TO: HEALTH AND WELL BEING BOARD
17 SEPTEMBER 2014

BETTER CARE FUND (BCF)
Director of Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 The Government has recently changed the requirements of the Better Care Fund programme, This report sets out those new requirements, the implications and risks for the Council and Clinical Commissioning Group to enable the Health and Wellbeing Board (HWBB) to understand and influence the submission of to NHS England (NHSE), which is due by 19 September.

2 RECOMMENDATIONS

2.1 That HWBB note the changes to the Better Care Fund requirements, and the potential implications for all organisations in the Health and Social Care economy.

2.2 That HWBB agree the submission in accordance with the requirements and delegates final sign off to the Chairman of the Better Care Fund Board.

3 REASONS FOR RECOMMENDATIONS

3.1 To ensure that HWBB are fully briefed on the national programme, and local implications.

3.2 To ensure that the plans developed by the CCG and the Council detailing the local response to implement the Better Care Fund take an appropriate approach to minimising risk whilst maximising benefits for the local population.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 The programme lead at NHS England has been clear that “any plans that are not submitted in time, will be rated as ‘not approved’ which means that those areas will not be able to get on and action their plans - as they will not be approved to do so.”

5 SUPPORTING INFORMATION

Historical context (see background papers)

5.1 Simplistically, the Better Care Fund is a national programme intended to improve services for local populations by enhancing or extending local community based services, thereby reducing avoidable hospital admissions, and over-lengthy stays in hospital. The resultant reduction in demand on Acute Trusts and associated reduction in funding requirement from NHS would then be available to fund the community-based services, both healthcare and social care.

5.2 Each local Health and Wellbeing Board was required to submit plans to NHS England detailing how they would achieve this, the performance areas under consideration being:-

- Reducing permanent admissions to care homes
- Older people being at home >91days after discharge
- Delayed Transfers of Care, out of hospital
- Avoidable emergency admissions
- Individual experience
- Falls - Local metric

5.3 The money available to achieve this was originally from existing resources (the S256 – NHS Transfer for Social Care - in Bracknell Forest £1,658K, which was money already committed to jointly agreed priorities). The CCG in 2014/15 allocated £302k to preparing for BCF and encourage use of the Bracknell CCG Transformation Fund of £1.048m making £3. 008m. The funding detail for 2015/16 is set out in Annexe 1 to this report.

5.4 The original intention had been for a proportion of the funding to be paid on the achievement of the predicted outcomes, but this – unspecified - condition was later removed (before submission due April 2014).

5.5 In June/July the NHS England and DoH analysed the plans submitted from all LA/CCG partnerships, and it became clear that the combined proposals for investment in community services would not achieve the reduction in demand – therefore savings - on Acute Hospital Trusts that would be required to release the funding. This then would create significant cost pressures in the NHS.

Implications

5.6 In July, NHS England issued revised requirements for the Better Care Fund plans. (See Annex 2 - revised planning guidance & Annex 3 – revised technical guidance). Whilst the original outcomes (as in 5.2) are still a consideration, there is an increased emphasis on achieving reductions in emergency admissions to hospital / A&E attendance. There is now a requirement to plan over a five year period rather then the two year period expected previously.

5.7 A proportion of the original funding (approx. 25%) has been identified for a more prescriptive approach to achieving the required outcomes. (£1bn nationally, £1,761K for Bracknell Forest) This has been removed from the original arrangements, and now has national performance requirements attached:- Pay for Performance (P4P), dependent on the achievement of targets associated with reduction in emergency admissions, and a ring-fenced allocation for the CCG to commission out-of-hospital services.

5.8 The “split” of this allocation into P4P and CCG ring-fenced allocation varies according to the performance targets submitted by the HWBB in the Plan. Each HWBB needs to agree a local target for the reduction in emergency admissions. The minimum target that NHSE will accept is 3.5% for 2015/16, unless an area can make a credible case as to why it should be lower. This target would see the performance fund split on a 30:70 (P4P/CCG) basis (£528K/£1,233K for Bracknell Forest). The full £528K would only be payable **to the fund** if the 3.5% target is achieved, with reduced payment made according to the relative performance achieved. **The proportion of the £528K that is not paid to the fund would have to be held by CCG to**

commission from health, most probably to pay the Acute Trusts for the emergency care provided. (This is known in health as over performance). Thus there are significant financial risks to the Council and CCG if the money is committed. And does not deliver the required reduction in Non elective admissions.

5.9 If a higher target is agreed, then the "split" changes, with a greater proportion of the funding being dependent on achieving the target. However any balance not paid to the Council is still paid to the CCG.

Developing the plan

5.10 At its meeting in February The HWBB agreed to the creation of a Better Care Fund Board, initially to get on with the business of looking at what is needed and to pursue the appropriate commissioning and decommissioning arrangements.

5.11 The changes required by NHSE have resulted in the BCFB having to focus its time on developing the necessary plans which will be assessed by NHSE and LGA with advice to ministers. The 19 September is the final deadline. According to NHSE "It is intended that by the end of October, every plan will have received an approval rating of: 'approved', 'approved with support' or 'approved with conditions'. There will be a programme of support and/or conditions after the initial BCF planning process, with different timetables depending on our area's status. This phase has yet to be developed. "

5.12 The revised plan is attached at Annexe 1 to this report, the Board will note that it is significantly more detailed than that required in February, as a consequence of the changing requirements.

5.13 The following sets out Key areas of the new plan.

Vision

5.14 The 'high level' vision for Bracknell Forest over the next five years has three key elements:

- **Prevention:** Our focus will be on health, not illness. The population will be happier, healthier and active for longer; through having access to better information and support to make the right choices.

- **Personalisation:** Our care and support will respond to the individuals' choices and needs. This will begin with ensure that people only have to tell their story once. We will then support them and their carers to achieve the outcomes that are important to them.

- **Partnership:** An integrated system across health and social care will develop with the individual at its centre. Improvement will also be driven by partnership with local people and learning from what they tell us about their health and experiences of using services.

5.15 Within each of these elements, there are clear changes needed between now and 2019. Specific improvements are planned, linked directly to our current Joint Strategic Needs Assessment, Health & Well-Being Strategy and Commission Plans.

Case for Change

"We need to consider older people as our key priority"
Our starting point in our analyses was a projection of changes in the structure of our population. Notable in these projections is the fact that our local growth population aged 65 years or older significantly exceeds the corresponding growth in this age group across England.

"We need to improve self-care of long term conditions"
Looking beyond the structure of the population, evidence also pointed to a need to prioritise prevention and self care, particularly within the context of long term conditions. This conclusion was drawn from a combination of data indicating a growth in the number of older people with long term conditions and data on how well we are supporting people to manage those conditions.

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"We need to improve our control of costs in relation to those at the high level of risk"
We conducted risk stratification analyses with the aim of exploring the potential for reducing costs related to hospital admissions. In terms of risk stratification, areas will vary according to the proportion of acute hospital costs that are attributable to people at different levels of hospital admission risk.

"We need to prioritise Musculo Skeletal and Trauma & Injuries admissions, with a particular emphasis on the prevention of falls among older people"

Analyses from Public Health England, together with NHS England, provided a triangulation of national datasets that indicated where individual CCGs could make the most improvements in relation to reducing costs. Specifically, the analyses predicted where significant improvements could be made if performance matched those of the top five CCGs within a cluster of 'similar' CCG areas.

In relation to non-elective admissions, the analysis suggested that most significant savings for Bracknell & Ascot were potentially related to Musculo Skeletal and Trauma & Injuries admissions.

- Plan of Action
  This identifies the key milestones and deliverables of the plan, alongside the governance arrangements for making this work. In determining the schemes identified, the BCFB felt that only schemes worth more than £100k or those of strategic importance should be included at this stage.

- Risks and Contingency

- Alignment with strategies

- Protection of Social Care Services

- National Conditions

- Engagement

- Implications for Acute Providers

- Detailed scheme description

- Provider Commentary

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal provisions and risks are set out in the main body of the report.

Borough Treasurer

6.2 There are considerable financial implications for the Council from the introduction of, and recent changes to, the Better Care Fund.

In respect of 2015/16, the minimum size of the Better Care Fund is £6.65m. It should be noted that £1bn of the total national fund of £3.8bn is payable on results, and £300m of the £1bn is at risk of not being paid if results on emergency admissions are not achieved. In Bracknell the money that is at risk is £528k.

There is a risk that money to this value will be spent on efforts to achieve the outcome required, but will not be paid if the required outcome is not achieved. Whilst it is the performance of the CCG that would be deemed to have been successful or otherwise, it is potentially the finances of the Council that are at risk. It is therefore essential that the agreed submitted plan for the Better Care Fund takes account of this risk in order to mitigate or avoid it.

However, the introduction of the Better Care Fund should be regarded as an opportunity to achieve better outcomes for people locally, and potential efficiencies in the local Health and Social Care Economy.

Impact Assessment

6.3

Strategic Risk Management Issues

6.4 In order to achieve the targets, funds must be committed to the development of new services, or new ways of working within the community. There are a number of workstreams that will contribute to the achievement of the target, and those must include both social care and joint ASC-CCG approaches to “replace” emergency admissions. However, to be effective, these initiatives **must** be accompanied by changes in behaviour within the NHS – particularly Acute Trusts and GP practices. The most crucial projects are not within the control of – or even significant influence of – the Council. Yet it is the Council that carries a proportion of the risk.

It should be noted that there is little incentive here for the Acute Trusts to change their behaviour: they are paid for activity undertaken, and this latest approach provides little or no additional impetus for change. In fact, there is a perverse incentive within the NHS, generated by the “tariff” approach to payments for Acute providers and block arrangements for Community Providers.

In summary – there are significant challenges to achieving the required change in practice within the NHS: however in order to do so, there must be an investment from Social Care, which may or may not be “refunded” through the BCF.

7 CONSULTATION

Principal Groups Consulted

7.1 n/a

Method of Consultation

7.2 n/a

Representations Received

7.3 n/a

Background Papers

HWBB paper: Better Care Fund – 13 February 2014
Revised Planning Guidance
Revised Technical Guidance

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