



Health and Wellbeing Board

5 February 2014

Time 2.00pm
Oversight

Public meeting? YES

Type of meeting

Venue Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Room Committee Room 3 (3rd floor)

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS – PART 1

1. **Apologies for Absence**
2. **Notification of Substitute Members**
3. **Declarations of interest**
- 4 **Better Care Fund**



Health and Wellbeing Board

5 February 2014

Report title	Better Care Fund	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group Wolverhampton City Council	
Accountable employee(s)	Richard Young	Director of Strategy and Solutions 01902 445797 Richard.young@nhs.net
	Viv Griffin	Assistant Director – Health, Wellbeing and Disability Viv.griffin@wolverhampton.gov.uk 01902 555370
Report to be/has been considered by	N/A	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

The Health & Well-Being Board are requested to:

- Receive the presentation and updates at the meeting in order to consider the first cut submission of the BCF Plan.
- Consider the first cut BCF Plan and approve its submission.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

- The contents of the report in relation to the creation of the Better Care Fund.

1.0 Purpose

- 1.1 The purpose of this report is to inform the Health & Well-Being Board of the requirements upon Councils and Clinical Commissioning Groups (CCGs) to create a pooled budget as an enabler for change within the local health and care economy.
- 1.2 Unfortunately, work on developing the Plan will be continuing almost up to the deadline for submission. As a result, it is not possible for a report to be produced for The Health & Well-being Board with sufficient detail in accordance with the routine deadlines for committee papers.
- 1.3 It is proposed that this report is submitted with the Agenda for distribution to provide members with a general overview of the BCF and that the Plan to be submitted on 31st January is circulated to members as soon as practical before the meeting of the Health & Well-being Board on 5th February. Copies will also be available on the day of the meeting.
- 1.4 A presentation will be given to members on the key elements of the Plan at the meeting to provide members with the necessary detail and information in order to consider the Plan. It should be noted that the Plan will be an initial document and still under development

2.0 Background

- 2.1 The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

What is the Better Care Fund?

- 2.2 The Better Care Fund (BCF) provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.
- 2.3 The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transform.

What is included in the Better Care Fund and what does it cover?

- 2.4 Nationally, The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.
- 2.5 There is very little new money or uncommitted resources in the BCF process.
- 2.6 In Wolverhampton, it means that a joint fund of just over £20m will be created using a variety of existing budgets, in brief these are:
- CCG mainstream allocations
 - NHS support for Social Care (section 256 monies)
 - Disabled Facilities Grant (DFG)
 - Some Social Care capital Grants
- Some of these funds will still be subject to restrictions placed upon them and further guidance is expected on their usage as part of the BCF.
- 2.7 It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.
- I. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
 - II. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will the Better Care Fund do differently?

- 2.8 The June 2013 Government Spending Round was extremely challenging for local government - handing councils reduced budgets at a time of significant demand pressures on services. Meanwhile, the NHS has increasing demand creating a significant affordability and sustainability challenge.
- 2.9 In this context the announcement of £3.8 billion worth of funding is to ensure closer integration between Health and Social Care. This has been viewed locally as a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society.

- 2.10 The funding – which is drawn from existing budgets - is described, nationally, as ‘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’.
- 2.11 One of the key tenets of the BCF is that we (the key agencies and stakeholders) must give people control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. In Wolverhampton we have the opportunity to do something radically different to improve services and quality of life.
- 2.12 It should also be noted that an element of the national funding will be ‘held back’ pending achievement of satisfactory performance against the national conditions and metrics (see section 3). Approximately 25% of the national budget will be initially retained and then distributed on a ‘Payment-for-Performance’ basis in year. Failure to achieve the target performance may require the local Health & Care economy to produce a recovery plan – to be approved by ministers – before the payment-for-performance element is released.

3.0 Progress, options, discussion, etc.

- 3.1 In June 2013, the four major statutory agencies and stakeholders in the Local Health & Social Care Economy in the city agreed to come together to find opportunities for better integrated working between the agencies. This initially culminated in ‘integrated Pioneer’ project based around dementia services. Whilst this bid for external funding was unsuccessful, all partners resolved to continue the work. This partnership has evolved into the basis of the Integration Transformation Fund / Better Care Fund.
- 3.2 This work has produced a whole series of events across the health and social care economy and also across the widest range of participants and staff. These events have included front line staff and all four CEO’s from the major agencies. All of this work has been underpinned by core planning group comprised of the planning and finance directors from each organisation with support from a small team of programme support management.

Four workstreams have been identified:

- Mental Health De-escalation
- Nursing & Residential Care
- Intermediate Care, Rehabilitation, Reablement
- Dementia Care Management.

Local Structures

- 3.3 The Chief Executives of the Provider Trusts (The Royal Wolverhampton NHS Trust and The Black Country Partnership Foundation Trust), the Accountable Officer of Wolverhampton Clinical Commissioning Group (CCG) and the Executive Director of the Community Directorate of Wolverhampton City Council have set up a structure to develop the response to the requirements of the Better Care Fund and implement the plan.
- 3.4 A Front Line Staff event was held on the 17th December 2013, where in excess of 50 people representing carers, voluntary groups, health and social care staff - who have a role in one (or more of the workstreams) - met to discuss :
- Work & successes to date
 - 'Opportunities from what we have now'
 - 'Opportunities in what we do'
 - 'Under what circumstances' – present assets & new opportunities
 - 'Opportunities in what we have lost'.
- 3.5 This event confirmed that the chosen workstreams were relevant and that not only was there an opportunity to effect some immediate, practical, actions but that there was scope for transformation of services.

National Requirements

- 3.6 The Plan (when finalised) will need to be jointly agreed between the Council and the CCG – and signed off by the Health & Wellbeing Board.

National Conditions

- 3.7 There are six national conditions which the Wolverhampton Better Care Fund plan has to meet.
- Protection for social care services (not spending);
 - Provide 7-day services in health & social care to support patients being discharged and
 - Prevent unnecessary admissions at weekends;
 - Better data sharing between health & social care, based on the NHS number;
 - 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;
 - Agreement on the consequential impact of changes in the acute sector.

National Metrics

- 3.8 In addition to the conditions, national metrics will underpin the delivery of the fund:

1. Permanent admissions of older people (aged 65 & over) to residential and nursing care homes, per 100,000 population – reducing inappropriate admissions of older people (65+) into residential care;
 2. Proportion of older people (65 & over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services – increase in effectiveness of these services;
 3. Delayed transfers of care from hospital per 100,000 population – effective joint working facilitating timely and appropriate transfer from all hospitals for all adults;
 4. Avoidable emergency admissions – reduce emergency admissions which can be influenced by effective collaboration across the health and care system;
 5. Patient/service user experience.
- 3.9 There is a requirement for an additional locally set indicator to be used as part of the outcomes reporting framework.

Reporting Requirements

- 3.10 The Health & Wellbeing Board must submit the first cut of the completed Better Care Fund template, as an integral part of the CCG's Strategic & Operational Plan by the 14th February 2014. A revised version will be submitted to NHS England, again as part of the CCG's Strategic & Operational Plan by 4th April 2014.
- 3.11 However, in addition to the above, the Midlands and East Regional Office of NHS England has stated that it requires the first cut template document to be completed and submitted via NHS Area Team offices by 31st January. At the time of writing, it is anticipated that the template will have been submitted – subject to ratification by the Health & Well-being Board at its meeting on 5th February 2014.

Report to the Health & Well-being Board

- 3.12 It is clear that the reporting framework provides a challenge in developing the plan and placing it before the Health & Well-being Board prior to submission. Indeed, work on developing the Plan will be continuing almost up to the deadline for submission. As a result, it is not possible for a report to be produced for The Health & Well-being Board with sufficient detail in accordance with the routine deadlines for committee papers.
- 3.13 To work around these logistical challenges, it is proposed that this report is submitted with the Agenda for distribution to provide members with a general overview of the BCF process. It is further proposed that the Plan to be submitted on 31st January is circulated to members as soon as practical before the meeting of the Health & Well-being Board on 5th February. Copies will also be available on the day of the meeting. A presentation will be given to

members on the key elements of the Plan at the meeting to provide members with the necessary detail and information in order to consider the Plan. It should be noted that the Plan will be an initial document and still under development.

Creating the Wolverhampton Plan

- 3.14 As part of the Wolverhampton Better Care Fund plan there is a need to agree a compelling narrative that can act as a springboard to action, to mobilise the system, ensuring a sense of community with a shared story, the ability to tell the story quickly, simply and memorably and clarity of ambition. An event has been arranged for the development of this narrative on the 28th January with representatives from of key stakeholders.

It is important that all stakeholders have been engaged in the development of the Wolverhampton Better Care Fund plan and to this end a 'Whole System Event' has been organised for the 28th January 2014. As indicated previously, a special meeting of the Health & Wellbeing Board – to sign off the plan – has been organised for 5th February 2014.

- 3.15 There will be a need for further meetings after the initial submission on the 14th February to prepare for the final submission on the 4th April 2014.

4.0 Financial implications

- 4.1 In 2015/16 the Fund will be allocated to local areas, where it will 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. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.
- 4.2 National Guidance has set out that Councils will receive their detailed funding allocations in the normal way and NHS allocations will be two-year allocations for 2014/15 & 2015/16 to enable more effective planning.
- 4.3 The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

BCF Allocations for Wolverhampton

- 4.4 The table below sets out the known detail of the allocation for the City. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.
- 4.5 The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

		£,000
Disabilities Facilities Grant	£	1,319
Social Care Capital Grant	£	766
<i>Sub-total :CCG Budgets</i>	<i>11,630</i>	
<i>Sub-total: S256 monies</i>	<i>6,309</i>	
Total £ from CCG for BCF	£	17,939
Total	£	20,024

5.0 Legal implications

- 5.1 Further advice will be sought in due course when creating the legal framework for the pooled budget. This will be reported back to the Health & Well-Being Board.

6.0 Equalities implications

- 6.1 Further advice will be sought in due course when creating the work programme for the pooled budget. This will be reported back to the Health & Well-Being Board..

7.0 Environmental implications

- 7.1 No direct implications at this stage.

8.0 Human resources implications

- 8.1 Further advice will be sought in due course when creating the work programme for the pooled budget. This will be reported back to the Health & Well-Being Board.

9.0 Schedule of background papers

- 9.1 **References:**
Better Care Fund Planning Guidance & support tools – Local Government Association

This report is PUBLIC
[NOT PROTECTIVELY MARKED]

Better Care Fund Planning – NHS England
NHS Act 2006

Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund
(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.
2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.
3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.
5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	2015/16
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
<p>£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise:</p> <ul style="list-style-type: none"> • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.
7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance¹ from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:
8. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*
9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*
10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*
11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.
13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement
14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.
 - i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
 - ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75² 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.
16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.
17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.
18. 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

² Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier 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 this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.
20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which 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 such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.
21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH 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. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.
23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).
24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.
25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.
34. CCGs and councils 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 disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

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

National Condition	Definition
Plans to be jointly agreed	<p>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.</p> <p>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.</p>

National Condition	Definition
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.
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	<p>Local areas are asked to confirm how their plans will provide 7-day 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.</p> <p>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 within existing resources.</p>
Better data sharing between health and social care, based on the NHS number	<p>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.</p> <p>Local areas should:</p> <ul style="list-style-type: none"> • 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. <p>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).</p>

National Condition	Definition
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	<p>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.</p> <p>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.</p>
Agreement on the consequential impact of changes in the acute sector	<p>Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in.</p> <p>Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.</p>

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.
37. 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.
38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: <ul style="list-style-type: none"> • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: <ul style="list-style-type: none"> • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. 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.

40. 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.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. 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.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two

of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

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

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.
45. 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.
46. A menu of possible local metrics selected from 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	Estimated 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 contact with secondary mental health services living independently with or without support
1D	Carer-reported 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”
2.24i	Injuries due to falls in people aged 65 and over

47. 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.

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

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. 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.

51. 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 be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be

achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.
54. 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.
55. 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.

What will be the consequences of failure to achieve improvement?

56. 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.

57. 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.
58. 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.
59. 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.
60. 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.
61. 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.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA's websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.
64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to:

NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	<Name of Local Authority>
Clinical Commissioning Groups	<CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s>
Boundary Differences	<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>

Date	<date>
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<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Please explain how local social care services will be protected within your plans.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG

Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them.
This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
<Risk 1>		
<Risk 2>		
<Risk 3>		
<Risk 4>		