	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**
TITLE OF REPORT **BETTER CARE FUND RESUBMISSION SEPTEMBER 2014**	
Report of the Cabinet Member for Adult Social Care and Health Councillor Vivienne Lukey	
Open Report	
Classification - For Decision **Key Decision: Yes**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care	
Report Author: Cath Attlee, Whole Systems Lead	**Contact Details:** Tel: 07903 956 961 E-mail: cattlee@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper reports on the requirement on the Health and Wellbeing Board to resubmit the Better Care Fund (BCF) Plan which was agreed on 24th March and submitted to the Department of Health (DH) in April 2014.

1.2. The plan is currently being revised but is not yet ready for presentation to the Board. However it has to be submitted on 19th September. The Health and Wellbeing Board is therefore asked to delegate authority to the Board Chair and Vice Chair to sign off the final document for submission on that date.

1.3. The report explains that the revised plan will contain some additional material and revision following further guidance and a revised template from the DH and the Department of Communities and Local Government (DCLG).

1.4. The key changes relate to the Pay for Performance and Risk Sharing arrangements which mitigate the risk of local areas failing to achieve the key target of reduced emergency admissions, but reduce the investment in integrated care, and potentially increase the risk to social care.

2. RECOMMENDATION

2.1. The Health and Wellbeing Board is recommended to note the requirement for resubmission and to agree to delegate to the Chair and Vice Chair final approval of the revised BCF Plan for submission to NHS England by 19th September.

3. REASONS FOR DECISION

3.1. The Health and Wellbeing Board approved the BCF Plan 2014-16 at the meeting held on 24th March 2014 and the Plan was subsequently submitted to NHS England on 4th April.

3.2. However, subsequently the DH and DCLG have issued revised plan requirements and the Local Authority and Clinical Commissioning Group are required to resubmit the BCF Plan.

3.3. Work is still being completed on the financial assumptions and the revised plan is therefore not ready for presentation to the Health and Wellbeing Board at this time.

3.4. This report therefore summarises the key revisions to the plan for the Health and Wellbeing Board to consider and asks the Board to delegate final approval to the Chair and Vice Chair of the updated plan templates for submission on 19th September 2014.

4. INTRODUCTION AND BACKGROUND

4.1. The BCF is “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”. A national allocation of £3.8bn was announced in the summer of 2013 for this purpose.

4.2. The BCF does not come into full effect until 2015/16, but an additional £200m was transferred to local government from the NHS in 2014/15 (on top of the £900m already planned) and it is expected that Clinical Commissioning Groups (CCGs) and local authorities will use these funds this year to transform the system. Consequently, a two year plan for the period 2014/16 had to be put in place by March 2014.

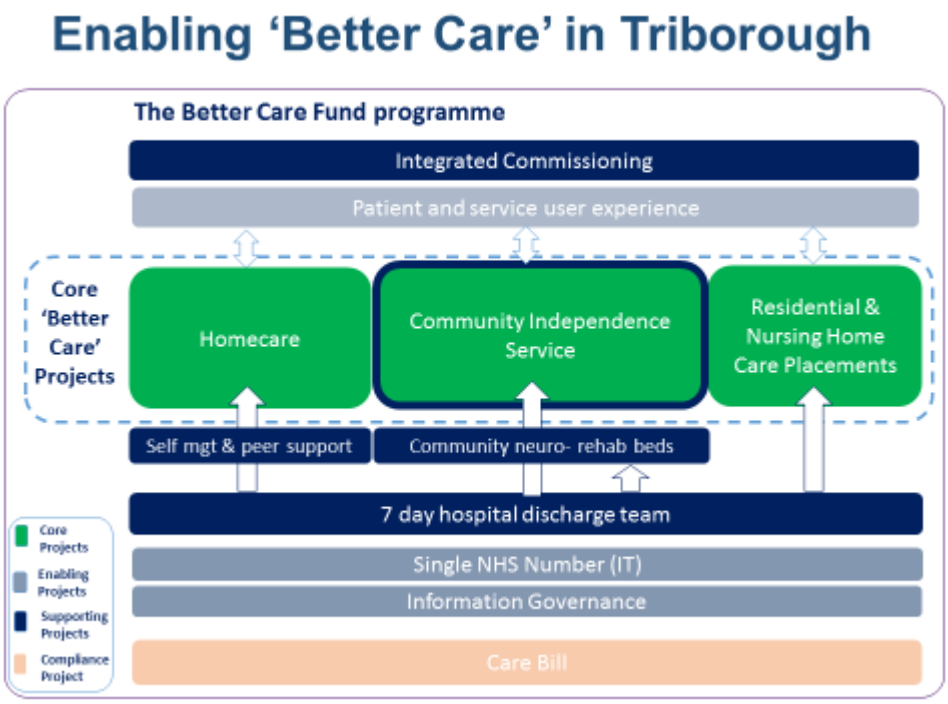
4.3. The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community settings. This will build on CCG Out of Hospital strategies and local authority plans expressed locally through the Community Budget and Pioneer programmes.

4.4. The development of an integrated BCF Plan is a requirement of the DH and the DCLG. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required.

4.5. The Better Care Fund Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including Healthwatch, and reflects the shared aspirations for integrated care.

5. REQUIREMENT FOR RESUBMISSION

5.1. The Health and Wellbeing Board approved the BCF Plan 2014-16 at the meeting held on 24th March 2014 and the Plan was subsequently submitted to NHS England on 4th April. A summary of the BCF schemes is captured in the diagram below.



5.2. The Tri-borough BCF Plan was considered of good quality by NHS England (NHSE), the Local Government Association (LGA), DH and DCLG, and the three authorities were among a small number approached in July to be "fast-track" BCF authorities, providing a further example to other authorities of how an acceptable BCF Plan could be developed (although this offer was declined). The plan was rated 2nd nationally following more detailed work on finance and metrics and external assurance.

5.3. Other parts of the country, however, were not able to submit satisfactory plans. In addition concerns were expressed, particularly by the hospital sector, about the arrangements for local risk sharing and pay for performance. A key ambition of the BCF is reducing pressures arising from unplanned admissions to hospital. There was a lack of confidence in the ability of CCGs and local authorities to deliver the necessary changes to achieve this ambition within the timescale and, consequently, a fear that funding would be transferred from the NHS to local authorities but that acute activity would continue unabated.

5.4. Consequently, in July 2014, Health and Wellbeing Board Chairs received letters from the DH and the DCLG announcing some changes to the BCF Programme. The changes related to the Pay for Performance and Risk Sharing arrangements which commence in 2015-16.

5.5. Each area has been asked to demonstrate how the BCF Plan will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

5.6. A proportion of the performance allocation (the local share of the national £1bn performance element of the £3.8bn fund) will be payable for delivery of a locally set target for reducing emergency admissions (they suggested at least 3.5% reduction). The balance of the allocation will be available upfront to spend on out of hospital NHS commissioned services, as agreed by the Health and Wellbeing Board. This provides greater assurance to the NHS and mitigates the risk of unplanned acute activity. If the target for reducing admissions is not met, a proportion of the £1bn funding will remain with the NHS and not transfer to the BCF for joint use.

5.7. The reduction in unplanned admissions indicator will be the only indicator underpinning the pay for performance element of the BCF. Hospital providers are being asked to confirm agreement with the proposed reduction in non-elective activity.

6. THE REVISED BETTER CARE FUND PLAN

6.1. On 25th July NHS England and the Local Government Association sent Health and Wellbeing Board Chairs revised BCF guidance and planning and templates for completion and submission by 19th September 2014. A revised BCF Plan is being prepared. The key changes from the BCF Plan previously approved by the Health and Wellbeing Board are as follows:

6.2. Target reduction of around 3.5% in total emergency admissions (replaces the previous metric of approximately 5 % reduction in avoidable emergency admissions). Funding linked to achievement of this target will be released by the CCG into the pooled budget on a quarterly basis, depending on performance, starting in May 2015, based on Q4 performance in 2014-15.

6.3. The remainder of the £1bn national fund (the performance element of the £3.8bn) will be released to the CCG upfront in Quarter 1 in 2015-16.

6.4. If the locally set target for reduction in emergency admissions is achieved, all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. Achievement will be measured against the total figure for the whole area, not just against those activities within the BCF Plan.

6.5. It should be noted that if the target is not achieved, the remaining performance money will not leave the local area, it will remain with the CCG to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board.

6.6. The system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. The revised arrangements need to be taken into account in both CCG and Local Authority planning for 2015-16.

6.7. Local authorities nationally have expressed concerns at the changes which step back from the core purpose of promoting locally led integrated care and reduce the resources available locally to protect social care and prevention initiatives.

6.8. However, within the Tri-borough area there is confidence that the target level of reduction in emergency admissions can be achieved so that the maximum level of allocation will be transferred to the BCF pooled budget for integrated services.

6.9. The NHS commissioned services can include NHS spend on those services currently commissioned by the local authority on behalf of the NHS or commissioned jointly through s75 agreements, which form a significant element in the Tri-borough BCF.

6.10. There is, however, a risk to Adult Social Care from these changes and the position will need to be monitored closely through the year to assess progress against target and the impact of any shortfall in the pooled budget on integrated services. A reduction in emergency admissions is likely to lead to an increased use of social care which needs to be funded.

6.11. The revised plan will provide additional material in relation to the following areas:

6.12. **The case for change** – analysis and risk stratified understanding of where care can be improved by integration, which has informed the key BCF workstreams of community independence services including reablement and 7 day working.

6.13. **A plan of action** – a clear evidence based description of the delivery chain which will support a reduction of emergency admissions, developed with all local stakeholders and aligned with CCG, local authority, provider and whole system strategies.

6.14. **Strong governance** – confirmation of local management and accountability arrangements and description of tracking arrangements to monitor the impact of interventions, take action to address slippage, and robust contingency plans and risk sharing arrangements across providers and commissioners locally.

6.15. **Protection of social care** – this reflects existing funding transferred via s256 from NHS England for current levels of work. The level of protection of social care identified for LBHF in 2014-15 is £3.287m with £85k identified for implementation of the Care Act; in 2015-16 £3.287m with £454k for the Care Act.

6.16. **Alignment with acute sector and wider planning** – evidence of alignment with the NHS two-year operational plans, five year strategic plans, and plans for primary care as well as the local authority. Evidence is provided that providers are engaged in the BCF programme and have understood the impact of the plan on their services.

6.17. In addition the revised BCF Plan will set out in more detail the amount of funding going into carer support and the nature of that support.

7. CONSULTATION

7.1. The revised BCF template seeks evidence of provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions have been held with major providers, acute and community, during June-September to increase their awareness of the detailed BCF programme. The strategic plans already agreed with local hospitals include a significant shift of work into the community and a reduction in emergency admissions.

7.2. Shaping a Healthier Future (SaHF) and the Out of Hospital Strategies set out the plan to reconfigure hospital services to focus on the needs of patients. These plans have been developed and consulted upon, with local authority, acute, community and mental health services and other local stakeholders fully engaged. The plans contained in the BCF are consistent with SaHF plans to shift work to community / primary care settings.

7.3. Acute Trusts are aware of the BCF and its intention to strengthen and harmonise the approach to community care and confidence in out of hospital provision, particularly through links to the Urgent Care Boards. The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. Arrangements for further engagement at Chief Executive level prior to plan re-submission are in progress. There will also be further engagement with all providers over the coming months to involve them in co-design of in depth solutions facing the health and social care economy in Tri-borough.

7.4. The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, informed by patient and service user feedback. The approach to developing the BCF is characterised by co-design and co-delivery, supported by extensive stakeholder engagement, including with clinicians, other CCGs and local authorities, provider organisations and national bodies.

8. EQUALITY IMPLICATIONS

8.1. Each workstream within the BCF programme will be preparing an Equality Impact Assessment and as the programme develops a programme-wide EIA will be prepared. The programme contributes to the implementation of integrated health and care services across the tri-borough area and will improve services for the most vulnerable adults in the community.

9. LEGAL IMPLICATIONS

9.1. The DH and the DCLG have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

9.2. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to 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, which will allow for the inclusion of the Disabled Facilities Grant.

9.3. Implications verified by: Andre Jaskowiak, Senior Solicitor, Bi-Borough Contract Law Team. Tel: 020 7361 2756

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. A summary of the financial implications included in the original BCF Plan is in the table below.

10.2. In 2015-16 the minimum value required of the BCF Pooled Budget across Tri-borough is £47.836m and the Tri-borough authorities are proposing around £210m, which mostly reflects existing pooled budgets or jointly commissioned services. Of this, around £47m will come from the London Borough of Hammersmith and Fulham) and around £32m from H&FCCG. **These figures will be refined prior to resubmission**.

10.3. The BCF Plan estimated that the programme will contribute to the delivery of around £15m in savings across Tri-borough partners in 2015/16, if targets are fully met, as shown in the table below**. This figure will be refined prior to resubmission.**

10.4. We have constructed and are finalising a detailed financial and activity model which demonstrates the linkages and flows of costs and benefits across health and social care as a result of the new proposed ICR/CIS. The model is based on current data and agreed assumptions of the Technical Working group. At the core of this is the new Integrated Crisis Response / Community independence Service and the linkages between that service, homecare and residential and nursing home placements.

10.5. The model will enable the local authority and CCGs to take an informed view over the different pressures and costs of redesigning core components of out of hospital care and the subsequent shift in activity and flows of people in order to come to a mutually beneficial agreement over the impacts and associated reimbursements. . **This is required to provide reassurance to the local authorities that social care will not be negatively impacted by the BCF.**

10.6. The revised BCF Plan will include figures based on latest estimates of costs and savings. These are continually being refined and it is anticipated that revised proposals will be submitted periodically through 2014-15 as the detailed modelling of the integration work is undertaken.

Tri-borough Better Care Fund Financial Summary (July 2014 figures)

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 '000	Minimum contribution (15/16) '000	Actual contribution (15/16) '000	Anticipated Benefit
Westminster City Council	Y	*28,765*	*1,379*	*26,252*	4,896
Royal Borough of Kensington and Chelsea	Y	*22,946*	*874*	*22,004*	
London Borough of Hammersmith and Fulham	Y	*49,720*	*1,052*	*47,781*	
Central London CCG	N	*26,171*	*13,553*	*42,768*	3,366
West London CCG	N	*15,811*	*17,830*	*39,746*	3,572
Hammersmith and Fulham CCG	N	*12,630*	*13,148*	*31,923*	3,873
BCF Total		**156,043**	**47,836**	**210,474**	**15,707**

Actual savings will be tracked by borough or, where at tri-borough level, will be pro-rated by population. Our intention is for the local authorities to hold the pooled budget, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, either LA or CCG.

10.7. Implications verified/completed by: Rachel Wigley, Director of Finance, Tri-borough Adult Social Care.

11. RISK MANAGEMENT

11.1. The BCF Plan includes a section on risks and mitigating actions.

11.2. Implications verified/completed by: Mike Rogers, Risk Lead Adult Social Care [confirm]

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. There are no specific procurement and IT strategy implications relating to the BCF Plan except that one of the national conditions

12.2. Procurement and IT Strategy implications relating to individual initiatives within the Better Care Fund Plan will be brought separately to the Cabinet and, where appropriate, to the Health and Wellbeing Board, for consideration.

12.3. Implications verified/completed by: (name, title and telephone of Procurement Officer)

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Better Care Fund Plan March 2014		