calls to London Ambulance Service in the 6 months after the referral. The number of conveyances to hospital after a 999 call in the six months before referral fell from 174, to 146 in the subsequent six months.
- 25 cases were identified from adult social care records as receiving care before and after support from MDT. Of this the total annual cost of care remained the same or decreased from 2013/14 to 2014/15 for 13 of the 25 people while 12 people experienced an increase in the annual cost for the same period. The average monthly cost of care did not change or decreased for 16 of the 25 people while it increased for the other 9.
- The MDT and CNS services support higher risk patients and six of the 32 individuals died in the pilot period. These factors affected the findings and further analysis of a larger number of patients covering more levels of risk is required to provide a clearer view of the impact. However the health and social circumstances of the other 26 patients did appear to stabilise or improve.

New Projects and Developments

1.6.10 Public Health and CCG are leading work to pilot and set up the new services planned for Tier 1. This includes:

- *Expert Patient Programme (EPP)* – Three courses are planned for early 2015, most likely in separate locations. Each course will have patients sourced from local GP Practices. A framework for evaluating the course based on levels of attendance at Practices and acute services before and after the course is in development.
- *Workforce Training / Development* – Implementation of a pilot scheme is underway based on an assessment of training needs for integrated care at GP Practices and service providers.
- *Healthy Living Pharmacy (HLP)* – Given the feedback on similar schemes in other London Boroughs the scale and ambition for the roll out of the pilot as detailed in the original Business Case has been increased to include all of Barnet rather than just two pharmacies initially. This is approximately 78 sites. Work to define this revised project and to gauge interest from these sites and model the potential impact is underway.

- *Health Champions* – Originally designed to be resourced from those who complete EPP, we are now considering options to include this as part of the wider HLP project outlined above. This will enable us to increase the number, breadth and depth of Health Champions across Barnet faster than waiting for resources to become available in stages, dependent on when and how frequently EPP runs.
- *Making Every Contact Count (MECC)* – We are developing a model that incorporates HLP, existing services such as NHS Health Checks and potential other new initiatives, including HLP. Work to define this project is underway and assumes a six month pilot to be evaluated to assess the cost effectiveness and other benefits of the approach.
- *Long-Term Conditions (LTCs)* –Barnet Community Health is on our behalf working to survey community and voluntary groups to assess the support they provide for managing LTCs, to assess if there are opportunities to put further resources or initiatives in place to delivery greater benefits.

1.6.11 We held a successful workshop on 31 October 2014 to discuss and develop initiatives in Tier 5 to reduce activity in this Tier and improve the quality of the care provided for those people for whom services in Tiers 1 to 4 cannot give the appropriate level of care needed.

1.6.12 Following the workshop we agreed with providers to combine ongoing work with the Barnet Integrated Care Strategy Steering Group, which directs work in Tiers 3 and 4. Many providers are involved across all Tiers, so this enables us to develop and embed system wide integration and change effectively with all the providers involved.

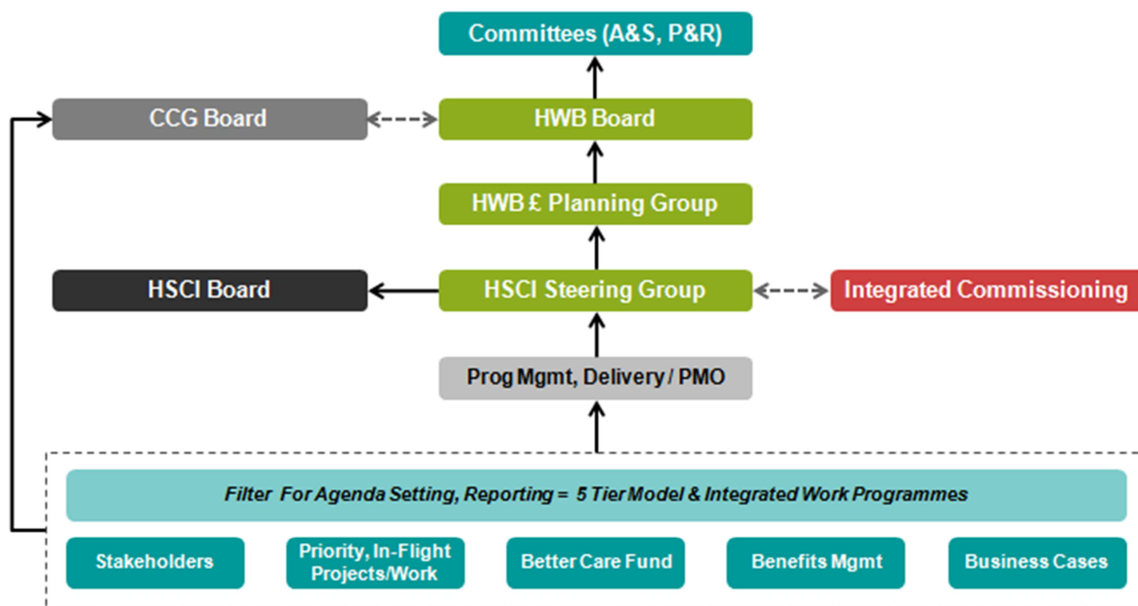
Governance and HSCI Board

1.6.13 The focus of our work is shifting from design and planning towards ongoing delivery of in-flight projects, benefits realisation and new projects or services.

1.6.14 We have updated the governance arrangements to create an HSCI Steering Group. It will direct work to meet joint aims and objectives to implement and embed the 5 Tier Model and BCF Plan. The Steering Group will:

- Monitor work to track and measure benefits realised against the targets in the BCF Plan and Business Case.
- Manage and quality assure delivery of the BCF Plan, internal or external reporting and performance of the Pooled Budget, offering challenge and scrutiny as necessary.
- Lead activities to facilitate the ongoing development and implementation of integrated services across all activities, e.g. stakeholder engagement or communications.
- Monitor progress and resolve exceptions in the delivery of priority and in-flight projects, offering guidance and support as required.
- Approve business cases for proposed new projects or work and to act as the change control authority.

1.6.15 The following diagram illustrates the current governance arrangements:



1.6.16 Our next HSCI Board meeting is set for 17 February 2015. This means we can continue to receive valuable feedback and strategic input into embedding the 5 Tier Model and system wide change and capture ideas for new services or developments.

1.6.17 Membership of the HSCI Board is comprehensive, including executives and Integration sponsors or leads from LBB, CCG and partner providers:

- Central London Community Health NHS Trust
- Royal Free London NHS Foundation Trust
- Barnet, Enfield and Haringey Mental Health Trust
- Housing 21
- Community Barnet
- MiHomeCare

1.7 Pooled Budgets – Status and Next Steps

1.7.1 BCF requires Local Areas to deliver integrated health and social care services through a pooled budget, for closer partnership working in the design and provision of such services. This underpins BCF as an enabler to take forward integration at scale and pace. Note: the BCF is not new or additional resources, rather the reallocation of existing service provision budgets to a pooled budget structure.

1.7.2 An important element of this pooled budget is the pay for performance (P4P) element for reducing NEL by our agreed target of 1,205 patients by 31 March 2016. This equates to an estimated benefit/risk of £2.054m and is the amount of the pooled budget therefore at risk depending on our performance on this target.

1.7.3 To deliver our vision for integration it is therefore necessary to establish a pooled budget compliant with BCF rules. In October NHS England advised Local Areas not yet fully approved that it would be unwise to enter into any formal pooled budget agreements until their plan was approved. This applies to Barnet.

1.7.4 Work is however underway to agree detailed principles and arrangements. A further schedule is to be added to the existing S75 Agreement for Integrated Care. To date we have identified or reached consensus on several key principles:

- The HWBB Finance Group should be considered to be the pool Executive with the HWBB to take and/or ratify decisions on the pool accordingly.
- The HWBB Finance Group will be responsible for monitoring all progress in delivering the target benefits and outcomes as detailed in the BCF Plan and Business Case, with ongoing oversight and sign off of work and spend.
- The HSCI Steering Group will deliver work and report progress to HWBB Finance Group and HWBB.
- We will review the pool every six months starting April 2015 (first review September 2015) to determine if there is a case to change the scope of it for the following year, to be decided by the following March.
- In principle LBB and CCG will monitor budgets for integrated care from the Business Case for Integration across health and social care via HWBB Finance Group, in order to track benefits realisation.

1.7.5 Work is ongoing to determine the best approach to including specific services and managing particular aspects or requirements of the pool, e.g.:

- Confirm the scope of services to include for the starting pool, taken from the schemes in the BCF Plan, to develop the Service Schedule to add to the S75 Agreement.
- Understand the impact on contracts for community health services and how and when the BCF services included them might be transferred to be managed though the pool.
- Define the most appropriate levels of benefits to track and the approach and process for recording benefits realised to help analyse progress and decide future direction and report internally and externally as required.
- How to mitigate against any loss in funding as a result of receiving only part of the 'at risk' funding of £2.054m for reducing NEL and develop a plan to manage this.
- Options to vary the amount and proportion of contributions each year, depending on policy direction, any changes to income and our agreed priorities for the future development of integrated care services against the benefits realised.

1.7.6 We will present the draft pool arrangements for contributions and sharing risk and reward to HWBB, prior to agreement by the Council Policy and Resources Committee and the CCG Board. The latest work plan for establishing the pool is attached (Appendix 2).

2. REASONS FOR RECOMMENDATIONS

2.1 The Final BCF Plan now includes significant additional detail to demonstrate the scale, quality and impact of the schemes of work planned to meet locally agreed targets for reducing NEL and other BCF benefits and outcomes.

2.2 It illustrates how each scheme contributes towards achieving the benefits and outcomes identified and the expected change in activity and financial benefit derived. This is given for how the schemes will support frail elderly people for the level of risk of admission to hospital or residential/nursing care (analysed via risk segmentation tools) and the level of investment or cost involved.

2.3 The Final Plan therefore underlines our ambitious plans for transforming and integrating health and social care in Barnet. The clear, analytically driven case for transforming care has been quality assured again and is now more robust.

2.4 BCF remains a key delivery vehicle for realising CCG QIPP plans and savings and Council Commissioning Plan priorities and savings. The Plan explains the work done and planned to maximise the chances of success in meeting these aims.

2.5 The BCF Plan has been subject to consultation and agreement with all key stakeholders in the Barnet health and social care economy. It demonstrates how we will use s256, CCG and LBB adult social care funding to invest to put in place new models of care.

2.6 The need to update the plan has diverted resources from the ongoing delivery of the schemes of work detailed. Ratifying the Plan and agreeing on progress to date and work to set up the required Pooled Budget for BCF will enable us to continue at pace to deliver the schemes of work and realise all the benefits and outcomes identified for 2014/15, 2015/16 and beyond.

2.7 Part 1 of the BCF Plan is attached (Appendix 1). There are no material changes to Part 2. Part 2 and the Action Plan are available for inspection on request from the Officers listed on the front page of this report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 n/a – All areas are required to submit a BCF Plan based on greater integration of health and social care.

4. POST DECISION IMPLEMENTATION

4.1 In anticipation of NHS England approval of the BCF Plan in January 2015, we will continue work to implement the schemes of work described and pooled budget, governance and benefits management arrangements, to evidence the successful delivery of the Plan and achieving the target benefits/outcomes.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The BCF Plan and Business Care align with the twin overarching aims of our Barnet Health and Well-Being Strategy 2012 to 2015 (October 2012), Keeping Well; and Keeping Independent. There are also clear links with the Barnet Council Corporate Plan, the Priorities and Spending Review, the outline aims of Council 5 year commissioning intentions for adult social care and Barnet CCG 2 and 5 year Strategic Plans. The London Borough of Barnet and Barnet CCG will lead delivery of the plan through the Joint Commissioning Unit (JCU) and with Public Health and partner service providers.

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

5.2.1 The BCF Plan and Business Case set out the overall investment required to implement the 5 Tier Model for integrated care and the links between it and published QIPP schemes and PSR proposals.

5.2.2 The BCF Plan details the financial LBB and CCG contributions which will likely comprise the pooled budget used to deliver integrated health and social care services to improved outcomes for patients and service users. Table 1 below provides a breakdown of this funding for 2015/16. Of this total the allocation for protecting social care is £4.20m (rounded). Most of the BCF is not new or additional resources, rather the reallocation of existing service provision budgets to a pooled budget structure. We will also where appropriate align budgets alongside the pool, including an agreed public heath contribution to deliver Tier 1 of the 5 Tier Model. Please note that existing s256 spending plans for 2014/15 (£6.634m) previously agreed by HWBB will continue in 2015/16.

Table 1 – 2015 /16 BCF

	£000
Adult Social Care Capital Grant	806
s256 Funding	6,634
Carers Breaks	806
Enablement	1,860
Disabled Facilities Grant (DFG)	1,066
NHS Funding *(Note - Includes £846K for Care Act Implementation)*	12,240
Total	**23,412**

5.3 **Legal and Constitutional References**

5.3.1 In 2015/16 BCF (the fund) will be allocated to Local Areas, placed into pooled budgets under joint governance arrangements detailed in S75 Agreements for Integrated Care between CCGs and councils (Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets).

5.3.2 A condition of accessing the fund is that CCGs and councils must jointly agree plans for how to invest the money, which must meet certain requirements. The fund will be routed through NHS England to protect the overall level of health spending and works coherently with wider NHS funding arrangements.

5.3.3 The Department of Health (DoH) will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to BCF and ensure it is deployed in specified amounts locally for CCGs and councils to use in pooled budgets.

5.3.4 Legislation is required to ring-fence NHS contributions to the fund at national and local level, to give NHS England powers to assure local plans and track performance and ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This ensures that the Disabled Facilities Grant (DFG) can be included in the Fund.

5.3.5 The DFG is included to incorporate the provision of adaptations into strategic considerations and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier local authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget so they can continue to meet their statutory duty to adapt the homes of disabled people, including for young people aged up to 17.

5.3.6 Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003). They will stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner so it can be spent in year. Further indicative minimum allocations for DFG will be provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the fund may decide additional funding is appropriate to top up the minimum DFG funding levels.

5.3.7 DoH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure DoH Adult Social Care capital grants (£134m) will reach local areas as part of the fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the fund.

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

(*3); '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.'*

(9); Specific responsibility for:

- *Overseeing public health*
- *Developing further health and social care integration*

5.4 Risk Management

5.4.1 LBB / CCG projects are delivered using programme and project management methodologies and governance arrangements. This includes clear processes to identify, report and manage individual and aggregate risks through LBB and CCG Programme Management Offices and senior management teams in the CCG and LBB Adults & Communities.

5.4.2 Specific risks relating to BCF are included in the BCF Plan and Business Case with mitigating actions. These will be monitored regularly in accordance with the aforementioned governance process.

5.4.3 Strategically work has begun to assess over-arching governance arrangements for BCF in the context of a pooled budget and shared risk. This is essential to ensure robust management of the fund especially as the size and scope of the BCF and true pool will increase (subject to necessary due diligence).

5.5 Equalities and Diversity

5.5.1 It is mandatory to consider Equality and Diversity issues in decision-making in the Council, pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must have due regard to the equality duties when exercising a public function.

5.5.2 The broad purpose of this duty is to integrate considerations regarding equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

5.5.3 The specific duty set out in S149 of the Equality Act is to have due regard to need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.4 Relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.5.5 Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports. Proposals are therefore assessed for their impact on equality and diversity in line with the Barnet CCG Equality Delivery System. A requirement of the BCF is to guarantee that no community is left behind or disadvantaged – the commissioning system therefore needs to be focused on reducing health inequalities and advancing equality in its drive to improve outcomes for patients and service users.

5.6 **Consultation and Engagement**

5.6.1 The BCF Plan details the public engagement with patients and service users as well as with providers.

6. BACKGROUND PAPERS

6.1 The first draft of the BCF was presented to the HWBB on 23 January 2014. A revised draft was presented on 20 March 2014 and full Plan for submission on 18 September 2014. It was submitted to NHS England in accordance with the nationally mandated timescales on 4 April 2014.

6.2 In addition, HWBB meetings held on 19 September and 21 November 2013, discussed health and social care integration and Integration Transformation Fund (which then became the BCF). Closely linked are discussions at the 21 November 2013 meeting (Agenda Item 10) regarding NHS England's "Call to Action" Programme, part of a national engagement exercise designed to build public awareness of the challenges facing health and social care in order to create a platform for future transformational change. The BCF represents part of the government's response to this challenge.

6.3 There are no material changes to Part 2 of the Final BCF Plan submitted to NHSE (v1.1, 14 Jan 2015). Part 2 and the Barnet BCF Action Plan submitted to NHSE (v1.7 Final, 9 Jan 2015) are both available for inspection on request from the officers listed on the front page of this report.

6.4 BCF Guidance and Planning is provided in a letter dated 25 July 2014, *NHS England Publications Gateway Ref No. 01977.*