HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Better Care Fund Re-submission**
Report of the Integrated Care Sub-Group	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
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Summary:

The Better Care Fund was announced in June 2013 as part of the 2013 Spending Round. The Fund provides an opportunity for the Council and the Clinical Commissioning Group to work together to transform local services so that people are provided with better care and support to enable the achievement of health and social care outcomes and accelerate the progress towards integration.

An earlier plan for the Better Care Fund was signed off by the Health and Wellbeing Board and submitted to NHS England and the LGA on 4 April 2014. NHS England and the LGA provided the Borough with positive feedback on the initial submission. However, since this submission, updated guidance has been issued which supersedes previous guidance and a requirement has been made that plans are re-submitted by all areas on the 19 September 2014. The main policy change, as described in the letter to Health and Wellbeing Board Chairs on 25 July from Andrew Ridley, Better Care Fund Programme Director, is to revise the payment for performance framework so that payment is linked to reductions in total emergency admissions with an expected reduction of 3.5% against baseline. The implications of this change are outlined in this paper for discussion by the Health and Wellbeing Board. Other changes are; to provide general and bespoke support for local areas and; the introduction of an assurance process which will be carried out by NHSE local area teams and Local Government Regional leads after plans are submitted before sign-off by Simon Stevens, Sir Bob Kerslake and Ministers.

Whilst our focus has been on delivering each of our 11 individual schemes in line with the previously agreed Better Care Fund plan we have needed to undertake further work to revise our Better Care Fund Plan in order to meet further requirements from NHS

England and the LGA and consider the implications of the new national assurance process. Our revised plan is currently well on the way to being finalised and an update on progress for each of our 11 schemes is attached for discussion and agreement by the Health and Wellbeing Board ahead of the new submission deadline of the 19 September. The plan will also need to be agreed by the CCG. This report also provides an update on our work to develop governance and management arrangements.

Recommendation(s)

It is recommended that Members of the Health and Wellbeing Board:

- Discuss and agree the approach to setting the target reduction in emergency admissions for the Barking and Dagenham BCF to enable the plan to be finalised for submission on 19 September.
- State their view on the possibility of setting a target lower than the 3.5% reduction in emergency admissions.
- Note the risks associated with setting a target lower than 3.5% for emergency admission reduction and the other associated risks for the BCF including those identified in the national assurance framework.
- Note the progress on developing governance and management arrangements and endorse the direction of travel for these.
- Consider the progress made in the delivery of the individual scheme plans provided within **Appendix 1.**
- Delegate to the Corporate Director of Adult and Community Services on behalf of the Council to finalise any outstanding matters from the Board's discussions and to further test our approach against national assurance with the Accountable Officer on behalf of Barking and Dagenham CCG, with the Chair of the HWBB, prior to formal submission to NHS England.

Reason(s)

It is a requirement of submission of the plan that it is signed off by the Health and Wellbeing Board ahead of submission to NHS England. If the plan includes a target for a reduction of less than 3.5% of emergency admissions this must be explicitly agreed by the Council.

The Better Care Fund underpins the Council's priority of improving health and wellbeing through all stages of life.

1 Introduction

1.1 The Better Care Fund (BCF) provides an opportunity to transform local commissioning and services so that people are provided with improved integrated care and support to achieve their health and social care outcomes. The Fund is intended to support the scale and pace of integration between health and social care and reduced reliance upon bed based services.

1.2 As Board Members will remember from the previous reports and presentations to the Health and Wellbeing Board in February and March the Fund is made up of a number of existing funding streams to the Clinical Commissioning Group (CCG) and the local authority as well as recurrent capital allocations.

1.3 In addition to the overarching integration agenda, a number of conditions and indicators are attached to the Fund, designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care home settings. The main policy change from the April submission has been the revision to the requirements for reduction in the total emergency admission rate for the local area (not just a reduction of avoidable admissions) with guidance stating that area plans should seek a minimum of 3.5% reduction in total admissions for 2015/16 . Failure to meet the agreed target will result in funds being withheld proportional to performance. Since discussions at the last meeting and since receiving feedback from NHSE on the earlier submission, Officers from across the Council and the CCG have been working to ensure that the Borough's Better Care Fund Plan resubmission due in September, as well as the eleven priority schemes that make up the Plan, are robust and focused on delivering high quality and effective outcomes for residents. We have however, had to shift our focus from delivering the schemes to revising our plan and meeting the new additional requirements.

1.4 Key changes are as follows:

- Requirement to now set targets for 15/16 in addition to 14/15
- A significant re-focusing on reductions in total emergency admissions (not just avoidable admissions as per the previous submission); a specified target for reduction (3.5%) and re-introduction (from earlier guidance) of a performance element (£1b nationally) linked to the achievement of this target with the balance to be spent on NHS Commissioned out of hospital services..
- A clear requirement to show that at least £135m nationally (and therefore Barking & Dagenham's estimated proportion of this) has been addressed in the BCF to support the additional cost burdens for the Council of the Care Act.
- A requirement for principal service providers – notably the hospital trust - to contribute to the plan. Local acute providers are required to explicitly state that they recognise the emergency admissions reductions and agree with them.
- An assurance process which will follow submission.

Whilst in some areas the guidance has been prescriptive there have been and remain, a number of challenges, not least those of late guidance and a determination that local areas find and agree solutions without the benefit of clear direction from central government. However, both the CCG and the Council are confident that the September BCF Plan and a summary of our progress against each of the individual Scheme Plans (**Appendix 1)** reflect a jointly held ambition to deliver 'better care' in Barking and Dagenham. We have also made good progress in developing governance and management arrangements for the fund.

1.6 The remainder of this report summarises the vision for the BCF in Barking and Dagenham and the feedback received to date from NHS England; the vision and proposed schemes remain as previously agreed by the HWB. The report then discusses the approach we might take to setting our local target and the associated risks and implications particularly of the assurance process, provides an overview of progress on developing governance arrangements and remaining issues to be

discussed by the Board and the final process for the submission of the BCF Plan in September.

1.7 The timetable for the submission and assurance process is outlined in brief below:

- Health and Wellbeing Board 9 September – agree approach.
- CCG Joint Executive Team 11 September – agree approach.
- BCF templates finalised w/c 15 September.
- Sign off BCF submission by Corporate Director of Adult and Community Services and CCG Accountable Officer w/c 15 September.
- Submission 19 September.
- Assurance and moderation process concludes 10 October.

1.8 Members of the Health and Wellbeing Board are asked to consider and agree the approach to take to respond to the revised guidance to enable the delegated officers to agree the final plan for submission to NHS England on 19 September 2014. Members of the Board are also asked to consider and note the progress on a) delivery of the BCF schemes outlined in the report and b) development of governance arrangements.

2 Vision

2.1 Barking and Dagenham Council and the Clinical Commissioning Group have been working together with shared intent and as trusted partners to ensure that the BCF Plan puts residents at the heart of the health and social care system. Against a backdrop of increased demand and reductions in resources, the BCF in Barking and Dagenham aims to:

- Improve how people experience care and ensure the best possible quality to deliver the right care, in the right place, at the right time;
- Ensure the health and social care system is 'future proof' and able to effectively manage increasing demand and need, not only today, but in years to come;
- Reduce reliance upon bed based services and ensure improved support closer to home.
- Ensure that services are efficient, sustainable and deliver value for money.

2.2 The Borough has a strong track record in developing integrated systems which are designed around people's needs. The development of the locality model, in which clusters of General Practices are brought together with community health and social care professionals to assess, plan and coordinate the care of patients at high risk of admission to hospital (as identified through risk stratification), exemplifies this approach. Additionally, the new Joint Assessment and Discharge service brings together discharge functions undertaken by acute trust staff and those undertaken by social care in order to improve hospital discharge and ensure that decisions are made closer to individuals and their families.

2.3 The Council and the CCG therefore seek to build on these approaches within the BCF, working with key partners such as Barking and Dagenham, Havering and Redbridge NHS University Hospital Trust (BHRUT) and the North East London Foundation Trust (NELFT) to deliver better health and care outcomes for residents.

2.4 The national ambition has been further strengthened, with guidance asserting that "… health and care services need to change from a 'sickness service' which treats people as a one –off and then sends them away to another part of the system to a joined up health and social care service...the ambition must be that people need to go into hospital as little as possible and when they do, they are admitted quickly, treated well and discharged as quickly as possible to enable them to get on with their lives. " (NHS E and LGA July 14).

2.5 Guidance states that "Of 5.3 million emergency admissions each year across the country – more than half of these are amenable to avoidance. The example provided within the latest guidance suggests that 380,000 admissions each year relate to falls for older people".

2.6 The locally agreed ambition for reducing emergency admissions is to be now measured from a baseline of the 12 month period Q4 13/14 to Q3 14/15 and is therefore based on our plans to reduce admissions previously submitted as part of the BCF in April.

3 Feedback from NHS England on earlier submissions

3.1 NHS England, in partnership with the London Social Care Partnership and London Councils, provided feedback to the local authority and the CCG on 28 February on the Borough's Draft Better Care Fund Plan.

3.2 At this point the Borough received positive feedback on its draft submission and NHS England expressed confidence in the plan, stating that they felt that remaining issues would be resolved ahead of final plan submission. This was very favourable when compared to feedback given to other areas.

3.3 NHS England also previously raised a concern for all Boroughs in the North East London sub-region regarding the reflection of patient and service user experience in the BCF Draft Plan. There are two main ways in which this has been addressed; firstly through the development of a BCF stakeholder engagement strategy which has already delivered engagement events on end of life care and on the emerging carers' strategy; secondly through the inclusion of the metric which measures the proportion of people who feel supported with a long term condition (LTC). This metric is drawn from the national GP survey which is an established method for gathering patient views. There has been and remains a lack of central guidance about how patient and service users experience can be measured in the BCF. In the absence of this guidance this metric is regarded as the best way to ensure that some measure of patient and service user experience is included in the BCF metric, drawing as it does on an ongoing national survey which allows for trends over time to be seen as well as using an established and robust methodology.

3.4 NHS England will be providing further assurance on the September submission of the BCF. This is expected in the two weeks following the submission date of 19 September.

3.5 Support is available to local areas on developing BCF plans and related governance processes and regular "temperature checks" are being requested to provide feedback to NHSE on progress on developing the final submission. Barking and Dagenham has indicated moderate to high confidence on progress and has indicated that additional support could be helpful to ensure the BCF resubmission is as robust as possible in terms of benefits management and evidence-based planning.

4 Update on remaining actions to be worked through

4.1 The development of the Better Care Fund has been a positive process for both the CCG and the Council and a great deal of discussion and work has been undertaken by colleagues to resolve issues that have arisen as part of the production of the BCF.

4.2 Agreeing a target for further reductions of emergency admissions

4.2.1 The resubmission requires a different kind of target to the previous submission; the April submission included a target which was calculated as a monthly average reduction in avoidable admissions. The target agreed for Barking and Dagenham was around 7 admissions avoided each month on average. This target took account of predicted changes in the population (growth). The September submission requires a target to be set which is a reduction on all emergency admissions, with an expectation that this will be a reduction of 3.5%. This target does not take account of changes in the population. Therefore a different metric needs to be calculated.

4.2.2 Our current estimates are that the target of 3.5% reduction in emergency admissions for Barking and Dagenham would require a reduction of more than 700 admissions in 2015/16. This would equate to a performance payment of c. £1million.

4.2.3 Data released by NHSE on 20 August along with further guidance on the 3.5% reduction target for emergency admissions provides some information on the trend for Barking and Dagenham's emergency admissions and comparative information. This data shows that from 2009/10 to 2013/14 there has been an 11.3% reduction in emergency admissions. The reduction rate has averaged 3% during the period 2010/11-2013/14. Barking and Dagenham's reduction in emergency admissions over this period compares well with other CCGs, in the top quartile nationally and with greater reduction than both Havering and Redbridge. It is not clear from this data what impact population change has had on admissions, and there are ongoing queries about the data source that need to be addressed to get a full understanding of what this shows us. The spreadsheet can be downloaded at http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

4.2.4 In setting a revised target the following factors need to be considered:

What is an optimum level for emergency admissions? Given that, according to the data referenced in 4.2.3 above, Barking and Dagenham has already seen a reduction in emergency admissions over the last 4 years, and a reduction that is greater than other comparators, it is important to have an understanding of what the end state is expected to be, a realistic trajectory can then be set. This question has been asked of the colleagues providing BCF support and we await a response.

The size of the target. Achieving the 3.5% target will require a reduction of c. 700 admissions. This is a much higher figure than has been previously calculated by the CCG for avoidable emergency admissions for 2014/15 (reflected in but not directly aligned with the previous BCF submission). Work done by the CCG to calculate

avoidable admissions built up a target of around 300 admissions based on a detailed understanding of the capacity and capability of the community services that are part of the BCF schemes to manage specific conditions in the community. To achieve a further c. 700 admissions in 2015/16 over and above this is a very significant task.

Ability to influence the target. The BCF schemes target specific cohorts of people who can benefit from preventative measures (e.g. falls prevention) that can stop them needing an admission; integrated measures (integrated health and social care) that provide better co-ordination of care to avoid crises and the need for admission and; care in the home that will otherwise be required in hospital or other institutional/bed-based settings (end of life care, Community Treatment Teams and Intensive Rehabilitation Service). These schemes are planned to have an impact on avoidable admissions. A target to reduce the total admission rate will potentially require a different approach, and be aimed at different groups of people. There are many factors that drive the total emergency admission rate and there are not always clear commissioning levers to affect these factors.

Maximising performance payment. We want to maximise the likelihood that the BCF receives the full sum available from the performance component of the Fund linked to the reduction in admissions. . For example, if a reduction target of 3.5% was chosen, and this was achieved in full, the BCF would receive approximately £1million. If half of the target was achieved, the BCF would receive half of the £1 million and so on. So, if the target is not achieved in full, the CCG will retain the money proportional to performance, and this is to be spent by the CCG in consultation with the Health and Wellbeing Board.

Setting a realistic and reasonable target. We need to ensure that the target reduction is deliverable; will have the maximum benefit for local people; and will meet the needs of our population.

4.2.5 The latest guidance is quoted below and confirms that local area target setting should take into account:

- The position from which the area is starting; e.g. an area which has already achieved top quartile performance in reducing emergency admissions may not be able to achieve further improvements as extensive as areas in the lowest quartile; as experienced in Barking and Dagenham
- The local trend in performance – Barking and Dagenham is showing an improving trend
- How current performance compares to peer areas; Barking and Dagenham compares well nationally and with local peers (Havering and Redbridge)
- Whether the local population is projected to increase more than the national average: this is the case for Barking and Dagenham
- A plan which sets an ambition lower than 3.5% in 2015/16 must explain how the planned level of improvement will contribute to a longer term trajectory: we are seeking further support on how we might set a longer term trajectory
- Any revised ambition lower than the assumed 3.5% must have the explicit support of the Council and must have the explicit written commentary of acute providers.

- Each area should ensure the contingency plans and risk sharing agreement make prudent provision for the costs of unplanned activity if emergency admissions are not reduced in line with the plan. The lower the planned reductions, the less money will be available through payment for performance element of the fund and more will need to be invested in NHS commissioned out of hospital services.

- The national assurance process introduces new risks in relation to how area plans will be graded and will take into account the extent to which the above requirements and conditions have been met.

4.2.6 The Health and Wellbeing Board is invited to discuss the factors above and in particular to state their views on the possibility of submitting a target for reducing emergency admissions lower than 3.5%.

4.3 The national assurance process has been subject to significant revision and it will be required that area plans are considered against national criteria and the extent to which BCF planning criteria have been met, the quality of the plans, the assurance checkpoint assessment of the risk to delivery due to the local context facing each health economy. The assurance process now has several layers and plans will be placed into four categories:

1. Approved

2. Approved with support

3. Approved with conditions

4. Not approved.

5. Governance

5.1 A workshop was held with the CCG and the Council on 13 August to develop governance arrangements. The two organisations agreed to establish a BCF s75 Board which would report to both the Health and Wellbeing Board and the CCG Governing Body. This Board will meet in shadow form for the first time in October 2014 ready to develop the s75 agreement that will need to be in place by April 2015.

5.2 The preferred model of a single “umbrella” s75 with schedules specifying lead commissioner responsibility for different schemes and contracts is currently being discussed with legal advisors.

5.3 The arrangements for sharing financial risk and hosting the budget will be subject to further discussion as the s 75 develops.

6. Delivery

6.1 The Integrated Care Sub-Group of the Health and Wellbeing Board (which also includes provider representation) will continue to oversee delivery of each of the 11 schemes and will also provide reports from time to time to the Health and Wellbeing Board.

6.2 As outlined under Scheme 5 (Integrated Commissioning), a joint commissioner post has been created who will initially be focused on managing the BCF programme and driving forward delivery of the schemes. We have now recruited to this role and also have interim programme support in place.

7. Risk

7.1 There are two orders of risks in relation to the BCF, firstly around submission of the revised BCF in September and the implications of the revision and secondly risks inherent in the BCF including risks to delivery. The latter are included in a high level risk register for the BCF which is provided at Appendix 2 and once finalised will form part of the submission.

7.2 The risks relating to the BCF submission in September are in summary, that the submission is not accepted (if for example the 3.5% reduction target is not set) or that the assurance process does not approve the plan. An assurance template has been provided which summarises the requirements of the plan. These are that the plan demonstrates that it meets the national conditions of:

- Protection of social care spending
- Seven day services to support discharge
- Data sharing
- Joint assessment
- Accountable lead professional for high-risk populations
- Agreed impact on the acute sector

7.3 The previous submission addressed each of these areas. The main areas of concern in relation to the national conditions for the new submission are; protection of social care spending and; agreed impact on the acute sector. Both of these areas carry financial risks. These are described in more detail in the finance section below The problem in relation to protecting social care spending is that the total of the funds that the HWB need to identify to cover the new costs of the Care Act (£513k), the allocation for carers and the existing services that are already commissioned with the funds that have been included in the BCF is greater than the current BCF budget. This risk will be further compounded by any reduction in performance payments which could be the consequence of either not setting a target of 3.5% for admissions reduction or of failing to achieve such a target. This would mean that payments intended to be included in the BCF and committed to e.g. community services would potentially be diverted to pay for over-performance of emergency admissions. The consequences of this could be to further undermine efforts to avoid admissions if resources are diverted from the services that are working to keep people well at home. Further work is required to agree the best way of managing these risks and will be reflected in the s75 agreement that will be developed by the end of the financial year.

8. Finance

8.1 There remains no clear guidance on some elements of how the Care Act burden is to be funded from the BCF, although there is now a clear requirement within our plan to state that the costs relating to the national £135million in the BCF will be spent from the BCF on elements of the Care Act costs. For Barking and Dagenham the proportionate share of the identified £135m is £513k-this is an estimate based on figures supplied by NHSE. It is recognised by both the Council and the CCG that this presents a financial risk to the local health and social care economy. Also, the risk of

not achieving the full reduction in emergency admissions target would be to reduce the potential funding for the BCF.

9. Next steps

9.1 Following discussions at the Board meeting, and with the Board's agreement, the Better Care Fund Plan will be finalised by the Corporate Director of Adult and Community Services on behalf of the Council and the Accountable Officer on behalf of the CCG. This will include finalising the target for the emergency admissions reduction. This will allow any further steps to be readily taken should further direction and guidance be forthcoming from the Department of Health or NHS England. The Plan will then be submitted to NHS England by the deadline of 19 September 2014.

9.2 The Shadow BCF s75 Board will be established in October and will report back to the Health and Wellbeing Board.

10. Mandatory Implications

10.1 Joint Strategic Needs Assessment

Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and support the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.

Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular the sections that relate to:

- Supported living for older people and people with physical disabilities
- Dementia
- Adult Social Care
- Learning Disabilities
- Mental health- Accommodation for People with Mental Illness
- End of Life Care

The relevant sections of the JSNA can be found by visiting the following link: http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

10.2 Health & Wellbeing Strategy

The Better Care Fund reinforces the aims of the Health and Wellbeing Strategy and provides an excellent opportunity for alignment between the ambitious integration plans and the Strategy which are both as much about keeping people well and independent as about ensuring they receive the services they need if they become unwell. Our focus is on people's wants and needs rather than the organisations and structures that deliver care. We aim to prevent ill health and support people to stay well rather than only intervening in a crisis.

10.3 Integration

Integrated commissioning and provision is at the heart of the BCF. The integrated Care Coalition (ICC) with the relevant CCGs and local authorities for Barking & Dagenham, Redbridge and Havering came together to agree the strategic commissioning case for integration and commissioning work accordingly. Barking and Dagenham have a strong history of integrated work and the Fund provides opportunity to strengthen this. Alongside this work, the Integrated Care Coalition is leading the work on the required 5 year Strategic Plan. This will set out our shared vision for fully integrated commissioning by year 5 of the Plan.

There is an agreed vision for integration confirmed at the Integrated Care Coalition in November 2012. This includes supporting and caring for people in their own homes or closer to home, shifting activity from acute to community services and particularly to locality settings. It places individuals at the centre of delivery, driving improvements to the quality of experience and outcomes. Examples of local integrated services and approaches include;

- Integrated multi-disciplinary teams across six clusters in Barking & Dagenham are well established aiming to achieve co-ordination of care across the health and social care economy with a focus on prevention and promotion of self management through Integrated Case Management.

- Work is currently taking place, establishing the Joint Assessment & Discharge team based at Barking, Havering, Redbridge University Hospital Trust and working with North East London Foundation Trust and London Borough of Baking and Dagenham, and the CCG, from 1st April 2014. The aim is to ensure timely co-ordinated discharge from hospital and admission avoidance of unnecessary admission to hospital. Seven day working is part of this service.

- The promotion of physical activity through sports and leisure services using public health to improve health and well being

Further integrated approaches will develop as part of the BCF Plan which will be overseen by the Integrated Care Subgroup of the H&WBB. Integration of funds and commissioning for people with learning disabilities is the subject of a separate piece of work between the Local Authority and the CCG.

11. Financial Implications

11.1 The draft Better Care Fund was discussed at the meeting of the Health and Wellbeing Board at its meeting on 11 February 2014, and the covering report set out broad financial implications for the Council and the CCG.

11.2 The Better Care Fund (BCF) is expected to lead to the transformation of health and social care services for people in the community; this is to be achieved through the integration of services between health and social care using pooled budget arrangements. These pooled budget arrangements are required to be in place from April 2015. NHSE is currently developing further guidance on pooled budgets. Further to this guidance being received the proposed shadow BCF board will develop S.75 pooled budget arrangements for the Health and Wellbeing Board to approve for implementation.

11.3 The delivery of integrated health and social care services at greater scale is expected to deliver improvements against national and local outcomes.

11.4 The Department of Health has indicated that the CCG revenue allocation includes funding for some of the costs arising from the Care Act 2014 (putting carers on a par with users for assessment, implementing statutory Safeguarding Adults Boards, and setting national eligibility). The national CCG allocation is £135m, an indicative allocation for Barking and Dagenham would be £513k based on figures from NHSE. In the next few months consideration will need to be given to how this additional £535k will be funded from the BCF; for example, de-commissioning of existing services; considering if there are any services which are currently being commissioned separately by the CCG or the Council which would be more efficiently commissioned jointly.

11.5 The proposed Better Care Fund is £13.182m in 2014/15 and £21.610m in 2015/16; in both years the Council proposes to include in the pool more than the minimum contribution it needs to make.

11.6 The substantive change in policy for the new BCF submission, is that of the £1.9billion additional NHS contribution to the BCF, £1billion will now be either commissioned by NHS on out of hospital services or be linked to a reduction in total emergency admissions. The intention of this policy change is to ensure that the risk of failure for the NHS in reducing emergency admissions is mitigated, and CCGs are effectively compensated for unplanned admissions.

The payment for performance element related to reducing emergency admissions, is to be determined by the Health and Wellbeing Board i.e. it is determined by the level of the reduction target. The balance is required to be spent on NHS commissioned out of hospital services.

There is a risk therefore that if the full activity reductions are not achieved there will be a reduction in payments for the BCF. The payments not made to the BCF will stay with the CCG, to be spent by the CCG in consultation with the Health and Wellbeing Board

11.7 Discussion are being held with local acute providers to agree the emergency admissions activity reduction targets.

12. Legal Implications

Implications completed by: Chris Pickering, Principal Solicitor

12.1 There are no specific legal implications that arise from this report at this stage. It is however, evident that legal implications will need to be fully considered in the development of the S.75 and pooled budget which is due to return to the Board for consideration.

13. Non-Mandatory Implications

13.1 Workforce Implications

The Better Care Fund and accompanying schemes will have various workforce implications and all relevant HR procedures will be followed to ensure that staff are consulted as these new services are developed. The BCF has included money for training and workforce development initiatives within the scheme plans. Each of the

organisations will have their own change management processes and the Council and the CCG will need to ensure that the appropriate processes are followed. Members of the Board should note that the development and implementation of the Joint Assessment and Discharge service has shown the complexity of working across a number of organisations and this complexity should not be underestimated.

13.2 Customer Impact

Integrating health and social care services is expected to not only generate cash efficiencies but to improve the patient/service user experience in a myriad of ways. The benefits for patient/service user experience can be read in each of the schemes of work.

14. List of appendices:

Appendix 1: **Progress in each of the 11 schemes** which are:

1. Integrated Health and Social Care Teams
2. Admissions avoidance and improved hospital discharge
3. Intermediate Care
4. Mental health support outside hospital
5. Integrated commissioning
6. Support for family carers
7. Care Bill Implementation
8. Prevention
9. End of Life Care
10. Equipment and adaptations
11. Dementia support

Appendix 2: **High-level risk register (revised for September submission)**