POLICY BRIEFING

Planning for the Better Care Fund

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Summary

This report by the National Audit Office (NAO) gives a blow by blow account of how government departments devised, amended and assured planning for the Better Care Fund (BCF). In essence, while the NAO believes that the fund has potential, it is highly critical of how it has been managed, and doubts whether the programme will make the expected savings.

This is one of the most highly critical reports ever published by the NAO. Many of the points made, however, are consistent with the views of a range of health and care experts – the BCF is a good policy, but savings are too ambitious, timescales too tight, and revisions have taken it from its original local, preventative focus.

Despite all this, a huge amount of excellent work has gone into developing plans for integration, and the focus must now be on delivering the benefits to people who need health and care services.

This briefing will be of interest to councillors and officers in councils with adult social care responsibilities, and to those involved in health and wellbeing boards and health overview and scrutiny.

Briefing in full

The Better Care Fund timeline

This timeline traces the development of the BCF over the past eighteen months. It shows that much has happened in a relatively short space of time.

June 2013

The BCF was announced in the spending round. The aim was to pool £3.8 billion of existing funding, mainly from the NHS, into a single budget to provide integrated health and care to provide seamless services, reduce the need for hospital admission, and protect adult social care services. The spending round made an

assumption of savings of £1 billion from implementing the programme. The Department of Health (DH) and Department of Communities and Local Government (DCLG) developed the policy with NHS England and the LGA.

October 2013

Draft guidance was issued. The BCF was to be a local initiative led by councils and CCGs with a range of support from the LGA and NHS England available to local areas on a voluntary basis. The NAO indicates that there was no central programme team, limited risk management and no analysis of local planning capacity and capability. The guidance did not include the £1 billion savings requirement, or the need to show how savings would be achieved.

Feb 2014

Health and wellbeing boards, which had to approve plans, submitted first drafts.

April 2014

Health and wellbeing boards submitted their plans for approval. The total amount of savings they identified for 2015-16 was £731 million, but 53 health and wellbeing boards submitted plans identifying no savings. Areas were planning to pool £5.5 billion, and the additional £1.7 billion was seen as an endorsement of the fund's potential to improve services. The government allocated £200 million so local areas could start reforms, such as recruiting and training staff.

May 2014

NHS England estimated that only £55 million of the £731 million proposed savings were 'credible' and concluded that plans were overly optimistic. It found that local areas that had not engaged effectively with acute trusts estimated greater savings than those that had involved local hospitals. DH and DCLG also concluded that aspects of plans needed further development, and the approval process was halted.

The NAO does not mention this, but during this period many NHS bodies, particularly hospitals and their organisations, were waging a high profile campaign expressing concern about the impact of the BCF on their ability to provide services, and voicing suspicions that funding would be used to plug holes in local authority budgets, sometimes, literally, holes in roads.

May to July 2014

New guidance was issued, with significant changes. Part of the £1 billion element of the fund which was related to performance would now be paid solely on one indicator – a reduction in emergency admissions to hospital. Areas were asked to aim for at least a 3.5 percent reduction on 2014 levels, representing £300 million savings to NHS commissioners – or a smaller reduction if agreed by all local parties.

For example, areas are at different starting points for what has already been achieved in reducing unplanned admission.

The rest of the £1billion would have to be spent on NHS commissioned (or jointly commissioned) out of hospital services (rather than social care or prevention). Plans had to show how acute providers were involved, and providers supplied a commentary on the planned activity changes.

Government also tightened up the governance and programme management of the fund, with single NHS England 'responsible owner' – the National Director for Commissioning Operations. A programme director was established, and those involved in supporting the BCF were combined into a task force. A risk register was introduced, and £6.1 million extra funding to support and assure local plan development was allocated.

September 2014

Health and wellbeing boards submitted revised plans.

October 2014

Following independent assurance process, of plans submitted by the 151 health and wellbeing boards – six plans were approved outright, 91 needed a small amount of extra work, 49 were improved with conditions and five plans were not approved. Areas planned to pool £5.3 billion, 39 percent more than the minimum requirement of £3.8 billion but £0.2 billion less than April. The savings projection is £532 million, with emergency admissions forecast to fall by 3.1 percent. The assurers identified protection of social care services as the biggest risk, with 21 areas assessed as having material risks. In 20 percent of areas, providers gave heavily qualified support for the plan. NHS England required 12 areas to improve provider engagement.

January to March 2015

The first quarter when the level of reductions in emergency admissions will determine payment for performance.

April 2015

The first non-performance related payment for the Fund.

May 2015

CCGs will release the first of four in arrears payments for performance, based on reductions in admissions in January to March 2015 compared to January to March 2014 – provided this is achieved, or that the CCG considers this is the best way to address why the target has not been met.

NAO analysis

The NAO indicates that the BCF is innovative, with real potential to integrate health and social care. However, it was based on assumptions that integrated care would be effective in reducing emergency admissions on a sustainable basis, improving outcomes and saving money. The NAO believes that the evidence for this is 'tenuous', particularly when emergency admissions have been rising for many years and data is variable. Another dubious assumption was that this could be done without additional or transitional funding and within the same year. A further constraint were the financial stresses facing local authorities and, increasingly, the NHS.

The NAO believes that government departments and NHS England 'underestimated the complexity of bringing together the different health and social care organisations around a single local vision in a relatively short time'. Measures put in place during the July hiatus have 'much improved' the Fund's governance and programme management. However, the requirement to resubmit plans also meant areas lost time which should have been used for preparation. While the pause was the right thing to do, it also 'undermined the Fund's credibility with local bodies and increased the risks involved in implementing it'. The NAO concludes that expectations for savings 'are based on optimism rather than evidence'.

NAO recommendations

The NAO makes a series of recommendations for national government including:

- clarify the fund's long term vision, including expected patient benefits and financial savings
- clarify how the fund's performance management will work
- draw up a fund accountability system statement saying how the accounting officers will gain assurance on how local areas spend the fund
- agree financial and service expects with HM treasury and reflect these explicitly in progressive objectives and guidance.

Comment

Nobody could accuse the NAO of pulling its punches in this report; however, Health Service Journal (HSJ) understands that an earlier draft included the comment that the BCF was a 'case study in how not to manage a major cross-departmental programme'.

Local Government Chronicle (LGC) reports that the permanent secretaries of DCLG and DH have strongly objected to the report, and refused to follow a civil service procedure to approve the NAO's use of information. LCG understands that the permanent secretaries believe that the NAO report fails to understand that the programme was seeking to encourage local innovation and delivery.

In one way, the permanent secretaries have a point. Most of the NAO's recommendations are audit-centric, based solely on financial planning and risk management and as such tend towards bureaucratic central command and control.

However, if their recommendations miss the point, elements in their analysis have been echoed by many health and care stakeholders, such as the Kings Fund. Richard Humphries blog states that 'defying gravity would be easier' than reducing hospital admissions by 3.07 percent. Latterly, the HSJ and Serco Commission on Hospital Care for Frail Older People, chaired by University of Birmingham Foundation Trust Chief Executive Dame Julie Moore, supports integration and prevention but warns there is no evidence that these will lead to financial savings in the near future. The belief by politicians that health and social care integration is a 'silver bullet' to tackle NHS financial problems is a 'myth', while the Better Care Fund had been planned in a 'hokey cokey' fashion.

The BCF was greeted enthusiastically at first, particularly by local authorities, but CCGs were often also engaged. In many areas it brought local partners together to have useful conversations about how they could work better together in a formal way. Health and wellbeing boards were often energised by the prospect of overseeing a large-scale development.

However, growing concerns about the impact of pooling so much NHS funding and transferring it so quickly from acute care, with the danger of emergency health services folding and the associated media headlines, led to a swift change of political tack. While these dangers were probably real, it was the speed of implementation without transitional funding and with a requirement for large, same-year savings which made this so.

From a local government point of view, the changes to how the fund operates have been a severe disappointment. The NAO says:
'The LGA sees the Fund's core purpose as promoting locally led integrated care. The Association has stated publicly that the revisions undermine the Fund's core purpose, and reduce the resources available locally to protect social care and prevention initiatives. The delays and changes to the fund have eroded local goodwill and the Association told us that they revised policy and subsequent programme management arrangements had in their view moved the integration agenda backwards and not forwards.' (Paragraph 14.)

Nationally, the Government is said to be considering extending Better Care Fund approaches to public health and children's services; in contrast, in its Five Year Forward View NHS England urges that it should be evaluated before being rolled out further in health and care.

So, the BCF was conceived with good intentions, then hindered by financial worries, political concerns and an excess of enthusiasm rather than sound planning. But plans are now mainly approved and set for implementation. A huge amount of joint work has gone into the plans and it is essential that these should drive forward into

delivery. There is no doubt that in many areas the BCF is going to have a major positive impact on patient care and that some savings will be made. In most areas it is likely to result in many positive outcomes. It is important now that learning and good practice emerging from the work on the BCF are shared and adopted, rather than being blighted by criticisms of its processes.

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