



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

Planning for the Better Care Fund

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

7 November 2014

This study examines the objectives, evidence, value-for-money risks and management of the Fund.

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The National Audit Office study team consisted of:
Chris Jamieson, Rose Martin, Robindra Neogi, Andy Whittingham and Chris Woolley, under the direction of Ashley McDougall, with assistance from Claire Fears, Jannan Gunaratnam, Jill Hearne and Lilian Ndianefo.

This report can be found on the National Audit Office website at www.nao.org.uk

For further information about the National Audit Office please contact:

National Audit Office
Press Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Enquiries: www.nao.org.uk/contact-us

Website: www.nao.org.uk

Twitter: @NAOorguk

Key facts

£3.8bn

minimum amount to be pooled for the Better Care Fund

£5.3bn

which local areas planned to pool, based on September 2014 plans, down from £5.5 billion in April plans

£1bn

2013 spending round planning assumption of savings from the Fund for the NHS in 2015-16

£731 million amount local areas said in their April 2014 plans they would save in 2015-16¹

£55 million NHS England estimate of credible annual savings from the Fund, based on local areas' April 2014 plans

£532 million amount local areas said in their September 2014 plans they would save in 2015-16, of which £314 million would be saved for the NHS from fewer emergency admissions to hospitals and fewer delayed transfers from hospitals

151² health and wellbeing boards in England

53 plans submitted in April 2014 which offered no savings

0 plans approved by ministers in April 2014

146 plans approved by ministers in October 2014, of which 6 were approved outright, 91 require a small amount of extra work, and 49 were approved with conditions

5 plans not approved by ministers in October 2014

Notes

1 We refer to the area covered by a health and wellbeing board as a 'local area' throughout this report.

2 There are 152 local authorities with adult social service responsibilities, but two of these, Bournemouth and Poole, share a single health and wellbeing board.

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.

Part One

Original planning phase

1.1 This part examines whether the departments' early planning phase for the Fund achieved its aims, including whether:

- the departments designed the Fund to meet policy objectives;
- the Fund's design is supported by evidence;
- the departments managed the Fund planning to achieve the desired outcomes; and
- the departments supported local areas to develop achievable plans.

Objectives and integrated care

1.2 The NHS and local government are facing increasing demand for healthcare and social care services respectively. Adults with long-term and multiple health conditions or disabilities are living longer. The number of adults aged 85 or over, the age group most likely to need care, is rising faster than the population as a whole. Local authorities' total spending on adult social care fell 8% in real terms between 2010-11 and 2012-13 and is projected to continue falling. There has been a lower fall in health sector funding. However, over 2014, an increasing proportion of NHS trusts and NHS foundation trusts are forecasting deficits.

1.3 The government made better cooperation between local services a main objective for the 2013 spending round with the goal of maintaining the quality of services while reducing the cost to the public. It announced the Better Care Fund (then known as the Integration Transformation Fund) in the 2013 spending round 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... with the aim of delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays”.³

The Fund will run from 1 April 2015, initially for 1 year. Local authorities received £200 million in 2014-15 from the Department of Health to prepare for the first full year of the Fund in 2015-16.

³ HM Treasury, *Spending Round 2013*, June 2013, available at: <https://www.gov.uk/government/publications/spending-round-2013-documents>

1.4 Under the Care Act 2014, NHS England can direct clinical commissioning groups to use and pool money to integrate health and social care services. NHS England can also impose conditions regarding plans to spend this money, and may withhold or recover payments where conditions are not met. The Care Act specifies the role of the Secretary of State for Health in setting the amount of funding and in overseeing the conditions set by NHS England. The Health and Social Care Act 2012 is also important background for the Fund as it established much of the current health system, giving a high degree of autonomy to clinical commissioning groups and establishing their relationship with NHS England. NHS England’s responsibilities for the Fund in 2014-15 are set out in the NHS Mandate from the Secretary of State to NHS England for that year: “NHS England needs to deliver the best possible foundation for the Fund’s implementation, working in partnership with local authorities and health and wellbeing boards”.⁴

Local activity

1.5 Local areas plan to use the Fund to develop new schemes and extend existing ones (**Figure 1**).

Figure 1
Examples of initiatives that local areas plan as part of the Fund

Type of initiative	Example
Seven-day working	Wokingham is establishing a single point of access for health and social care services available 24 hours a day and 7 days a week. This team has one telephone number and will manage all referrals for short-term health and social care services.
Multidisciplinary team	Sunderland is creating multidisciplinary teams, including community nurses and GP practice nurses, to bring together social care, primary and community health resources. They will be linked to hospital-based services.
Alternative to emergency services	Dudley’s community rapid response team provides an alternative to hospital admission, particularly in relation to patients who might be admitted having travelled by ambulance. This includes patients from residential and nursing homes.
Mental health	Wolverhampton will create a dementia hub to provide information and services. They also plan an early referral system to mental health services.
Reablement (a short-term service to support people with disabilities and those recovering from an illness or injury)	Nottinghamshire will negotiate a new homecare contract for the council to provide a timely nightsitter service. This aims to support patients to stay in their own home during rehabilitation and reablement.
Adaptations and housing for disabled people	The Disabled Facilities Grant is well established. By law, housing authorities must commission and provide the relevant services. Nottinghamshire is developing its extra care housing: housing modified to suit people living with long-term conditions or disabilities.

Source: Better Care Fund plans

⁴ The government provides direction and ambitions for the NHS through the annual NHS Mandate.

Responsibility for the Fund

1.6 The Department of Health and the Department for Communities and Local Government (the departments) set policy for the Fund. The revenue element, £3.46 billion, is NHS money and is accounted for by NHS England. The capital funding, £354 million, consists of two central government grants to local authorities and is accounted for by the departments (**Figure 2**). Both the revenue and capital elements of the funding are pooled between clinical commissioning groups and local authorities. Given that local authorities and NHS England are involved, the departments asked NHS England and the Local Government Association to jointly create guidance for, and to support, local organisations planning for the Fund. Plans are to be signed off locally by the 151 health and wellbeing boards set up in 2013. Ministers from the departments oversee progress planning for the Fund nationally.

How the Fund works

1.7 In 2015-16, each local area, overseen by its health and wellbeing board, will receive a share of the £3.8 billion Fund. Local areas will oversee amounts varying from £0.14 million (Isles of Scilly) to £101 million (Kent). The Fund will have a minimum value of £3.8 billion nationally. Local authorities or clinical commissioning groups, or both, may add money to their local allocations from their own budgets. The challenging financial environment limits the opportunity to start the Fund with extra money because of the government's approach to reducing the deficit.

1.8 The 151 health and wellbeing boards are, formally, committees of the English local authorities with adult social care responsibilities. Boards have a core statutory membership of:

- a local authority councillor;
- clinical commissioning group representative(s);
- local authority directors of adult social care, children's services and public health; and
- a local Healthwatch representative.

Boards can have further members at local discretion, such as representatives of local acute trusts. They must encourage integrated working between commissioners of services across health, social care, public health and children's services.

Figure 2

The Fund consists of existing funding, with no new money

Funding source	Amount (£m)	Application in previous years	Restrictions in 2015-16
Revenue			
NHS funding from clinical commissioning group allocations	1,930	Clinical commissioning group spending on secondary healthcare.	£135 million to be spent on Care Act implementation, the rest for the broad aims of the Fund.
Social care transfer	1,100	In 2014-15, this amount was transferred from the NHS to social care, to be spent on adult social care services that also have a health benefit.	For the broad aims of the Fund.
Clinical commissioning group reablement funding	300	Included in clinical commissioning groups' baselines to support integrated working with local authorities to reduce avoidable hospital admissions and facilitate more timely hospital discharges.	No ring-fencing, but plans should say how authorities will use the Fund for reablement.
Carers' breaks funding	130	Included in clinical commissioning groups' baseline allocations to support breaks for long-term carers.	No ring-fencing, but plans should say how authorities should use the Fund for breaks for carers.
Capital			
Disabled Facilities Grant	220	Capital money made available to local housing authorities as part of their allocations to award grants for changes to a person's home.	The holder of the pooled fund must by law pass the Disabled Facilities Grant allocation to housing authorities. Grant conditions are set by the Department for Communities and Local Government.
Social Care Capital Grant	134	Capital funding from the Department of Health to local authorities to support investment in adult social care services.	Grant conditions are set by the Department of Health and the Department for Communities and Local Government. £50 million earmarked for the capital costs (including IT) associated with Care Act transition. The Fund does not ring-fence the Care Act money, but local plans should show how they meet new duties.
Total	3,814		The plan as a whole must meet the Fund's national conditions.

Source: NHS England and Local Government Association (2014), *Better Care Fund guidance*; Chartered Institute of Public Finance and Accountancy and Healthcare Financial Management Association (2014), *Pooled budgets and the Better Care Fund*

Overseeing early planning

1.9 The Fund builds on many areas' earlier work across health and social care and previous pooled budgets, but it is larger and more ambitious. For example, it requires pooling of NHS funding, and for local authorities and NHS commissioners to jointly approve spending plans. NHS England and the Local Government Association had day-to-day responsibility for helping local areas to plan for the Fund by:

- giving clear guidance on planning, performance indicators and goals;
- providing resources and programme management for effective planning; and
- reviewing plans to assure ministers that they would be a sound basis to implement the Fund and meet objectives.

Where the money comes from

1.10 The Fund builds on transfers of funding from the NHS to local authorities, made between 2011-12 and 2014-15 to help provide adult social care, as well as new transfers for 2015-16 (Figure 2).

1.11 The £1.9 billion transferred from clinical commissioning group budgets represents around 4% of expenditure on hospital services.⁵ The revenue part of the Fund is 7% of 2015-16 local government revenue spending power. Based on 2012-13 spending, this is around 18% of gross local authority spending on adult social care.⁶ The 2013 Autumn Statement set out the government's aspiration of "making sure pooled funding is an enduring part of the framework for the health and social care system beyond 2015-16".⁷

Local planning

1.12 NHS England and the Local Government Association gave health and wellbeing boards draft guidance in October 2013, and final guidance in December 2013, with a standard planning template. Local areas had to produce jointly agreed plans that met the Fund's aims, describing what services and projects they would spend the Fund on. They had to state how their plans would meet national conditions, and their locally set targets for progress against 6 performance indicators (**Figure 3**). They had to develop a contingency plan in case they did not meet these targets, estimate the expected savings, identify where NHS savings would be realised and estimate the risk of the savings not being realised. However, many health and wellbeing boards did not provide detailed information on expected savings.

5 Hospital services includes spending on maternity; general and acute; and accident and emergency care in 2012-13: Department of Health (2013), *Annual report and accounts 2012-13*. We adjusted for inflation using HM Treasury's GDP deflator, published in September 2014.

6 Gross local authority spending is based on gross current expenditure, Personal Social Services Expenditure (PSSEX) data for 2012-13, plus the funding transfer from the NHS to social care in that year. We adjusted for inflation using HM Treasury's GDP deflator, published in September 2014.

7 HM Treasury, *Autumn Statement 2013*, Cm 8747, December 2013, p. 83.

Figure 3

Original Fund national conditions and performance indicators

National conditions

Plans jointly agreed by health and wellbeing board members.

Protect existing social care services.

Seven-day working in health and social care.

Better data sharing between health and social care.

An accountable professional for integrated packages of care.

Agree the impact of the plan on the health and social care providers.

Performance indicators

Reduce avoidable emergency admissions to hospitals.¹

Reduce admissions to residential and care homes.

Improve effectiveness of reablement.

Reduce delayed transfers of care.

Improve patient or service user experience.

A locally defined performance indicator.

Note

¹ 'Avoidable emergency admissions' here counts unplanned hospitalisation for chronic conditions for which active management reduces 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.

Source: Better Care Fund technical guidance, December 2013

1.13 December 2013 guidance from NHS England said that clinical commissioning groups should keep 1% of their funding in 2014-15 to develop and carry out plans for change. These plans should focus particularly on preparing to introduce the Fund. Clinical commissioning groups' financial and operational plans covering 2014-15 and 2015-16 were due on 4 April 2014 – the same time as Fund plans. NHS England required clinical commissioning groups to submit their 5-year plans by June 2014.

1.14 Under the original scheme design, the Fund would pay £1 billion in stages, which would link to local areas' outcomes. The Fund would pay up to £500 million in April 2015. This comprised up to £250 million for progress against 4 of the national conditions; and up to £250 million for progress in reducing delayed transfers of care, reducing avoidable emergency admissions and progress against the local performance indicator. These payments would therefore have reflected performance of local areas in 2014-15. They would have depended on local areas planning, and implementing their plans, in 2014-15. Up to £500 million was to be paid in October 2015 for progress towards the locally determined targets for all the performance indicators.

1.15 Local areas had to agree contingency plans for not meeting targets. In these cases, some of the area's allocation would go to the organisations that had met the higher-than-expected demand. For example, if an area did not meet targets to reduce residential care admissions, resources would fund the extra care packages. If performance was well below target the local area would have to produce a recovery plan, or, in extreme cases, NHS England could direct the clinical commissioning group on how to spend the Fund.

Assurance of local plans

1.16 Health and wellbeing boards had to approve local plans. Boards had to get agreement from all local organisations involved in planning for and implementing the Fund, before submitting the draft plan to NHS England by 14 February 2014. NHS England area teams and local government regional peers (organised by the Local Government Association) then reviewed and rated the draft plans against criteria in 3 broad areas:

- confidence that the plan would achieve the national conditions;
- realistic but challenging levels of ambition for outcomes and performance indicators; and
- that the plan met several general criteria, including confidence that it was achievable and affordable (**Figure 4**).

Ministerial approval was a core element of the assurance phase.

1.17 All local areas submitted valid plans in April 2014. In the plans, local areas proposed pooling £5.5 billion, a significant increase on the minimum pooling of £3.8 billion. The extra funding would come from local authorities' existing adult social care budgets and from clinical commissioning groups' budgets for out-of-hospital services, and was a sign of their support for the Fund.

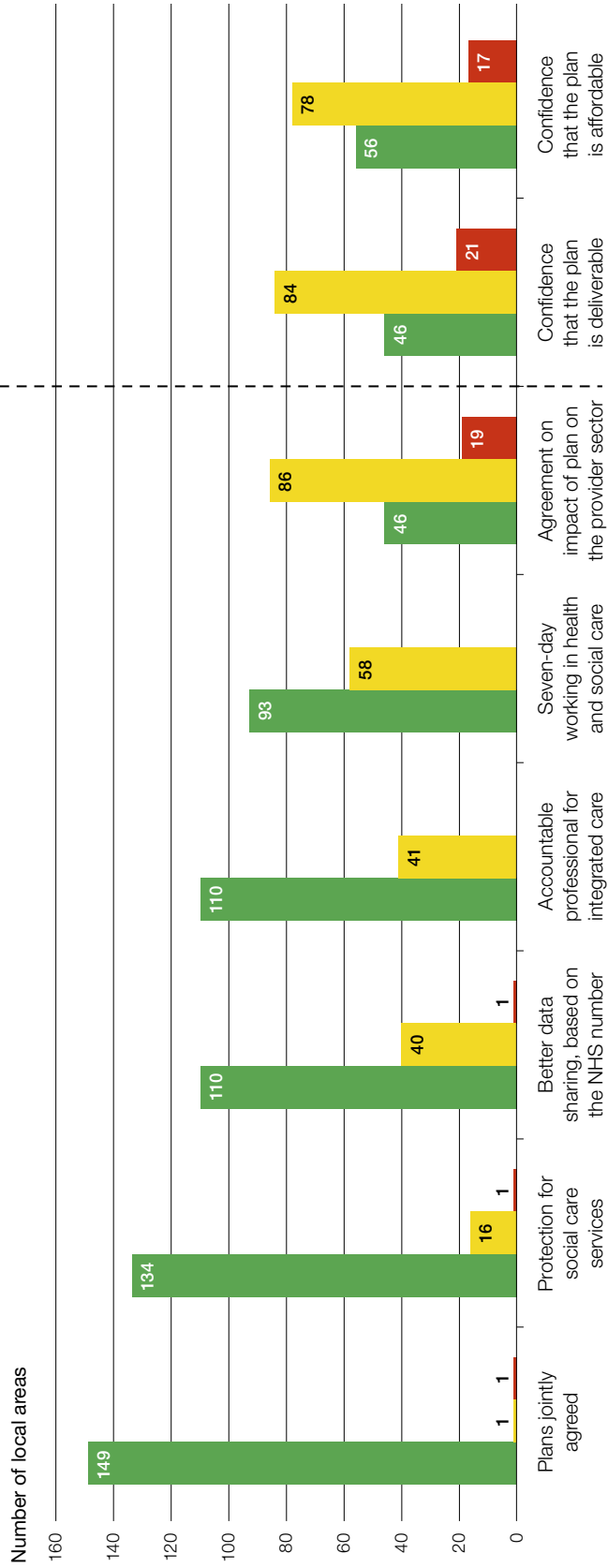
1.18 In April 2014, assurance by NHS England area teams and local government regional peers indicated that, nationally, there had been improvement against most of the criteria when compared with draft plans from February. They determined that 90% of the plans (136 of 151 plans) were ready for sign off, or would be after areas resolved minor issues.

Figure 4
Assurance of local plans

Local assurance in April 2014 indicated some concerns about the plans

Confidence that plans would deliver national conditions

Confidence in affordability and deliverability



Green – confident the plan will fully address this condition
 Amber – concerned the plan will not fully address this condition
 Red – do not believe this condition has been sufficiently considered

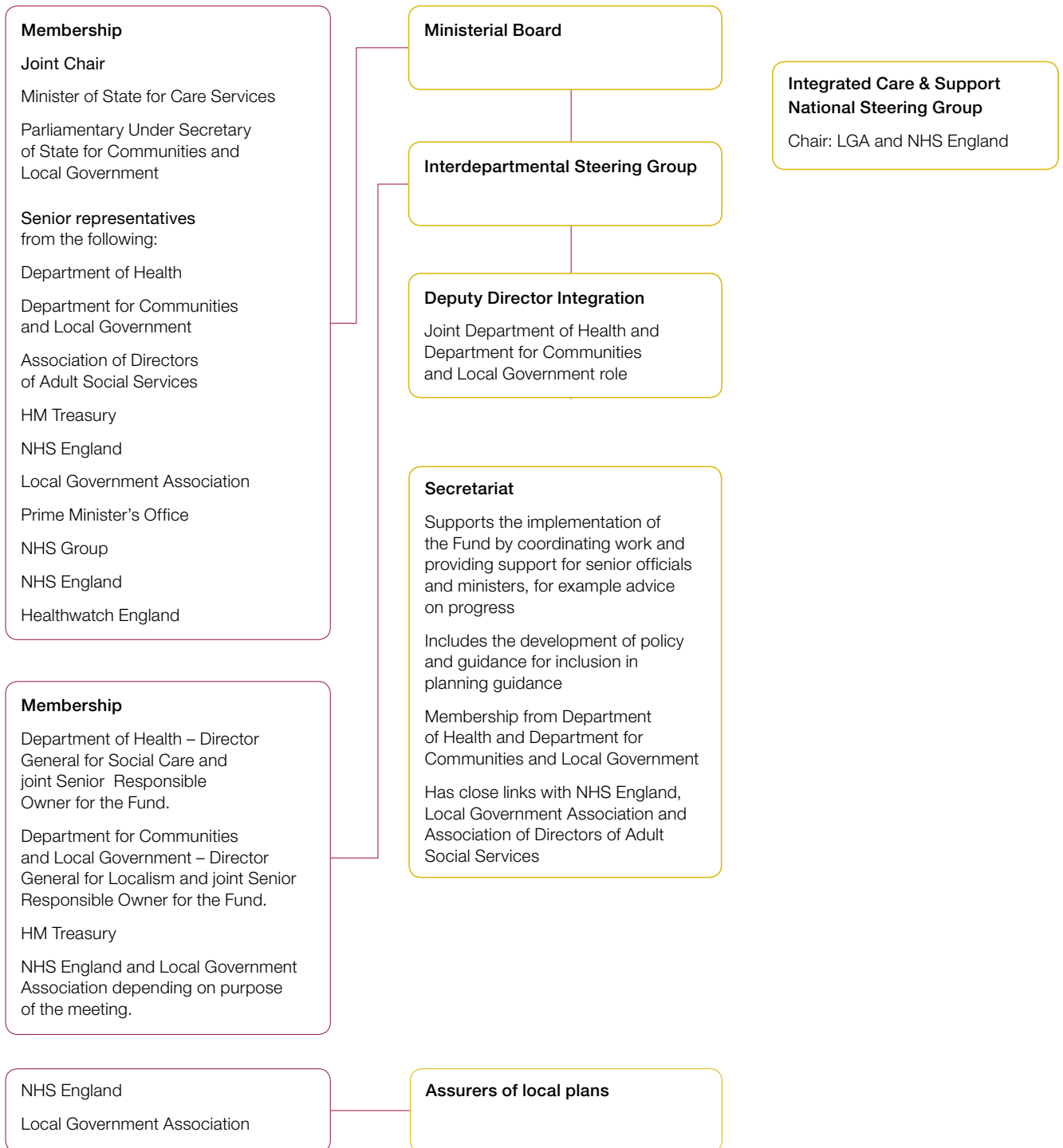
Source: NHS England and local government regional peers assurance findings, April 2014

Original programme management and governance

1.19 The Fund is a major change programme involving many organisations and billions of pounds of public funding. An interdepartmental steering group reporting to a ministerial board provided the central governance for the Fund (**Figure 5**). The responsible directors general from the 2 departments were the Fund's senior responsible owners. The departments were responsible for Fund policy and national oversight of the programme. There was a small central secretariat that supported the boards, and coordinated work with NHS England, the Local Government Association and other partner organisations. The departments decided not to have a central team coordinating the Fund. Delivery and implementation of the Fund were the responsibility of NHS England, in line with the NHS Mandate, working alongside the Local Government Association. In turn, they devolved planning for the Fund to local areas, to encourage local innovation and service transformation.

1.20 NHS England and the Local Government Association developed and provided guidance and support to local areas. Local areas could access nationally available support, such as toolkits (for example, to model reductions in emergency admissions), additional guidance and webinars. NHS England area teams and Local Government Association regional teams coordinated regional clinics and peer-to-peer support. Where there were particular challenges with agreeing a plan locally, bespoke support was available. This drew on external expertise from consultants and peers from across the NHS and local government. NHS England sent local areas data on populations and levels of avoidable emergency admissions. All support was voluntary. It was for local areas to identify what help and support they needed from NHS England and the Local Government Association. The Major Projects Authority was not involved at this stage.

Figure 5
Governance arrangements for the Fund, September 2013



Source: September 2013 ministerial board papers

Part Two

Redesign of the Fund

2.1 The departments changed the Better Care Fund considerably in July 2014. In this part, we describe the events and work that led to those changes. We assess the origin of the changes in the 2013 spending round and the departments' design for implementing the Fund.

Identifying the problem: April to July 2014

2.2 The original guidance for the Fund did not set a financial target for savings expected from implementing it. This was consistent with the formal documentation for the 2013 spending round, which contained no target for the Fund. However, in May 2014, after assessing local areas' plans (paragraph 1.18), NHS England's new chief executive asked for extra work to show whether the Fund would make £1 billion of savings by reducing emergency admissions and delayed discharges from hospitals in 2015-16. In NHS England's submission to the ministerial board in May 2014, it said "the spending round assumed £1 billion of savings from the Fund." This was based on a planning assumption shared by the Department of Health and NHS England, which had been discussed with HM Treasury during the spending round but was not formally agreed in the spending round settlement.

2.3 NHS England and the Department of Health did not have confidence in the amount of savings proposed by local areas in April 2014. The local areas estimated in their plans that savings would total £731 million, but they were not required to set out the analysis underlying their savings, and 53 areas did not offer any savings. However, NHS England's rapid analysis suggested that the annual savings for the NHS, from planned reductions in avoidable emergency admissions and delayed discharges from hospitals, would amount to only £55 million. The Department for Communities and Local Government told us it had no expectation of £1 billion of savings from the Fund.

2.4 A lack of engagement between health and wellbeing boards and trusts in the early stages of planning the Fund may have led to local over-optimism. Only 54% of NHS trusts and NHS foundation trusts that responded to a Foundation Trust Network survey in March 2014 said they had been involved in planning the Fund; only 2% said they had been fully involved.⁸ Planned savings were lower in areas where local assurers thought boards were engaging well with providers than in areas where engagement was weaker (**Figure 6**). NHS England concluded that improving provider engagement could reduce planned benefits. The departments also concluded that some aspects of the plans needed further development.

⁸ Available at www.foundationtrustnetwork.org/influencing-and-policy/integrated-care/better-care-fund/

Figure 6

NHS England's May 2014 analysis of local savings estimates

Savings estimates were higher in areas where local assurers were not confident that health and wellbeing boards had engaged providers in planning

Assurance rating for provider engagement	Number of health and wellbeing boards	Total planned benefit for 2015-16 (£m)	Average planned benefit per health and wellbeing boards (£m)
Green – confident the plan will fully address the condition	46	132	2.9
Amber – concerned the plan will not fully address this condition	86	425	4.9
Red – do not believe this condition has been sufficiently considered	19	174	9.1

Note

1 The 'average planned benefit' column above does not take into account size differences in local areas. For example, larger areas might expect larger savings and might be concentrated in a certain category. Further NAO analysis shows that the overall conclusion is not substantially different when size differences, as measured by funding allocation, are taken into account.

Source: NHS England analysis presented to the Fund's ministerial board, May 2014

Fund redesign and planning process: July 2014

2.5 Ministers were scheduled to approve Fund plans in April 2014. However, no plans were put to ministers because NHS England concluded then that local plans would not collectively save £1 billion in 2015-16. NHS England concluded that this was an unacceptable risk to the NHS's financial position. The departments told us that ministers also took the view that, after central moderation, some of the plans lacked important information and needed further development. The central moderation of plans conflicted with the previous proposal by NHS England local area teams and local government regional peers that 90% of plans could be approved. NHS England told us that this was because the local teams were not asked by the departments to review plans against a £1 billion expectation since no formal target existed. The goals of the scheme, it now appeared, had not been those that local planners were working towards. Ministers paused Fund planning while targets and incentives were redesigned.

2.6 The main change was to the framework for the £1 billion payment-for-performance part of the Fund (**Figure 7** overleaf). The proportion of the £1 billion linked to performance now depends on the level of the local target for reducing total emergency admissions to hospitals. NHS England made a national planning assumption. It assumed that local areas would set targets that the number of emergency admissions in 2015 should be around 3.5% lower than the number of emergency admissions in 2014. Local areas can set more ambitious targets, and the funding linked to performance will increase accordingly. They may also set lower targets, so long as all partners agree on them.

Figure 7

Revisions to the payment-for-performance part of the Fund

Revisions emphasised savings for the NHS and transferred some risk to local government

Aspect of the payment-for-performance pot	Old payment-for-performance design	New payment-for-performance design, since July 2014
Indicator(s) on which payments for performance would be based	Number of admissions to residential and care homes; effectiveness of reablement; number of delayed transfers of care; number of avoidable emergency admissions; patient and service user experience; a locally chosen indicator.	Reduction in number of total emergency admissions.
Size of the payment-for-performance pot	<p>£1 billion was to be linked to performance against locally determined targets.</p> <p>Local areas were asked to set out expected financial benefits in their area, but were not asked:</p> <ul style="list-style-type: none"> ● to meet any particular target; or ● to set out who would benefit. 	A portion of the £1 billion protected for the NHS will be linked to performance against locally determined emergency admissions targets. If all areas aim to reduce admissions by 3.5%, the payment-for-performance pot would be £300 million.
Any guaranteed spending for the NHS?	No	The balance of the £1 billion protected for the NHS (£700 million in the scenario above) will be spent on NHS-commissioned out-of-hospital services.
Consequences of failure to meet locally set targets	<p>Local areas were asked to agree contingency plans.</p> <p>Poor performance would result in a portion of £1 billion from within the £1.9 billion from the NHS being allocated to the locally agreed contingency plan, which could include support to acute services; if performance was well below target the local area would be required to produce a recovery plan; or in extreme cases there was to be direction by NHS England.</p>	Any money held back from the payment-for-performance part may be used to fund acute services.
Requirement to involve acute providers	Local areas were asked to describe their engagement with acute providers.	Requirement to demonstrate that local acute providers have been consulted – local providers supply a commentary on planned activity changes.
Risks that Fund outcomes are not achieved fall on:	Clinical commissioning groups. Money was to be withdrawn from the acute sector and pooled, to be spent jointly by local authorities and clinical commissioning groups. If local areas' plans did not result in immediate reductions in activity, clinical commissioning groups would end up paying both into the pooled Fund and to hospitals for acute activity.	Local authorities and clinical commissioning groups. Money is still to be withdrawn from the acute sector and pooled. However, the new design of the payment-for-performance pot makes it more likely that money will be protected for spending on NHS-commissioned services, albeit on out-of-hospital services.

Source: National Audit Office assessment of NHS England and Local Government Association guidance on the Better Care Fund

Managing the problem: July 2014 onwards

2.7 As well as the new pay-for-performance arrangements, all partners recognised they had to strengthen governance and introduce new arrangements for managing the programme. They also recognised that they needed to intensify support for many areas if these were to meet the government's expectations for the Fund. This was particularly the case in areas that were not sufficiently committed to partnership working. We tested the new arrangements against our success criteria for programme management and found them to be stronger (**Figure 8** overleaf).

2.8 In July 2014, the departments established the Better Care Fund task force, including representatives from the departments, NHS England and the Local Government Association, headed by the new programme director. The Fund task force and partners, including the NHS Trust Development Authority and Monitor (the independent regulator for NHS foundation trusts), identified risks to delivery of plans of suitable quality and ambition. The Fund task force also asked local areas where they felt they have weaknesses and needed support. The task force arranged new support, including the following:

- **Universal support**

Through webinars, 'How to' guides, expert clinics for review of draft plans, and information published on the Local Government Association and NHS England websites, including more detail about the evidence for the success of initiatives supporting integration.

- **Targeted support**

For local areas that say they need it most, as well as those identified as in need of support. The Fund task force arranged for consultants to give this targeted support for local areas' general, analytical and modelling needs.

- **Regional support**

Workshops and peer-to-peer support, coordinated by regional teams.

2.9 The new assurance arrangements include:

- **Risk profiling**

To identify local areas most in need of support. The Fund task force has sent all areas a 'temperature check' seeing where they most need help. NHS England area teams, Local Government Association area teams, Monitor, and the NHS Trust Development Authority are also using local data and intelligence to identify local areas with the greatest challenges.

Figure 8

Changes to the Fund's programme management

The Fund's early programme management did not meet the NAO's success criteria; the new structure is stronger

Success criteria	Programme arrangements before summer 2014	Programme arrangements from summer 2014
Focused on managing the things that matter	No regular review of risks at board level. No additional funds to support local plan development.	Risk register created and regularly updated. £2 million support for local plan development.
Tolerance of risk clearly defined and articulated	No communication about which organisations would bear financial risks and how large these would be.	Identifying specific savings target.
Ownership and accountability for risks is clear	Two senior responsible owners, neither within NHS England as the accountable body. No programme director.	Introduced a single senior responsible owner. Programme director, heading the Better Care Fund task force. Programme board chaired by Department of Health and Department for Communities and Local Government officials.
Decision-making underpinned by good-quality information	Local risks not sought and collated by the centre. No central guidance issued on 'what works' in sustainable integration.	Continuing concern about over-optimism of emergency admissions target. Evidence base for integration still in development.
Decision-making underpinned by considered and rigorous evaluation and costing of risk	No assessment made of local planning capacity/capability or challenges. Support for local areas' plan development was not targeted.	Checkpoints introduced to assess local need for support and contracts let to provide such support.
Future outcomes improved by implementing lessons learned	Feedback mechanisms to respond to local questions. No involvement of Major Projects Authority. Cabinet Office Implementation Unit involved in challenge role.	Continued feedback mechanisms to respond to local questions. Major Projects Authority now giving expertise. Cabinet Office Implementation Unit also giving assurance on local plans.

Note

1 Criteria are based on National Audit Office (2011) *Managing risks in government*.

Source: National Audit Office review of Department of Health, Department for Communities and Local Government, NHS England, Cabinet Office and Local Government Association documents from bodies and boards responsible for managing the Better Care Fund

- **Extra funding to support planning**

An extra £6.1 million in 2014-15 to support and assure local plans, including £2.1 million for consultancy support for local areas with specific needs.

- **Acute trust commentary**

A requirement in Fund plans that local hospitals should give their commentary on planned changes in activity, to ensure that their trust perspective is represented.

- **Independent review of plans**

NHS England has commissioned the North East London Commissioning Support Unit to oversee this review carried out by external consultants. The Fund's programme director is on secondment to the Fund task force from this Unit. The task force has excluded him from decisions that would cause a conflict of interest.

Immediate consequences of the redesign

2.10 All the changes above affect Fund planning. Local areas' time to prepare for the Fund has been reduced by the time taken to redesign the Fund, and by the time taken to replan. Over August and September 2014, local areas would have been preparing to implement the Fund (such as workforce planning and recruiting staff). Instead they were reviewing and resubmitting their plans. This is significant for local areas, and for value for money, because the first payment for performance will examine progress over January–March 2015 against a baseline of January–March 2014.

2.11 The Local Government Association has said publicly that the revisions undermine the Fund's core purpose of promoting locally led integrated care. The revisions reduce the resources available to protect social care and prevention initiatives. The Association has highlighted that delays and changes to the Fund have eroded local goodwill, and it told us that the revised policy and subsequent programme management arrangements had in their view moved the integration agenda backwards and not forwards. Both it and the Association of Directors of Adult Social Services are also concerned that linking only NHS emergency admissions to payment for performance undermines the programme's aim of integrating health and social care better to improve outcomes for service users.

2.12 In summary, the original arrangements did not give adequate assurance over NHS England and clinical commissioning groups' funds, so the pause was right. The delays and redesign may have improved the plans' quality and assurance. However, they also undermined the Fund's credibility with local bodies, and increased the risks involved in implementing it.

Outcome of the revised planning process

2.13 In October 2014, ministers approved 146 of the resubmitted Fund plans following independent external assurance of the plans (**Figure 9**). The plans propose pooling £5.3 billion – £200 million less than the April plans. Forecast savings, which the reviewers assessed as credible, total £532 million. Local areas expect savings for the NHS through reduced emergency admissions (£283 million), reduced delayed transfers of care (£31 million) and increased effectiveness of reablement (£30 million). They anticipate £50 million savings from reduced permanent admissions to residential care homes, and £136 million savings through other means. The payment-for-performance pot is £253 million, representing a reduction in emergency admissions of 3.1% against a planning assumption of 3.5%.

2.14 Support for the further development of plans will be through experts identified by the Fund task force. Where local plans have been approved with conditions local areas will have to prepare action plans to address weaknesses. Until such plans have been agreed by NHS England, local NHS funds will not be released and any expenditure will be at local risk. If necessary, local areas will receive extra support to help them meet these conditions. Where plans are not agreed by 1 April 2015, it is likely that NHS England will impose a spending plan on the local area. The profile of reviewed plans reflecting assessments of plan quality and the scale of local delivery challenge, for example a challenged health economy, is at **Figure 10**.

Figure 9

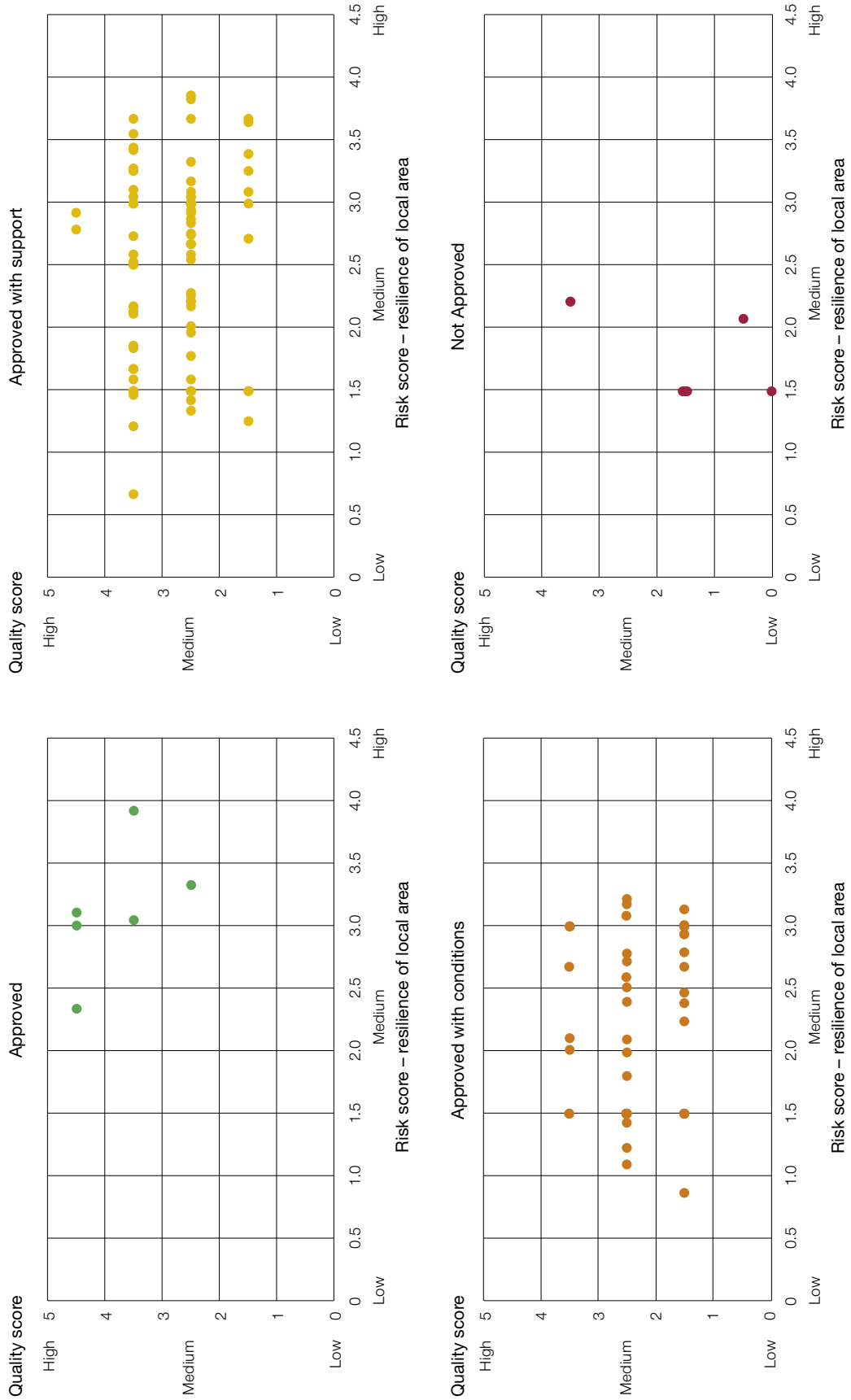
Outcome of the review of the September Fund plans

Almost two-thirds of plans have been approved to allow local areas to proceed with planning

Proposed status	● Approved	● Approved with support	● Approved with conditions	● Not approved
Number of health and wellbeing boards	6	91	49	5
Health and wellbeing boards				
Common issues driving status	High quality plans where any actions were easy to resolve and delivery risk was low Plans were well articulated	Outstanding actions but could be resolved relatively straightforwardly	Material actions that need to be addressed that will take some effort to resolve Material outstanding risks relating to the National Conditions or non-elective targets	Plan not submitted Plans not jointly owned Plan of poor quality
Size of pooled fund (£bn)	0.152	3.046	1.811	0.253
Non-elective reduction (%)	-3.29	-3.13	-3.34	-1.12

Source: Nationally Consistent Assurance Review, North East London Commissioning Support Unit

Figure 10
 Quality and risk of plans submitted by local areas in September 2014
 Most plans are of medium or high quality



Source: Nationally Consistent Assurance Review, North East London Commissioning Support Unit

Part Three

Risks to implementation, 2015-16

3.1 In this part, we look at implementation of the Fund in 2015-16, and examine the main risks.

Risks to local authority adult social care services

3.2 Local government is concerned that the new focus on emergency admissions, as the main indicator for the payment-for-performance part of the Fund, changes the Fund's national focus. The previous design emphasised savings to social care (that is, local authorities) and to the NHS. The new focus on emergency admissions means that more attention is focused on savings for the NHS. However, central government has asked local areas to submit their ambitions for a wider group of performance indicators, which may help retain the Fund's original purpose.

3.3 Our report *Adult social care in England: overview*⁹ found that adult social care spending fell 8% in real terms between 2010-11 and 2012-13. Recent changes to the Fund mean that less of the pooled money is available for unrestricted use. However, one of the Fund's national conditions is that local authorities protect adult social care services (although not spending). As part of plan assurance, NHS England and the Local Government Association required local areas to explain how they will protect adult social care services and how much this will cost. The biggest risk area identified is to the protection of social care services with 21 local areas assessed as having material risks.

3.4 New restrictions on how £1 billion of the Fund can be spent (summarised in paragraph 2.6 and Figure 7) reduce the amount available for local authorities to commission adult social care services. In most areas, a large proportion of the £1 billion must be spent on NHS-commissioned out-of-hospital services. These can include services jointly commissioned by clinical commissioning groups and local authorities. However, only the element of the funding from the clinical commissioning group will count towards the total of NHS-commissioned out-of-hospital services.

⁹ Comptroller and Auditor General, *Adult social care in England: overview*, Session 2013-14, HC 1102, National Audit Office, March 2014, available at: www.nao.org.uk/report/adult-social-care-england-overview-2/

Risks to acute providers and clinical commissioning groups

3.5 Under the revised payment-for-performance part of the Fund, clinical commissioning groups and local authorities now share a limited financial risk that schemes within the Fund do not make savings for the health sector. This reduces the risks to clinical commissioning groups. However, the Fund still requires the NHS to contribute £1.9 billion to the pooled fund from clinical commissioning group allocations (Figure 2). Of this, £0.9 billion is not linked to performance in reducing emergency admissions, nor to clinical commissioning groups' spending on NHS-commissioned services.

3.6 Part of the income for acute trusts, which manage hospitals, comes from emergency admissions. Higher volumes of emergency admissions generally result in more income. If local areas reduce emergency admissions there will be a reduction in acute trusts' income. In the plans submitted in April 2014, health and wellbeing boards were asked to specify the level of engagement with acute providers and what the impact of their plans on acute providers would be. Since July 2014, NHS England and the Local Government Association's planning guidance required local areas to quantify the impact of plans on NHS acute services and relate this to the benefits expected. Acute providers also completed a template providing their commentary on the plan:

- saying whether they agreed with the local area's statement of expected impact on emergency admissions;
- explaining, where relevant, why they did not agree with the projected impact; and
- confirming that they had considered the implications for their services.

The assurance process concluded that most providers were at least engaged in the plan and supportive of the direction of travel, but in approximately 20% of local areas, providers heavily qualified their support. For 12 local areas, NHS England imposed a condition that the area must improve provider engagement. These conditions will have to be met before areas can proceed with their plans. The template did not require providers to comment on estimates of financial savings.

3.7 Both clinical commissioning groups and acute providers could potentially reduce their costs if emergency admissions reduced. However, the departments' and NHS England's planning assumptions appear optimistic:

- **Savings for commissioners**

NHS England's estimate of how much money can be saved does not consider which types of emergency admissions local areas can prevent in 2015-16. Our report *Emergency admissions to hospital: managing the demand*¹⁰ found that short-stay emergency admissions¹¹ account for most of the increase in total emergency admissions over the past 15 years. NHS England assumed a cost saving of £1,490 for each emergency admission avoided in 2015-16. The short-stay emergency tariff is generally lower than this, at around £800 per short-stay emergency admission.¹² The average long-stay¹³ emergency tariff is higher, at around £3,000 per long-stay emergency admission. This illustrates that local savings depend not only on how many admissions a local area avoids, but also on the admissions' cost. Furthermore, commissioners may be paying at 30% of the tariff where admissions exceed the 2008-09 level due to the marginal tariff rate, reducing the potential for savings. Since 2013-14, commissioners have been required to invest the remaining 70% of the tariff income in schemes to manage demand for emergency admissions. However, our report on emergency admissions found that this rule was not consistently applied by commissioners and that it is unclear how much of the remaining income has been reinvested.

- **Savings for providers**

If commissioners pay less because activity is lower, and if acute trusts can continue to provide the same level of service with a lower income, this would be a good outcome. However, this will be a challenge for many providers in the current context. Providers may be unable to make short-term reductions in their spending due to fixed costs. Also, staff in hospitals work on multiple tasks, not exclusively on emergency care. Reducing staff numbers when the proportional decrease in emergency admissions is relatively low could be challenging.

10 Comptroller and Auditor General, *Emergency admissions to hospital: managing the demand*, Session 2012-13, HC 739, National Audit Office, October 2013, available at: www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/

11 Short-stay admissions are stays of less than 2 days.

12 Deloitte for Monitor (2014), *Short Stay Emergency Tariff Review*, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/317569/Supporting_document_D_-_Deloitte_SSEM_for_publicationedd6.pdf; Department of Health (2013), *Reference costs 2012-13*, available at: <https://www.gov.uk/government/publications/nhs-reference-costs-2012-to-2013>

13 Long-stay admissions are stays of 2 days or more.

Evidence that the Fund will be successful

3.8 Local areas have to propose how to change and integrate services to improve patient outcomes. However, there is limited evidence that integrated care is cost-effective in sustainably reducing unplanned hospital admissions. Previous attempts to integrate health and social care locally have had mixed results. The Department of Health recently commissioned a review of the evidence by the University of York's Centre for Health Economics. The review concluded that:

“Compared with ‘usual care’, schemes that integrated funds and resources to support integrated care seldom led to improved health outcomes. Although some schemes succeeded in shifting care closer to home, and some achieved short-term reductions in acute care utilisation, no scheme demonstrated a sustained and long-term reduction in hospital use.”¹⁴

3.9 In November 2013, the Department of Health announced 14 local areas as Integrated Care and Support Pioneers to establish best practice and share evidence. These will not be evaluated until 2015. The National Institute for Health and Care Excellence, through its National Collaborating Centre for Social Care, will publish recommendations on the cost-effectiveness of social care interventions from 2015 onwards. The departments initially issued no specific guidance on effective schemes to local areas. The Fund task force gave local areas a support pack in late August 2014 on the developing evidence. The government hopes that local areas will, through the local projects the Fund will support, generate examples and evidence for how to transform and integrate social care and healthcare.

3.10 The national planning assumption that emergency admissions will fall by 3.5% in 1 year is ambitious given the long-term trends. Emergency admissions increased by 47% over the 15 years to 2012-13.¹⁵ Local areas have forecast, on average, a 3.1% reduction in emergency admissions between 2014-15 and 2015-16 (**Figure 11** overleaf).

¹⁴ A Mason, M Goddard, H Weatherly (2014), *Financial mechanisms for integrating funds for health and social care: an evidence review*, Centre for Health Economics, University of York, available at: www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP97_Financial_mechanisms_integrating_funds_healthcare_social_care_.pdf

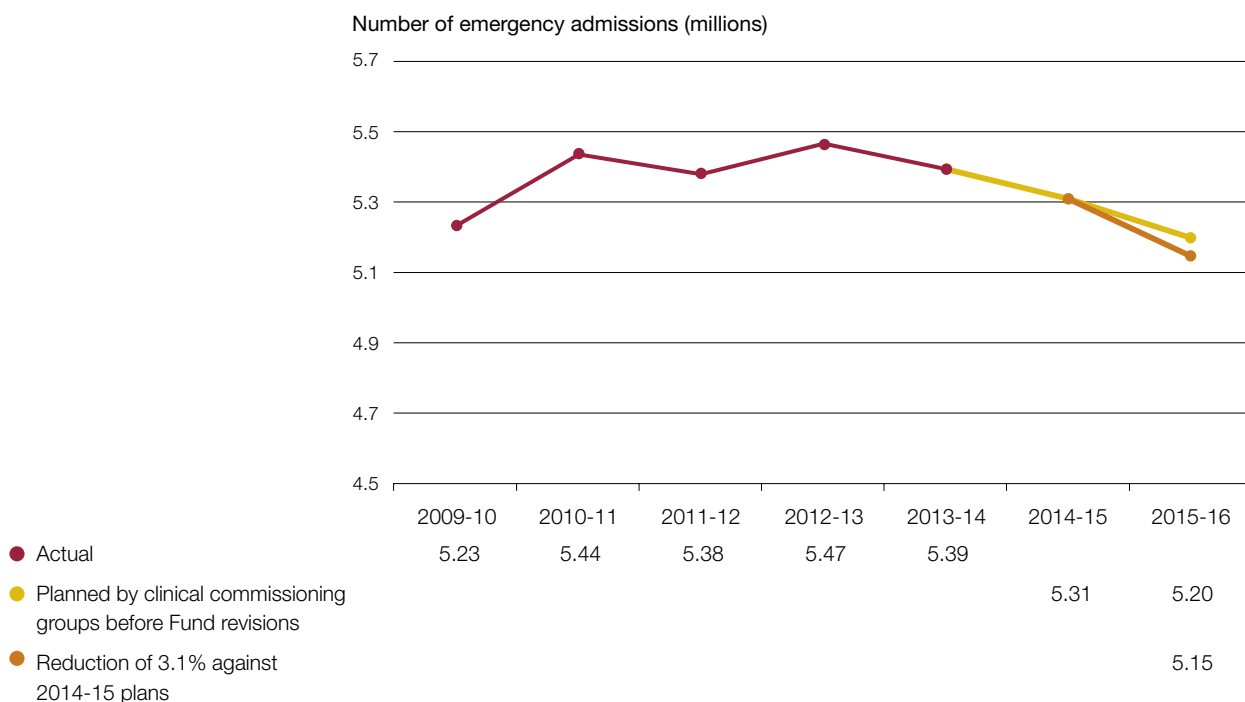
¹⁵ Comptroller and Auditor General, *Emergency admissions to hospital: managing the demand*, Session 2012-13, HC 739, National Audit Office, October 2013, available at: www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/

3.11 The target will be particularly stretching for some local areas because several have already reduced their emergency admissions. The annual change in emergency admissions between 2010-11 and 2012-13 varies considerably across local areas when averaged over this period (**Figure 12**). There have been initiatives for many years aiming to reduce emergency admissions.¹⁶ If the emergency admission target is missed, the clinical commissioning group can still choose to put the payment-for-performance money into the pooled budget, if it considers that to be the best way to address the problem that has led to the target being missed.

Figure 11

Total emergency admissions in England

The Fund sets an ambitious national expectation for reducing emergency admissions



Note

1 There was a change in the way that NHS England collected the data from the start of 2010-11, which increased the number of patients included.

Source: National Audit Office analysis of Monthly Activity Return data submitted by clinical commissioning groups through UNIFY, the Department of Health's online system for collating, sharing and reporting NHS and social care data, published by NHS England

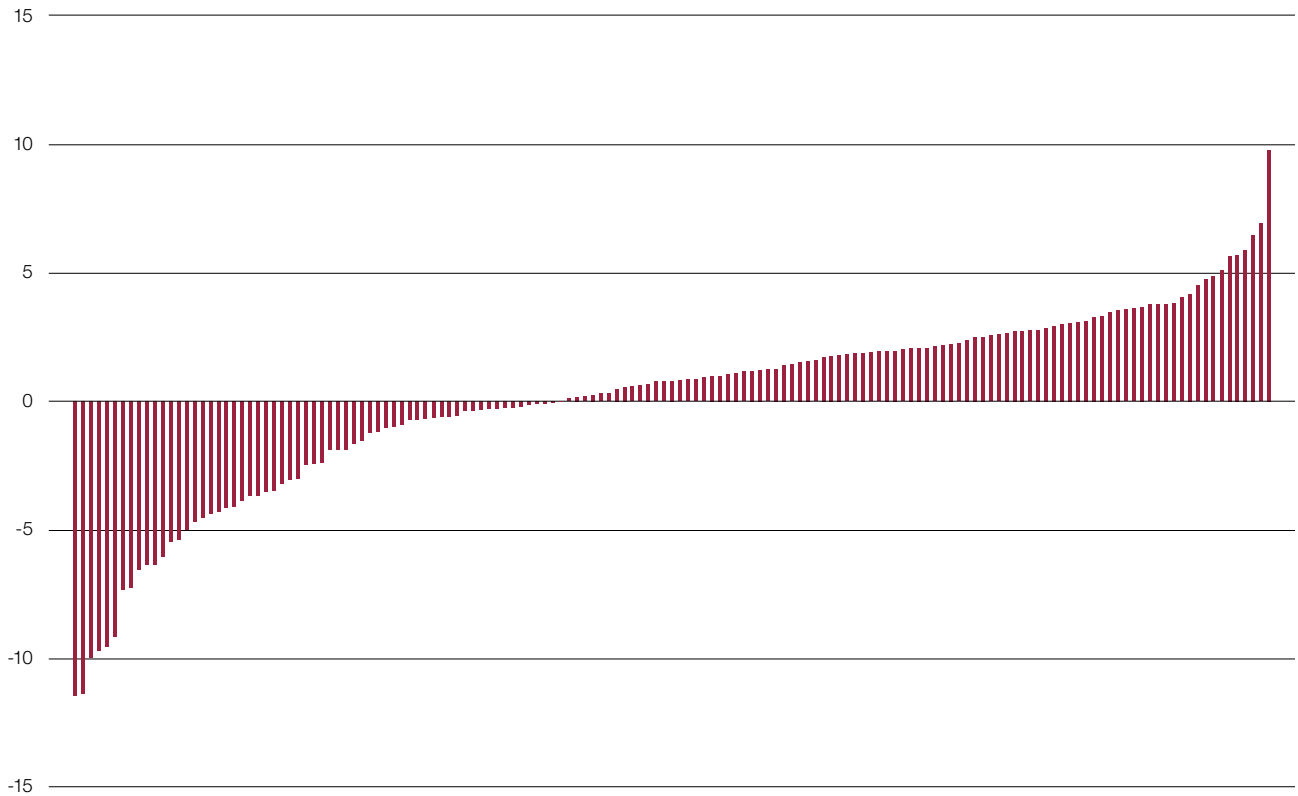
¹⁶ As discussed in Purdy et al (2012), *Interventions to reduce unplanned hospital admission: a series of systematic reviews*, available at: www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf

Figure 12

Average annual change in emergency admissions across local areas, 2010-11 to 2012-13

Change in emergency admissions varies across local areas

Percentage



Note

1 There was a change in the way that the Monthly Activity Return data were collected from the start of 2010-11, and changes to the mapping of data to local areas in 2013-14. The change to the mapping does not affect national data, but does affect local data, so we have excluded 2009-10 and 2013-14 from these local averages.

Source: National Audit Office analysis of Monthly Activity Return data submitted by clinical commissioning groups through UNIFY, the Department of Health's online system for collating, sharing and reporting NHS and social care data, published by NHS England

Suitability of total emergency admissions as the payment-for-performance indicator

3.12 We assessed the suitability of total emergency admissions as an indicator for the Fund against a framework for performance information (**Figure 13**).¹⁷ The indicator has some strengths, such as clarity and availability. A weakness for 2015-16 is that local areas may be paid in response to changes unrelated to the Fund, since local areas will be unable to attribute changes in emergency admission numbers to the Fund. Also, emergency admissions in some local areas fluctuate year on year, according to the data that NHS England has published to assist health and wellbeing boards' planning (**Figure 14** on page 38). The data were therefore of limited use in informing local decision-making. From our discussions with NHS England and a small number of local areas, we believe that this volatility may be in part because of the way data were recorded:

- NHS England changed the way they collected the data between 2009-10 and 2010-11, which increased the number of patients included; and
- there was a change in the mapping of data to local areas in 2013-14, because primary care trusts were replaced by clinical commissioning groups, so the 2013-14 data are not comparable to previous years for the same local area.

Accountability arrangements

3.13 The main bodies that oversee the Fund are shown in **Figure 15** on page 39. The Fund is part of the Department of Health's budget so overall accountability to Parliament sits with the Permanent Secretary for the Department of Health. The NHS England Accounting Officer is accountable to the Permanent Secretary for the revenue element of the Fund (around £3.46 billion). It is unclear how health and wellbeing boards fit into the accountability arrangements. This is because both clinical commissioning groups and local authorities represented on the boards will jointly agree how to spend revenue and capital funds. The Permanent Secretary for the Department for Communities and Local Government acknowledged to the Committee of Public Accounts on 30 June 2014, that he needs to adapt the accountability system statement model to account for health and wellbeing boards and the Fund. However, the departments have not yet clarified accountability or determined assurance and monitoring arrangements for 2015-16. The Chartered Institute of Public Finance and Accountancy and the Healthcare Financial Management Association published guidance for local areas in October 2014.¹⁸

3.14 Besides the main accountability, the Major Projects Authority and the Cabinet Office Implementation Unit are also scrutinising and advising on the Fund. The Department of Health approached the Major Projects Authority around June 2014 for assistance. The Fund is now listed on the government's portfolio of major projects. Between September and November 2014, the Authority is reviewing the Fund's programme management arrangements. The Authority believes that the Fund fulfilled the criteria for, and would have benefited from, being on the portfolio from its initial design in 2013.

¹⁷ HM Treasury, Cabinet Office, National Audit Office, Audit Commission, Office for National Statistics (2001), *Choosing the right FABRIC: a framework for performance information*.

¹⁸ CIPFA and HFMA (2014), *Pooled budgets and the better care fund*.

Figure 13

Assessing the total emergency admissions indicator

Criterion: the performance indicator should be:

Relevant to what the organisation is aiming to achieve

Avoid perverse incentives, do not encourage unwanted or wasteful behaviour

Attributable: the activity measured must be capable of being influenced by actions which can be attributed to the organisation, and it should be clear where the accountability lies

Well-defined, with a clear, unambiguous definition so that data will be collected consistently and the indicator is easy to understand and use

Timely, producing data regularly enough to track progress, quickly enough for the data to still be useful

Reliable: accurate enough for its intended use and responsive to change

Comparable with either past periods or similar programmes elsewhere

Verifiable, with clear documentation behind it, so the processes that produce the indicator can be validated

Our assessment: is this criterion met?

Mixed: broadly aligned to the need for health savings since emergency admissions are a major cost. However, admissions vary greatly in cost; small reductions in admissions may not lead to savings; and the indicator does not necessarily reflect outcomes for patients.

Mixed: there are other incentives in the health sector (such as the system of payment) which are more significant than the Fund.

No: there are several factors influencing total emergency admissions, and academic studies suggest factors which are hard for local areas to manage in the short term explain the majority of (not all) variation.

Mixed: the indicator is simple and easy to understand, but there have been changes to its definition in the past. The mapping required to produce numbers in health and wellbeing board areas requires an approximation.

Yes: performance will be measured quarterly and the total emergency admissions data permit this.

Mixed: incomparability in past years' data suggests the measure is vulnerable to changes in definition. However, the measure is widely used and NHS England believes it is more reliable than alternatives.

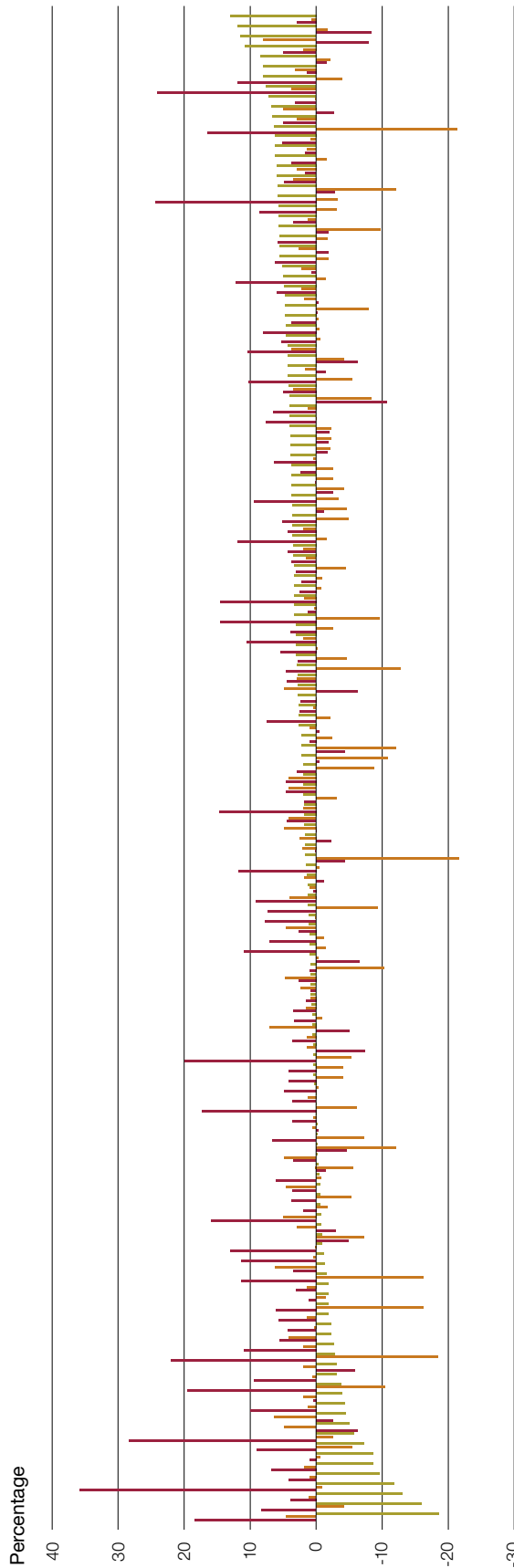
No: data provided by NHS England for 2009-10 to 2013-14 were not comparable across these years. Use of an absolute number, not a rate, means the indicator is unsuitable for long-term comparisons because it does not take into account changes in population size or structure.

Not tested for this report. Documentation of the indicator is not publicly available.

Source: National Audit Office assessment based on HM Treasury, Cabinet Office, National Audit Office, Audit Commission, Office for National Statistics (2001), *Choosing the right FABRIC: a framework for performance information*; the NAO's review of documents; and discussion with NHS England.

Figure 14
Annual changes in total emergency admissions to hospital from 2009-10 to 2012-13

Changes vary substantially year-on-year for each local area



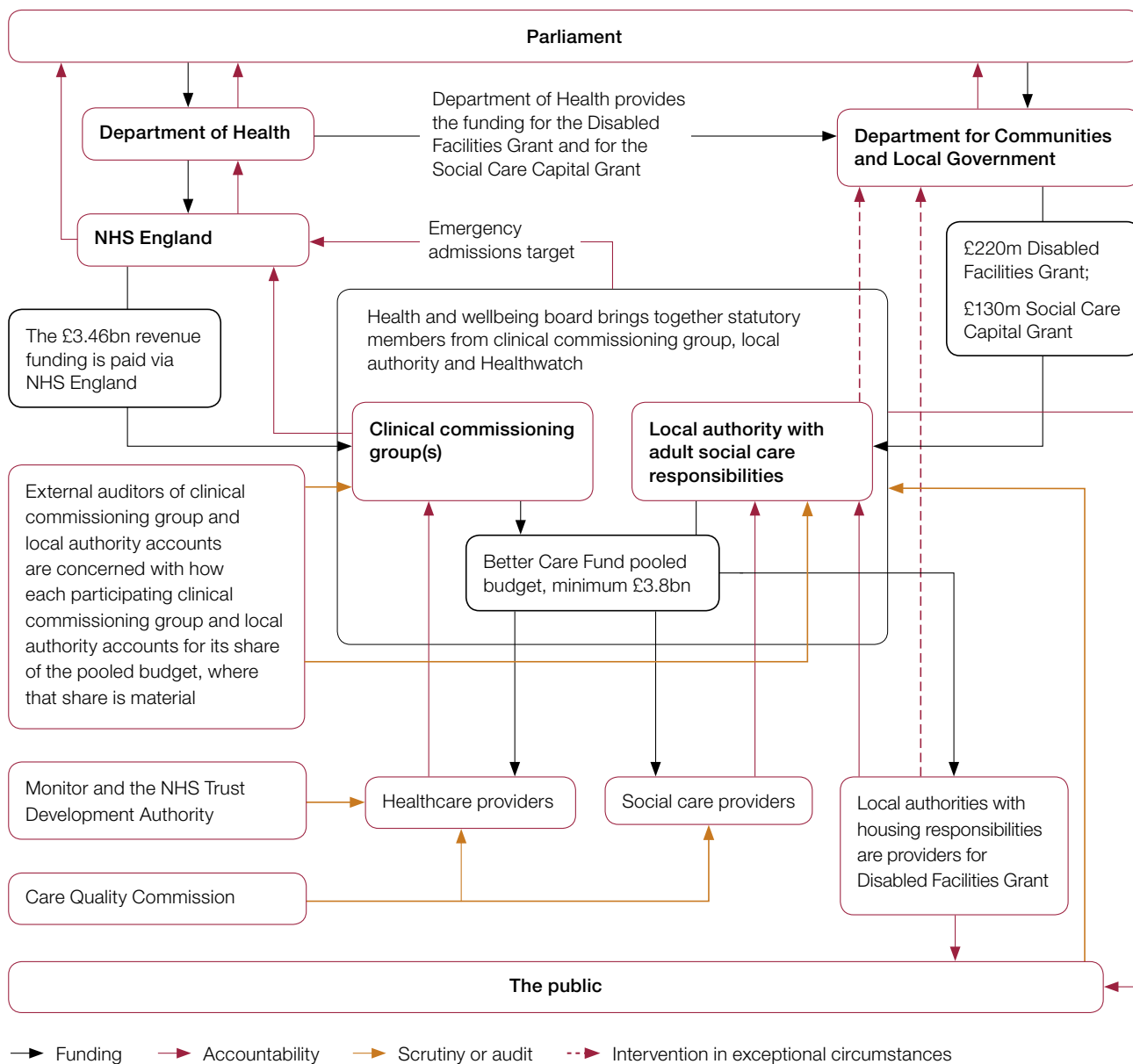
- 2009-10 to 2010-11
- 2010-11 to 2011-12
- 2011-12 to 2012-13

Notes

- 1 Each set of bars relates to one health and wellbeing board area.
- 2 There was a change in the way that NHS England collected the Monthly Activity Return data from the start of 2010-11, and changes to the mapping of data to local areas in 2013-14. Despite this, we have included 2009-10 data in the chart above because the indicator may be subject to further definition changes. We have, however, excluded 2013-14 data because mapping changes are unlikely to recur in the near future.

Source: National Audit Office analysis of Monthly Activity Return data submitted by clinical commissioning groups through UNIFY, published by NHS England

Figure 15
Funding and accountability for the Fund in 2015-16



Notes

- 1 Health and wellbeing boards may include non-statutory members such as providers or housing authorities.
- 2 Providers are accountable to the organisation that commissions their services. While this may be clinical commissioning groups for healthcare providers and local authorities for social care providers, as shown above, this may vary depending on local agreements such as who is host of the pooled budget. Clinical commissioning groups' and local authorities' statutory service obligations are unchanged by budget pooling.

Source: NHS England and Local Government Association (2014), *Better Care Fund technical guidance*; Department of Health and NHS England (2014), *Framework agreement between the Department of Health and NHS England*; Chartered Institute of Public Finance and Accountancy and Healthcare Financial Management Association (2014), *Pooled budgets and the better care fund*

Appendix One

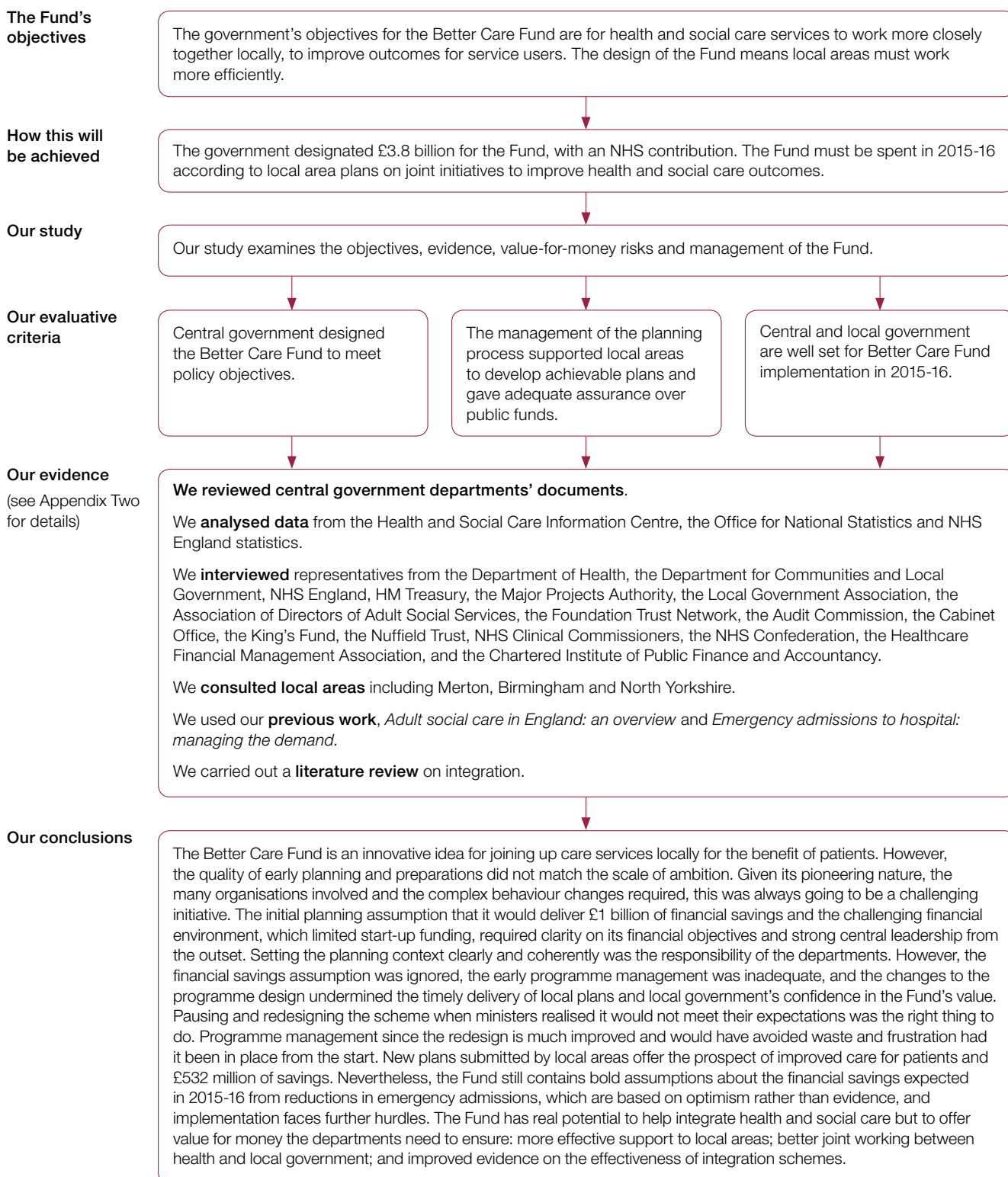
Our audit approach

- 1 Our study examined the Better Care Fund, including:
 - how NHS England, the Department of Health and the Department for Communities and Local Government designed the scheme to meet policy objectives;
 - how NHS England and the departments managed the Better Care Fund programme, including their risk management and the support they offered to local areas; and
 - the impact of the Fund's revision in July 2014.
- 2 We used our previous reports such as our guide *Initiating successful projects*¹⁹ and our report *Managing risks in government*²⁰ to inform our evaluative criteria.
- 3 We collected evidence from those involved with the Fund and wider health and social care reports, and evaluated it against our criteria.
- 4 Our evidence is described in Appendix Two.

19 National Audit Office, *Initiating successful projects*, December 2011, available at: www.nao.org.uk/wp-content/uploads/2011/12/NAO_Guide_Initiating_successful_projects.pdf

20 National Audit Office, *Managing risks in government*, June 2011, available at: www.nao.org.uk/wp-content/uploads/2011/06/managing_risks_in_government.pdf

Figure 16
Our audit approach



Appendix Two

Our evidence

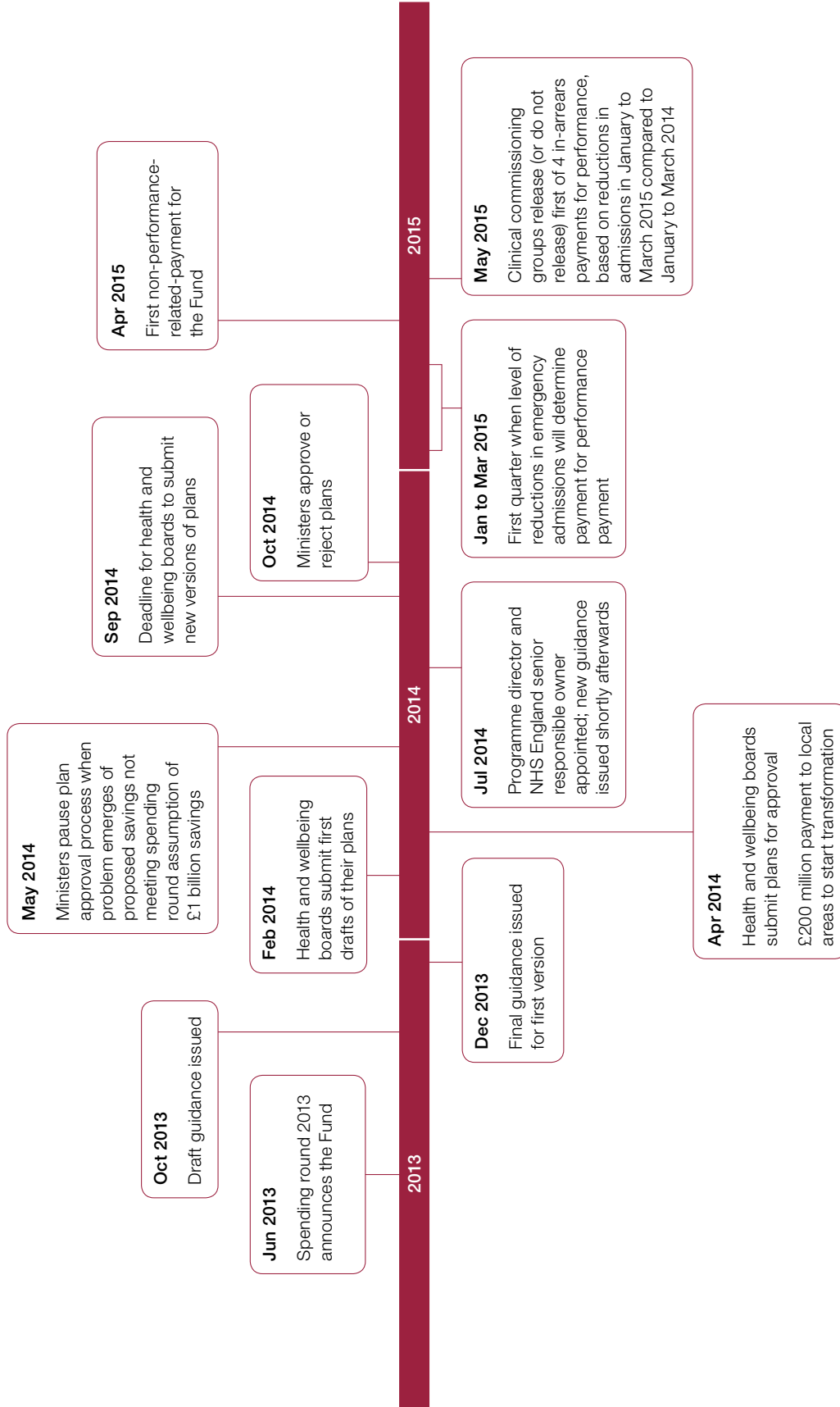
- 1 We reached our independent conclusions on implementing the Better Care Fund after analysing evidence from the period June 2013 to October 2014. Our audit approach is outlined in Appendix One.
- 2 We **reviewed documents** about the Fund from NHS England, the Department of Health, the Department for Communities and Local Government and the Local Government Association.
- 3 We **analysed data** from the Health and Social Care Information Centre, the Office for National Statistics and NHS statistics, to understand the data behind the indicators used for the payment for performance. We did descriptive analysis to understand trends, relationships and geographical distributions.
- 4 We held **semi-structured interviews** with senior people from organisations with responsibilities for the Fund and other experts.
- 5 We **consulted** local areas to get local views of the Fund.
- 6 We **used our previous work** on adult social care, emergency admissions, integration in government, managing risks in government and initiating successful projects.
- 7 We **reviewed literature** on the evidence base for integration.

Appendix Three

Better Care Fund timeline

Better Care Fund timeline, June 2013 to May 2015 (**Figure 17** overleaf)

Figure 17
Better Care Fund timeline, June 2013 to May 2015



Note

1 Fund implementation will continue after May 2015.

Source: HM Treasury, *Spending Round 2013*, June 2013, available at: www.gov.uk/government/publications/spending-round-2013-documents; NHS England and Local Government Association (2014), *Better Care Fund technical guidance*; unpublished documents from NHS England, Department for Communities and Local Government and Department of Health.

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