APPENDIX A

BETTER CARE FUND BRIEFING NOTE

Introduction and Background

1. A number of changes were anticipated to the arrangements for the BCF nationally following Department of Health and Department of Communities and Local Government announcements on July 5 and July 11, 2014. This briefing note summarises the key points of the new BCF guidance issued on 25 July 2014.

Refreshing BCF Metrics and Implementing Pay for Performance

2. There is now a pay for performance requirement on the fund linked to achieving a reduction in *total emergency admissions*.

3. Each Health and Wellbeing Board must approve the local threshold for the reduction in total emergency admissions. However there is an expectation that this will need to equate to a 3.5% reduction in 2015/16.

4. The metric is defined as follows: general and acute non elective admissions (*this excludes some categories of admissions, specifically those relating to maternity and mental health acute admissions).*

5. If an area is unable to set a minimum 3.5% reduction threshold then a case will need to be made to NHS England.

6. Of the £1bn to be allocated to BCF plans nationally in 2015/16, £300m will be allocated against the pay for performance requirement for reducing emergency admissions. The remaining £700m must be shown to be invested on care outside of hospital, which must be commissioned from NHS providers.

7. The planning guidance explicitly states that the protection of adult social care remains a top priority.

8. The other national metrics which were introduced with the BCF plans in April will still apply to the BCF resubmissions.

9. See table below for summary details:

BCF Metrics	Original Guidance	New Guidance
Reducing Emergency Admissions	Defined as Avoidable Emergency Admissions only – able to set local ambition Not subject to pay for performance.	Defined as Total Emergency Admissions – must set a minimum of 3.5% reduction in 2015/16. Baseline period has changed. Pay for performance will apply. Monies to be held back by CCGs and released quarterly in arrears dependent on performance.
Improving Patient Experience	National metric was due to be developed, with locally set ambition. Not subject to pay for performance	No national metric will be available. Local metric and level of ambition to be developed. List of possible data sources from patient surveys provided as menu. Not subject to pay for performance.
Reducing the number of permanent admissions to residential and nursing homes	National metric defined with locally set ambition. Not subject to pay for performance	No change to this in new guidance.
Reducing delayed bed days in hospital	National metric and baseline defined with locally set ambition. Not subject to pay for performance.	No change to this in new guidance.
Improving the number of people at home 91 days after hospital discharge into reablement services	National metric and baseline defined with locally set ambition. Not subject to pay for performance	No change to this in new guidance.
Local Metric	Local metric to be selected from national menu (or alternate to be proposed which meets benchmarking criteria). Not subject to pay for performance.	No change to this in new guidance.

10. Baseline periods have been updated to new time periods where applicable and data has been prepopulated for each Health and Wellbeing Board area against which to refresh trajectories where needed.

11. For example, the template for the metrics (Template 2) includes the calculations needed to achieve the total emergency admissions threshold within the given time period.

12. An average unit cost has been given for the cost of an emergency admission which has been applied to the excel templates (£1490).

13. The first period against which performance against the emergency admissions metric will be measured is Q4 2014/15.

14. Payment will be made in May 2015 and will be issued by CCGs. It will be based on the level for performance, so if only 70% of the target has been achieved, only 70% of the payment will be made.

15. Payments will then be made quarterly in arrears on the same basis.

16. Any monies not paid into the fund due to lack of performance will be held by the CCG and spent by agreement with the Health and Wellbeing Board.

17. It is intended that the monies will offset activity incurred in the acute sector as a result of failing to avoid sufficient admissions.

Improving BCF Scheme Benefits and Confirming Provider Support

18. Template Part 1 of the BCF resubmission (the narrative BCF plan) includes two new appendices:

a. The first of these is designed to provide a clearer articulation of each individual scheme within the BCF, showing more detail on the evidence base, activity/financial assumptions, how benefits are to be apportioned across the system and the overall outcomes linked to the vision for health and care integration.

b. The other is for local acute providers to complete, to provide written assurance to the BCF plan, and in particular their agreement to the activity assumptions with respect to emergency admissions reduction.

19. The technical guidance for Template Part 1 includes an extensive checklist against which each plan should be constructed, with a definition of “what makes a good response” in each section of the template.

20. All BCF plans are likely to require a substantial refresh to achieve the level of detail and evidence required to meet all the aspects this checklist now covers.

21. The guidance also highlights where various sections have been updated/added in Template Part 1. These include:-

a. A more structured section on implications of the Care Act and 7 day services, reflecting the national developments in these areas since the last BCF submission was made
b. A stronger set of tests on governance of the delivery of the BCF/integration
c. Greater visibility of the alignment to the 5 year planning arrangements
d. Greater emphasis on how the acute activity shifts will be delivered and managed locally.

22. Template Part 2 (metrics projections and financial analysis) has also been extensively updated per the payment for performance scheme etc., and includes a much more detailed breakdown of benefits analysis by BCF scheme to tie in with the changes in the narrative plan.

23. Due to the requirement to spend a proportion of the fund on local NHS provided care outside of hospital, a detailed breakdown is also required by provider by scheme showing the exact proportion of activity being applied to each scheme and benefits impact by provider.

24. An outline timetable has been given for the assurance of BCF plans. There will be 3 regional check points prior to the 19 September, with support from within local government and the NHS to ensure local areas are on track with resubmission requirements.

25. BCF plans will then be assessed between 19 September and 17 October including at ministerial level.

Risks affecting BCF Plans in light of new Guidance

26. There are a number of risks as a result of the changes to the BCF guidance. These include:

27. Financial Risks:

a. Local areas cannot achieve the pay for performance threshold leading to a reduction in income into the fund
b. Ability of CCGs to achieve financial balance esp. if emergency admissions avoidance significantly outstrips the reduction target and/or other QIPP schemes underperform

c. Impact on funds available for adult social care protection, consequent impact on MTFS.

28. Risk to Assurance:

a. Meeting the other national conditions such as the protection for adult social care/7 day working etc.
b. Meeting the other metrics within the plan (that are not subject to payment for performance).
c. Achieving acute provider sign off (especially if 3.5% reduction in total emergency admissions is very challenging).

29. Risks to Overall Balance of BCF Plan.

a. Disputes on how to re-profile the plan due to the changes
    i. e.g. the plan becomes centralised on emergency admissions avoidance, with investment within the plan diverted primarily to this
b. Less income available for/less priority given to evidence based medium term solutions such as
    ii. Increasing the type/capacity of wrap around services in the community
    iii. Increasing the type/capacity of preventative services in communities

30. Risks to Delivery

a. Resources are diverted to further planning and assurance rather than delivery
b. Stalling in year progress while plans are refreshed
c. Not capitalising on the progress already being made in 2014/15 between partners to deliver new ways of working (which could contribute to BCF impact in 2014/5 and 2015/16, 5 year vision)
d. Further analysis/disputes on impact assessment and benefits of BCF interventions against the metric

31. Reputational Risks

a. Achieving buy in from all stakeholders including H&WB Board to new requirements and plan revisions
b. Impact of “knee jerk” reactions/behaviours on partnership relations
c. Lack of political support
d. Lack of support from acute providers
e. Lack of public confidence in integrated care solutions

National and Regional Response to the new Guidance

32. The publication of the new guidance raised a large number of questions and clarifications across the country. These have been handled through a number of routes over the past few weeks as follows:

- National Webinars with Q&A **-** scheduled via the BCF national web pages, available also as archived files.

- Individual questions/regionally collated questions submitted to the national BCF team/central email address – leading to a FAQs section of the webpages.
- Ebulletins issued from Andrew Ridley, national BCF lead.
- Additional materials and guidance published since July 25th (e.g. on 20/8/14 additional guidance on was published on the 3.5% metric and the circumstances in which flexibility might be agreed).
- Check point returns from each HWB area – these are template forms that have to be submitted nationally which test the readiness for resubmission at 3 specific dates between 25th July and 19th September.

33. In recognition of the more onerous and complex process for BCF resubmissions, some additional (nationally procured) support was made available with effect from 26th August in each region. This has included:

- **Additional BCF Webinars** on key topics
- **BCF Regional Workshops** - in the East Midlands this took place on 1/9/14 and consisted of booked "surgery" sessions where individual BCF teams could bring their draft plans and raise specific concerns/queries.
- **A New BCF "How to Guide"** was published on 2/9/14 setting out guidance covered primarily in national webinars and workshops.
- **Additional "hands on" support into individual HWB areas** – this is being coordinated by NHSE and the LGA using a nationally procured supplier. Support was targeted on the basis of need highlighted at BCF check point 1.

34. While the additional support is welcomed, feedback has been given that this all comes at a very late stage in the process raising some practical/logistical difficulties for local areas to make best use of this in sufficient time for the resubmission.

35. There is also the need to factor in the lead time needed to secure approval of BCF resubmissions through various governance routes (including getting specific assurance from providers and approval of the overall plan by health and wellbeing boards), ahead of the 19th September.

Additional Guidance on the 3.5% metric

36. On 20th August further information was published on the flexibilities associated with this metric, which can apply in certain circumstances. A local target below 3.5% can be proposed with the agreement of the local health and wellbeing board, if there is a clear rationale for this - e.g. if the historical performance of the local health and care economy has already taken the area into the top quartile of performance nationally, if there are problems with the

local baseline information or other specific local challenges which mean the target is unachievable in the short term.

BCF Assurance Process

37. The assurance process is being led by North East London Commissioning Support Unit. On 20th August details of this process were published showing the methodology and criteria for assessing BCF plans, aiming to give a consistent process across the country. See BCF web pages *NHS England* and *LGA* for the detail.

38. This is an intensive process involving a technical desk top review, triangulation of other evidence about the wider context of the financial and delivery challenges facing local health and care economies, plus it involves a telephone interview with representatives from each BCF plan/HWB Board area.

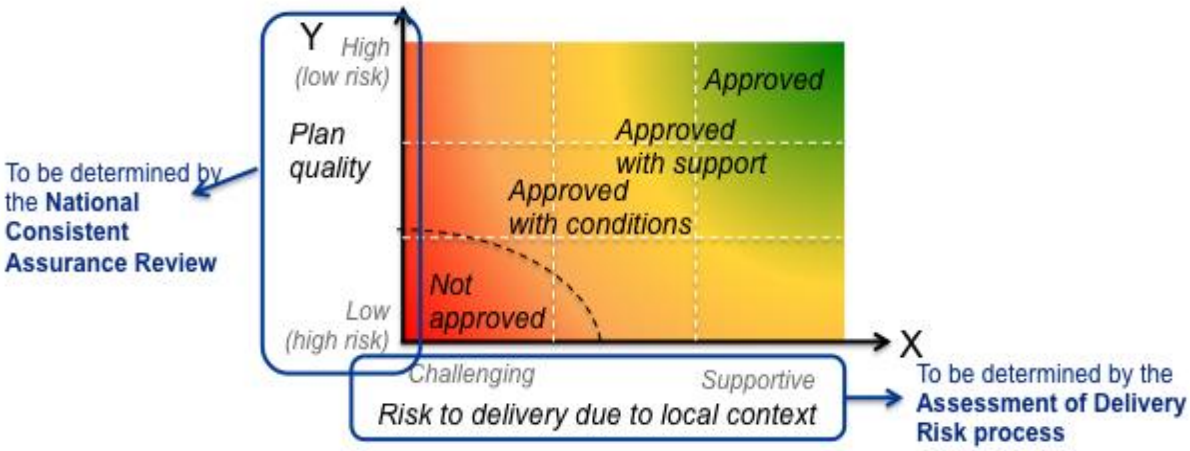
39. The outcome of the review will be that all BCF plans fall into one of four categories below, which have specific definitions:

1. *Approved*
2. *Approved with support*
3. *Approved with conditions*
4. *Not approved*

40. The assessment for categorisation will be determined by:

- The National Consistent Assurance Review of the quality of the plans
- The assurance checkpoints' assessment of the risk to delivery due to the local context facing each local health economy

The diagram showing the two axis for assurance is given below:



41. There is a requirement for each region to complete the delivery risk analysis by 16th September through regional panels to include both NHSE and local government representation. The assurance process will then take place w/c

22/9/14 and w/c 29/9/14. This will be followed by national moderation, with reporting up to ministerial level.

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