Title of Report:	Better Care Fund Briefing – January 2014
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	23 January 2014

Purpose of Report:

To inform Members of the Health and Wellbeing Board about the Better Care Fund.

Recommended Action:

To Note

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Councillor Gordon Lundie (01488) 73350
E-mail Address:	glundie@westberks.gov.uk

Contact Officer Details	
Name:	Cathy Winfield
Job Title:	Chief Officer, Berkshire West CCGs
Tel. No.:	0118 982 2732
E-mail Address:	cathywinfield@nhs.net

Better Care Fund Briefing – January 2014

1. BETTER CARE FUND OVERVIEW

The Better Care Fund (BCF) plans offer the opportunity to transform local services and provide better integrated care and support. It provides an opportunity to improve the lives of the most vulnerable providing them with better services, support and improved quality of life. It enables the integration agenda to be taken forward at scale and pace and provide a catalyst for change. It requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled BCF budget will be implemented to facilitate closer working between health and social care services. Joint plans should be agreed between CCG's and the Local Authorities and approved through the local Health and Wellbeing Boards. Local health and social care providers should also be closely involved in the development of the plans. The plan should demonstrate clearly how it meets all of the national BCF conditions, include details of the expected outcomes and benefits of the schemes involved, and confirm how the associated risks to existing NHS services will be managed. CCGs will be expected to meet the national conditions and measures and consider the quality of the impact of the BCF alongside the development of the BCF plans

CCGs and Local Authorities need to engage from the outset with all providers likely to be affected by the use of the BCF so that plans are developed in a way that achieves the best outcomes for local people. Commissioner and provider plans should have a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support service change.

2. FUNDING FOR INTEGRATED CARE

In 2014/15, a total of £1,100 million (increased from £859 million) will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will be through a Section 256 transfer. In 2015/16, this funding will be part of the pooled BCF while it will continue to be allocated to areas on the same basis as in previous years; the funding will be added to CCG allocations. CCGs will be required to pass this funding to the BCF pooled budget along with the funding from core CCG allocations. There are no additional conditions attached to the £859m transfer already announced and NHS England will only pay out the additional funding based on jointly agreed BCF two year plans.

From 2015/16, the BCF will also include a £1.9 billion contribution from core CCG funding, over and above the existing £300 million reablement funding and £130 million carers' breaks which will also be pooled in the BCF. Core CCG funding in the pooled BCF will be allocated based upon the CCG allocation formula. Additional contributions to the BCF from Local Authorities will be in the form of social care capital grants and disabled facilities grants, which will be allocated to them by central government on the same basis as for 2014/15.

The additional £241m should be used to prepare for the implementation of the pooled budgets and early progress against the national conditions and performance measures.

The BCF includes the £130m of NHS funding for carers breaks. Local plans should set out the level of resource dedicated to carer support including breaks. The BCF also included £300m of reablement funding and plans need to include this.

In 2015/16 the BCF will be a pooled budget under Section 75 governance arrangements. Funding will come through NHS England to protect the overall level of health spending. The DH will use the mandate to instruct NHS England to ring fence its contribution to the BCF. Legislation is needed to achieve this. The Disabled Facilities grant has also been included in the BCF so that planning and investment for adaptations can be included and lead to improved outcomes. The DH Adult Social care capital grant will also be included in the BCF. Relevant conditions will be attached to these grants and are in development.

The BCF will also include costs to councils resulting from care and reform. £135m revenue funding is linked to the new duties in the Care Bill which will be implemented in April 2015.The funding is not ring fenced and local plans should identify how the new duties are being met. Most of the costs result from new entitlements for carers and the introduction of national minimum eligibility thresholds.

3. Local Allocations

Council will receive their funding allocations in the normal way. NHS allocations will be two years for 2014/15.and 2015/16.The formula for distribution of the £3.8bn funds in 2015/16 will be based on the financial framework agreed by ministers.

The LA's and CCGs will receive a notification of their share of the pooled fund for 2014/15 and 2015/16.The remainder of the BCF will be allocated on the basis of CCG allocations formula. Local Authorities and CCG's will receive their share of the pooled fund based on the aggregate of the allocation mechanisms. The pay for performance will be included.

The wider powers to use the Health Act flexibilities are unaffected by the BCF requirements.

4. Agreeing a Joint BCF Plan

The Health and Wellbeing Boards will be responsible for signing off the plans. The plan must be developed as an integral part of the CCG's strategic plans.

The plans should include the following:

- Priorities and performance goals
- Ambitions set for the BCF
- Achievement of national conditions
- Understanding of the performance goals and payment regimes
- Use of agreed national template
- Shared risk register
- Engagement with providers
- Shared view of the shape of future services
- Assessment of future and capacity and workforce requirements/education and planning

5. Rewards for Meeting the Goals

Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

6. National Conditions and Metrics

What are the conditions?

The Spending Round established six national conditions for access to the Fund

Plans to be jointly Agreed	The Better Care Fund Plan, covering a minimum of the pooled fund Specified in the Spending Round, and potentially extending to the totality Of the health and care spend in the Health and Wellbeing Board area, Should be signed off by the Health and Well Being Board itself, and by the Constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best Outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care Services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
	Local areas are asked to confirm how their plans will provide 7-day

As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: ●● confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; ●● confirm that they are pursuing open APIs (ie. systems that speak to each other); and ●● ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the

	resolution of some Information Governance issues by DH).
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help – following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- Effectiveness of reablement;
- delayed transfers of care;
- Avoidable emergency admissions; and
- patient/service user experience.

Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential care homes	N/A	April 2014- Mar 2015
Effectiveness &reablement	N/A	April 2014- Mar 2015
Delayed transfers of care	April – Dec 2014	Jan- Jun 2015
Avoidable emergency admissions	Apr - Dec 2014	Oct 2014- Mar 2015
Patient/service user experience	N/A	Details TBC

When	Payment for performance amount	Paid for
April 2015	£250m	Progress against four of the national conditions: • protection for adult social services • providing 7- day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care will be an accountable lead professional
	£250m	Progress against the local metric and the two of the national metrics; • delayed transfer of care; and • avoidable emergency admissions
October 2015	£500m	

The metric for patient user experience and integrated care is not currently available but is in development.

In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15

A menu of possible metrics selected form the NHS, Adult Social care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long Term) condition
2.6i	Estimate diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 30/120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contract with secondary mental health services living independently with or without support
1D	Carer-related quality of life
Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as "inactive"
2.24ii	Injuries due to falls in people aged 65 and over

Local areas must either select one of the metrics from this menu, or agree a local alternative.

Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- Data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- Timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

Each metric will be of equal value for the payment for performance element of the Fund.

In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to beset such that it rewards a small improvement that is purely an artefact of variation in the underlying data set.

7. How will plans be assured?

The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers.

The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).
- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA
- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.
- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG,HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.
- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.
- Ministers will give the final sign-off to plans and the release of performance related funds.

8. What will be the consequences failure to achieve improvement?

Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary

If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving

colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

9. Timescales for Submission of Plans

Health and Wellbeing Boards should provide the first cut of their completed BCF template, as an integral part of the constituent CCGs' Strategic and Operational Plans by 14 February2014,

The revised version of the BCF should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by April 2014.

10. Berkshire West CCG's and Local Authorities Joint BCF Plans Progress

The Wokingham, West Berkshire and Reading Integration Steering groups have been meeting to take forward their local joint working and integration programmes and developments.

A Berkshire West Integration workshop was held on the 6th December which outlined each organisations financial position/plans, the opportunities and barriers to integration and progress to date on the local integration plans.

Extraordinary meetings have been scheduled in January/February.

Health and Wellbeing Board sign off:

Reading	West Berkshire	Wokingham
14th February 2014	23rd January 2014	30th January 2014

Proposals include:

Reading	West Berkshire	Wokingham
Hospital @ Home	Hospital @ Home	Hospital @ Home
Nursing/Care Home Developments	Integration of Intermediate care/Reablement Services	Nursing/Care Home Developments
Intermediate Care Integration	Joint Access to the Health and Social care Hub	Integration of Reablement/Intermediate Care including two hour response for social care assessment
Time to Think Beds-Assessment beds/24hour support (Willows)	Case Coordination model	Supporting primary care developments/neighbourhood cluster tea
GP Clusters	Development of GP/community/social care clusters	Joint Access to the Health and Social care Hub
24/7 Working Plans	24/7 Working	24/7 Working
Data Sharing		

Gabrielle Alford
Director of Joint Commissioning
Berkshire West CCG's
6/01 /2014