National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health, Department for Communities and Local Government and NHS England

Planning for the Better Care Fund

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Summary

1 The government made better cooperation between local services a main objective of the 2013 spending round. The Chancellor of the Exchequer announced that in 2015-16, the government would for the first time pool £3.8 billion into a single budget for health and social care services to work more closely together – the Better Care Fund. The Fund consists of sums reallocated from existing budgets. The Autumn Statement in December 2013 confirmed the government's aim that the Fund would be an enduring part of the health and social care system. Ministers have stated their ambition that integrated care will become the norm by 2018. Local areas can choose to pool more than their Fund allocations.

2 There is widespread support for improving patient experience and outcomes by integrating health and social care better. Local areas have been exploring joint working between health and social care for many years. Demand for social care is increasing because adults with long-term and multiple health conditions are living longer. The Fund requires local bodies to:

- bring health and social care planning together;
- support people's health and independence in the community; and
- meet the challenges of increasing demand for care and constraints on public funding.

3 The Department of Health and the Department for Communities and Local Government ('the departments') developed the Fund's policy with NHS England and the Local Government Association. The Care Act 2014 sets out the relationship between the departments, NHS England and clinical commissioning groups with regard to pooled budgets intended to integrate health and social care.

4 NHS England and the Local Government Association issued guidance on the Fund in December 2013. The guidance described the national conditions that ministers set at the 2013 spending round, which local areas should adhere to in their plans for spending their Fund allocations. It also described the indicators for measuring performance. Local health and wellbeing boards had to approve the plans before submission. The boards comprised, as a minimum, representatives from local government, NHS commissioners and Healthwatch (which gathers and represents the public's views on health and social care services in England).

5 All local areas submitted plans by April 2014 for how they would spend their Fund allocations in 2015-16, in accordance with the timetable. Ministers did not, however, approve plans in April as originally intended. Planning for the Fund paused between April and July 2014 while the government reviewed and revised the Fund's scope and how the £1 billion pay-for-performance part of the Fund would work. In July 2014, NHS England and the Local Government Association issued new guidance on the Fund's objectives and a revised timetable requiring local areas to submit new plans in September 2014. Our report discusses the reasons for changing the Fund, the consequences and implications, and challenges and risks to implementing it. We do not discuss the contents of local plans in depth because ministers were just approving plans as we finalised our report.

Key findings

Original planning phase

6 The Fund is innovative and ambitious with many organisations planning and implementing it. Implementing the plans and improving care for patients depend on the departments' assumptions, including that:

- Local health and social care providers can improve patients' services in 2015-16 without transitional or additional funding (paragraph 1.10 and Figure 2).
- Funding transferred from the NHS into a pooled budget for health and local government and spent on social care or on integrated care in 2015-16 will save money in acute hospitals in the same year (paragraph 2.2).

Furthermore, planning for the Fund is constrained because:

- Health and social care are under stress so neither is working at their best (paragraph 1.2).
- The challenging financial environment limits the opportunity to start up the Fund with extra money (paragraph 1.7).
- Local plans for spending Fund allocations must align with hospital activity plans (paragraph 1.13).

7 **The original Fund design had strengths.** Each of the 151 local health and wellbeing boards had to agree how the NHS and local authorities should spend funding. The core requirement was to improve local care while achieving national conditions, including protecting social care services. £1 billion of the Fund was to be released to local areas based on their performance against a group of 6 indicators, including reducing avoidable emergency admissions.[1] The departments originally intended to approve plans in April 2014, giving local areas 11 months to prepare to implement them. In 2014-15, the Department of Health allocated £200 million to local areas for preparations such as recruiting and training staff (paragraphs 1.3, 1.6 to 1.8, 1.12, 1.14, 2.5 and Figure 3).

8 **All parties agreed at the outset that the Fund would be a locally led initiative with national oversight from the departments.** In line with the Health and Social Care Act 2012, once the 2 departments set the policy framework for the Fund, delivery and implementation of the Fund were the responsibility of NHS England, working alongside the Local Government Association, with the departments providing joint senior responsible owners for the programme. The departments, NHS England and the Local Government Association wanted local areas to develop plans for spending the Fund with minimal central prescription, in order to drive local innovation from the bottom up. As a result, there was no central programme team, no programme director and limited risk management. NHS England and the Local Government Association offered voluntary support to local areas. However, there was no analysis of local planning capacity, capability, or where local areas would need additional support. The departments and NHS England therefore underestimated the complexity and challenge of bringing together the different health and social care organisations around a single local vision in a relatively short time (paragraphs 1.4, 1.19 and 1.20).

9 **The initial scheme guidance did not mention the scale of savings expected from the Fund.** As part of the 2013 spending round discussions, the Department of Health and NHS England had a shared planning assumption that the Fund would deliver £1 billion of savings in 2015-16. This was discussed with HM Treasury at the time, but was not formally agreed in the spending round settlement. The Department for Communities and Local Government told us it was aware of this expectation when the Fund policy was being designed. But as there was no target for the Fund in the 2013 spending round, this did not affect the Fund policy. The guidance issued to local areas asked them to identify how they would make savings and the risk of not making the savings, but did not ask them to set out the analysis underlying their savings calculations (paragraphs 1.12, 2.2 and 2.3).

10 **Plans submitted by local areas appeared to support the Fund's objectives.** All 151 health and wellbeing boards submitted valid plans in April 2014, covering £5.5 billion of pooled funds. Some local authorities and clinical commissioning groups had chosen to commit an additional £1.7 billion of their planned spending on adult social care and out-of-hospital services to the pooled fund. This was a significant endorsement of the Fund's potential to improve services for local people (paragraph 1.17).

1 'Avoidable emergency admissions' here includes unplanned hospitalisation for chronic conditions which can be actively managed to reduce the need for hospital admissions (all ages); unplanned hospitalisation for asthma, diabetes and epilepsy in children; emergency admissions for acute conditions that should not usually require hospital admission (all ages); emergency admissions for children with lower respiratory tract infection.

11 NHS England and the Local Government Association assured plans against a set of centrally determined criteria, which did not include achieving £1 billion in savings for the NHS. Without that requirement, they determined that 90% of plans were of sufficient quality to be approved after small improvements, but 53 plans did not offer any savings. Local teams assessed local areas' plans for meeting the national conditions and their targets for the Fund's performance indicators. Their review suggested problems in some local areas, including concerns that in many areas acute trusts were not being consulted sufficiently (paragraphs 1.16, 1.18, 2.2 to 2.4).

12 In May 2014, NHS England concluded that the Fund plans submitted in April were biased towards over-optimism and would not make the expected £1 billion of savings. Local areas estimated that Fund benefits would total just over £700 million. NHS England's new chief executive asked for extra work to show whether the Fund would make £1 billion of savings. After analysing plans and activity levels for emergency admissions and delayed discharges, NHS England concluded that savings estimates were not credible and only £55 million of deliverable financial savings could be safely relied on. NHS England considered that some over-optimism came from poor engagement with acute trusts in planning. NHS England found that those local areas that had not engaged effectively with acute trusts estimated savings higher than those areas that had worked with providers in planning. The departments also concluded that some aspects of the plans needed further development and therefore did not recommend any plans for approval. The departments paused planning for the Fund and revised the approach to managing it (paragraphs 2.3 to 2.5 and Figure 6).

Revisions to the Fund in May to July 2014

13 The departments changed the conditions attached to the £1 billion pay-for-performance part of the Fund, focusing on reducing total emergency admissions and sharing the risk that savings will not be made between the NHS and local authorities.[2] Revisions to the £1 billion pay-for-performance part of the Fund reduced the number of indicators on which payments for performance would be made from 6 to 1. Now, a portion of this £1 billion will be paid for performance in reducing total emergency admissions to hospitals. Areas were asked to aim for at least a 3.5% reduction on 2014 levels, representing £300 million of savings to NHS commissioners or a smaller reduction if agreed by all local parties. The rest of the £1 billion performance pot will remain part of the Fund in 2015-16. However, it is now to be spent on NHS-commissioned out-of-hospital services, which must be agreed by the health and wellbeing board. The 2 departments asked local areas to submit revised plans to meet the new expectations by 19 September 2014. Local areas still need to set appropriate ambitions against the original performance indicators. No other Fund objectives are now linked to financial incentives (paragraphs 2.6, 2.10, 3.2 and Figure 7).

2 Throughout the report, 'emergency admissions' refers to all general and acute non-elective admissions, i.e. emergency admissions, maternity admissions and some other admissions of adults and children. The measure is based on data submitted by clinical commissioning groups.

14 Local government does not agree with the changes. The Local Government Association 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 the revised policy and subsequent programme management arrangements had in their view moved the integration agenda backwards and not forwards (paragraphs 2.11, 3.2 to 3.4).

Implementing the new policy

15 Following the analysis of the plans, the departments revised and improved the Fund's governance and programme management in July 2014. The improvements included:

- changing governance, through the ministerial board, to involve the 2 departmental Secretaries of State, the Chief Secretary to the Treasury, and the Cabinet Office Implementation Unit;
- appointing NHS England's National Director: Commissioning Operations as the Fund's sole senior responsible owner, replacing the original 2 senior responsible owners (directors general from the 2 departments) who now jointly chair the programme board, to which the new senior responsible owner and programme director report on delivery of the Fund;
- introducing a new programme director role – and combining programme personnel into a single Better Care Fund task force;
- creating a risk register which is now regularly updated;
- profiling risks to identify centrally what types of support local areas need most;
- securing £6.1 million extra funding to support and assure local plan development; and
- introducing the requirement for a commentary on plans from local hospitals, although they are not asked to comment on estimates of financial savings.

These initiatives are all likely to improve the quality of plans, but the Fund's effectiveness will depend on local implementation (paragraphs 2.7 to 2.9 and Figure 8).

16 The Department of Health is still developing evidence on cost-effectiveness of initiatives to promote integration, so, despite revisions, central and local assumptions may still be over-optimistic. Local areas must decide how best to spend the Fund. There is limited evidence that integrated care is effective in reducing emergency admissions sustainably, improving outcomes for patients, and saving money. Acute providers have fixed costs; there is uncertainty over reductions becoming sustainable; and large-scale changes are needed to decommission services. These facts suggest that saving £300 million in 2015-16 is ambitious, even if emergency admissions do reduce overall by 3.5%. The Fund task force gave local areas a support pack in late August 2014 on the developing evidence (Figure 7 and paragraphs 3.7 to 3.10).

17 Recent trends and feedback from local areas suggest that some areas will struggle to reduce emergency admissions by the assumption of 3.5% in one year. Nationally, emergency admissions have been rising for many years. Furthermore, the data given to local areas on numbers of emergency admissions show fluctuation from one year to the next. This is partly because data collection has not been consistent. Data provided to local areas to inform local planning were therefore not reliable (paragraphs 3.10 to 3.12).

18 The changes to the Fund announced in July 2014 reduced the time for local planning. From April 2014 onwards, local areas would have been preparing to implement the Fund, for example, doing workforce planning and training staff. Instead they were reviewing plans to resubmit them by September 2014, for expected approval in late October. This reduced from 11 months to 5 months the time available for such preparation and it is less for areas without approved plans (paragraph 2.10).

19 Independent assurance of the September Fund plans found them to be stronger and better supported than the April plans. Ministers approved almost two-thirds of plans with no or minor changes, and they approved a third with conditions. Only 5 plans were not approved. In total, local areas plan to pool £5.3 billion, 39% more than the Fund minimum of £3.8 billion but £0.2 billion less than the April plans. Local areas project savings of £532 million (at least £314 million for the NHS) with emergency admissions to hospitals forecast to fall by 3.1%. The assurers identified protection of social care services to be the biggest risk area, with 21 local areas assessed as having material risks (paragraphs 2.9, 2.13 and Figure 9).

Conclusion on value for money

20 The Better Care Fund is an innovative idea for joining-up care services locally for the benefit of patients. However, the quality of early planning and preparations did not match the scale of ambition. Given its pioneering nature, the many organisations involved and the complex behaviour changes required, this was always going to be a challenging initiative. The initial planning assumption that it would deliver £1 billion of financial savings and the challenging financial environment, which limited start-up funding, required clarity on its financial objectives and strong central leadership from the outset. Setting the planning context clearly and coherently was the responsibility of the departments. However, the financial savings assumption was ignored, the early programme management was inadequate, and the changes to the programme design undermined the timely delivery of local plans and local government's confidence in the Fund's value. Pausing and redesigning the scheme when ministers realised it would not meet their expectations was the right thing to do.

21 Programme management since the redesign is much improved and would have avoided waste and frustration had it been in place from the start. New plans submitted by local areas offer the prospect of improved care for patients and £532 million of savings. Nevertheless, the Fund still contains bold assumptions about the financial savings expected in 2015-16 from reductions in emergency admissions, which are based on optimism rather than evidence, and implementation faces further hurdles. The Fund has real potential to help integrate health and social care but to offer value for money the departments need to ensure: more effective support to local areas; better joint working between health and local government; and improved evidence on the effectiveness of integration schemes.

Recommendations

22 The departments should:

a Clarify the Fund's long-term vision, including expected patient benefits and financial savings, and the time period over which the departments expect these.

b Clarify, with local government, the balance between local areas' freedom to set Fund objectives and centrally mandated objectives.

c Clarify how the Fund's performance management will work once ministers approve the plans, and in particular how health and wellbeing boards will work.

d Develop indicators to measure the extent and effectiveness of local service change and integration.

e Draw up a Fund accountability system statement, saying how the accounting officers will gain assurance on how local areas spend the Fund.

For future major and innovative cross-departmental programmes, and in line with our previous recommendations about integration across government, the departments should:

f agree financial and service expectations with HM Treasury, and reflect these explicitly in programme objectives and guidance;

g have programme governance, management, resources, risk management and timescales appropriate to the programme's scale and ambition;

h clarify the separation of responsibilities and duties between departments and arm's-length bodies; and

i prepare evidence at an early stage on the costs and benefits of different types of proposals to integrate services.