The better care fund – six months on

Survey Report November 2015

Executive summary

In a survey of NHS bodies and local authorities representing almost a third of Better Care Funds (BCF), HFMA and CIPFA found that, although positives are emerging after six months of the programme, the particular mechanics of the BCF have led to at least as many negatives.

There is widespread enthusiasm for the integration agenda that the BCF seeks to advance and the HFMA and CIPFA welcome the announcement[1] that the BCF will continue in the life of this Parliament. This announcement makes it all the more important that lessons are learnt from the first year of the BCF if it is to be the cornerstone of the journey to full integration of health and social care by 2020.
The main findings were that:

- Health and social care communities have typically embraced the new arrangements keenly, as shown by around half of them pooling more money through the BCF than the minimum required

- Local implementation arrangements differ considerably in structure as well as in the detail of plans. For example:

    - Governance is often complicated: with numerous CCGs and local authorities formally required to take part; and many other stakeholders, notably providers, needing to be involved. Arrangements in areas with unitary authorities tend to be much simpler
    - No one method of setting up and accounting for the flow of funds involved has emerged as preferred practice
    - It was assumed that local authorities would most commonly host the BCF. This assumption has proved to be the correct. Having said that, a diverse range of approaches has emerged based on financial, geographical, historical, practical and political factors.

Respondents made positive and negative points about the BCF. Positive implications mostly related to the improvement in working relationships between organisations, the breaking down of organisational boundaries, better collaboration and improved understanding of each other's pressures. The impact on services was also acknowledged, with wider consideration being given to the links between social care and acute activity, some examples of new and innovative investments. All of these findings can be built on as the improved BCF.

[1] Spending Review 2015 www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents. A summary of the impact of the review on the BCF can be found an Appendix to this document.

The main negatives were:

- The level of bureaucracy: the BCF is seen as unwieldy, consumes a disproportionate management time, and comes with demanding metrics and oppressive reporting requirements
- The unrealistic expectations for the BCF, fuelling disputes between partners and 'giving integration a bad name' in the words of one respondent
- The pressure it added to already-stretched health finances, essentially because the BCF merely reuses existing funding while assuming it creates additional investment.

Not surprisingly, then, respondents called for improved clarity, simplification, and a recognition that implementing joint working arrangements is difficult and takes time: 'relationships begin to get tested when the money dries up', said one CCG. However, they also recognised the benefits of integration, especially where a common purpose can be built, joint posts set up, and alignment achieved with other major change programmes in the local health and social care economy. No-one argued with the need to focus the whole system on the key activity of developing alternatives to hospital admission.

Given that context, CIPFA and the HFMA call on the Government to:

- Review the administrative and monitoring arrangements prior to the start of 2016/17 with a view to simplifying and streamlining; and consult as early as possible on the proposals so as to facilitate effective planning
- Continue to modify and liberalise the arrangements going forward so that there is maximum synergy with the emerging devolution programme, which is likely to prove the most sustainable model for taking forward integration at scale
- Use the lessons learnt from the BCF so far when developing the arrangements for the development of plans for full integration of health and social care by 2017 to be implemented in 2020.

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Introduction

In October 2014, the HFMA and CIPFA published a briefing on pooled budgets and the better care fund (BCF). In that briefing we set out the regulations which apply to the BCF and issues the partners to the BCF should consider when establishing governance arrangements, operational structures and financial arrangements.

In October 2015, the HFMA and CIPFA jointly surveyed their members to try to assess what has actually happened in practice and to look ahead to the second half of 2015/16 and beyond to see whether there are lessons to be learned and whether any further guidance is needed.

The results of this survey are being shared with the Department of Health (DH), NHS England, Monitor and the NHS Trust Development Agency and the National Audit Office.

Overview

In total 48 responses were received, from organisations involved in over half (£3.6bn of £5.3bn) of the national BCF total:

- 37 CCGs
- 10 local authorities
- 1 joint CCG/local authority.

Not all individuals answered every question and the percentages referred to are percentages of respondents answering the specific question. (Some tables may not add up to 100% due to rounding.) None of the responses received have been verified.

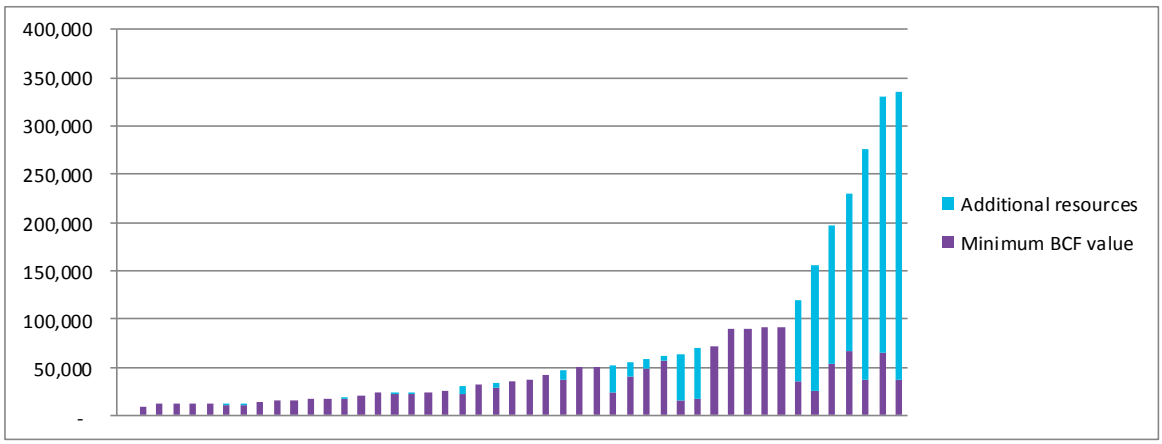
The survey revealed the following key points:

- The BCF arrangements in place are varied and, in some places, complex involving multiple NHS bodies and multiple local authorities
- In the most part, section 75 agreements underpinning the BCF are in place but this was not always the case on 1 April 2015
- Some section 75 agreements are still subject to change
- Generally, and as anticipated, local authorities are hosting the BCF
- A variety of models are being used for funding the BCF but the most common model moves cash to the host body (usually the local authority) and then back to the CCG for contract payment
- Respondents report that the BCF has had both a positive and negative effect on working relationships between organisations – it has forced organisations to work together and to understand each other's' business and risks but the bureaucracy and unrealistic expectations has hampered progress
- Less than half of respondents have read the guidance issued by the DH and NHS England on accounting for the BCF and fewer still have shared it with their partners
- The majority of respondents do not expect to meet the performance targets set out in the BCF agreement.

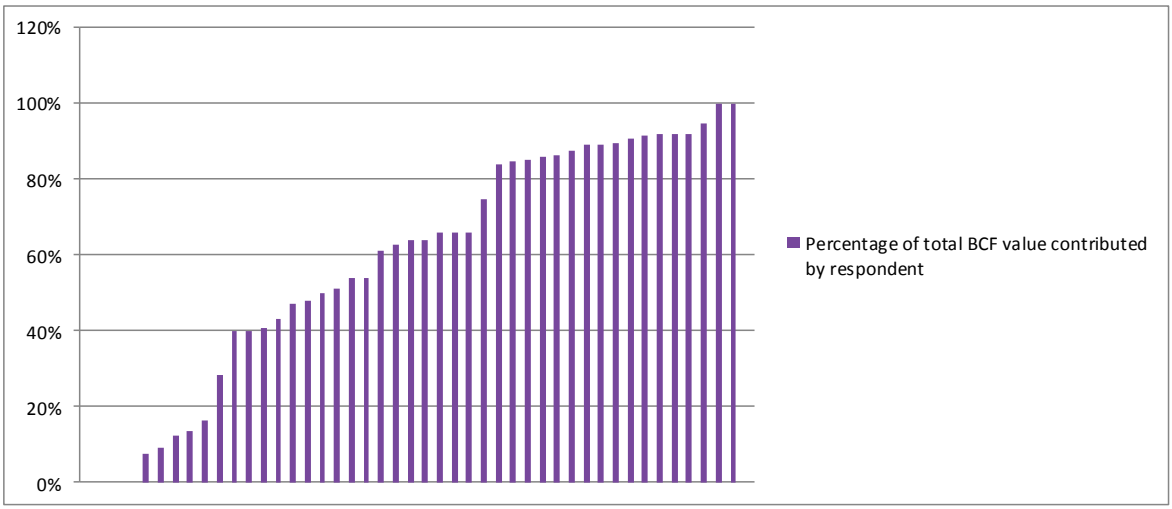
Value of the better care fund arrangements in place

The respondents[2] to the survey are involved with BCF arrangements valued at £3,562m. This is 55% over the minimum amount that the respondents were required to include in their BCF.

25 respondents did not include anything other than the minimum required in their BCF.

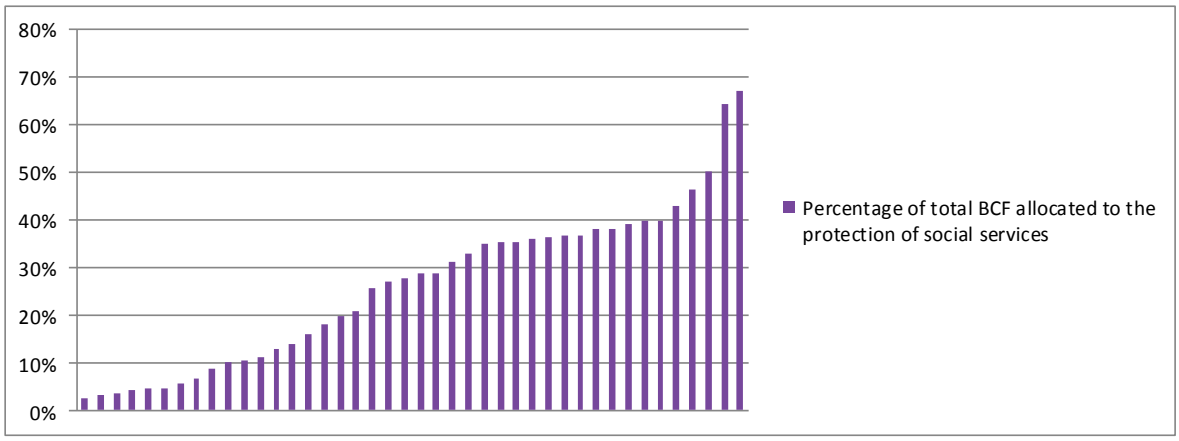


Of the total BCF amount, the amounts contributed by respondents ranged from 7% to 100%.

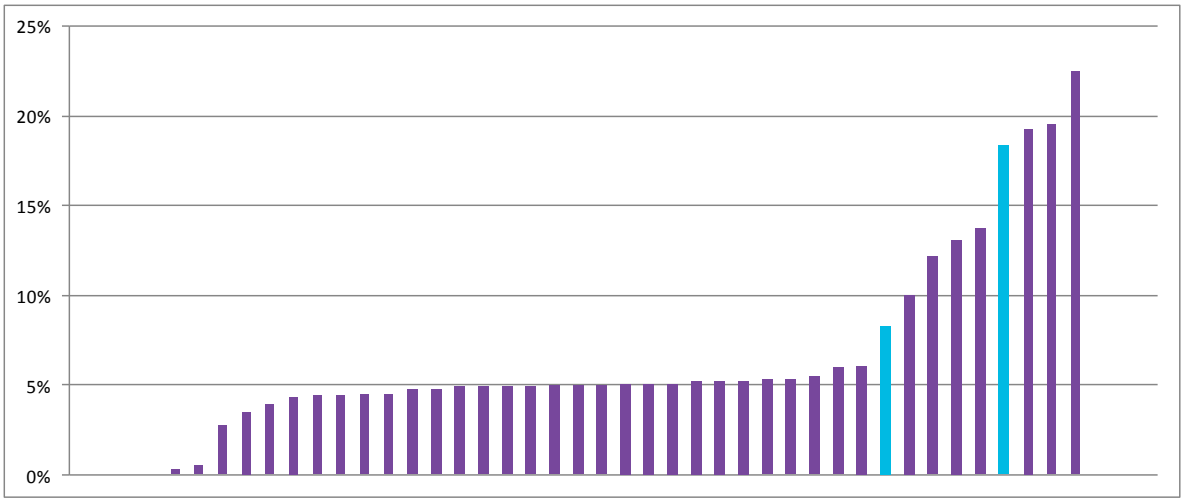


The amount of the BCF allocated to protecting social services ranged from nothing to 67% of its value.

[2] Note: only 39 respondents provided us with this information



The total contribution to the BCF made by the respondents ranged from nothing to 23% of their gross expenditure budget for 2015/16. Anecdotally, we have been told that the BCF is material for CCGs but less so for local authorities. Our survey confirms this – the chart below shows the respondents' contribution to the BCF for 2015/16 as a percentage of its gross budget for the year. The only local authorities to make a contribution to the BCF as shown in blue.



Number of organisations involved in better care fund arrangements

We asked how many bodies were included in the respondents' BCF arrangement. As expected there are a variety of models in place and the number of bodies involved varies immensely. All BCF arrangements should include at least one CCG and one local authority to meet the requirements of section 75 of the NHS Act 2012. The number of CCGs and local authorities involved in any one agreement is, to some extent, a matter of geography and whether the boundaries of the different organisations are co-terminus.

In twenty two cases (47% of respondents), there are at least six different organisations involved in the BCF agreement and in eleven of those cases there are more than ten bodies involved illustrating the complexity of the arrangements. Where there are exceptionally large numbers of bodies involved, it is usually due to the involvement of district councils in a county:

'There are 10 local district/borough councils in the County who have been involved with

regard to the Disabled Facilities Grant (DFG)[3]

'7 district/borough councils - although their involvement has been limited to the DFG'

'6 CCGs, 15 district authorities'

	No.	Percentage
Multiple CCGs, multiple providers and multiple local authorities	10	15%
One CCG and one local authority	8	17%
Multiple CCGs and one local authority	8	17%
One CCG, multiple NHS providers and one local authority	7	17%
One CCG, multiple NHS providers, one local authority and other(s)	4	9%
One CCG, one NHS provider and one local authority	3	6%
Multiple CCGs and multiple local authorities	2	4%
CCG(s) alone	2	4%
One CCG, one provider and one other body'	1	2%
One CCG, multiple providers and multiple local authorities	1	2%
One CCG, one local authority and one other body'	1	2%

Whilst it is compulsory to consult with NHS provider bodies on BCF plans, it is not a requirement to formally include them in BCF arrangements. However, it is considered good practice to do so. It is pleasing to report that over half of the respondents to this question (26 out of 47) indicate that at least one provider body is involved in their arrangements. The involvement does not always have to be so formal; two of the respondents who did not include providers in the list of bodies involved in the BCF arrangement noted that they were involved in other ways:

'The better care fund and section 75 are between 5 CCG's and 1 county council. However, at local level the BCF for our CCG locality has a joint board including 2 providers (1 acute, 1 mental health) and 2 district councils'

'Providers involved through membership of Transformation Group which oversees system transformation and through delivery of BCF funded services'

The section 75 arrangements in place

The BCF has now been operating for just over six months but the s75 agreement underpinning it should have been in place on 1 April 2015. Just over half of respondents (26 out of 48) said that their agreement was in place at that date.

The reasons for the agreements not being signed by 1 April 2015 were mainly related to the amount of time taken to agree contract documentation and protracted on-going discussions:

'Agreement was going through relevant governance and Boards at both organisations'

'Contract issues'

[3] The Disabled Facilities Grant has to be included in the BCF and in areas where there is a two tier local government regime is administered through district councils. Social services are the responsibility of county councils so in these areas all of the local authorities have to be signatories to the better care fund.

'In principle everything was agreed it was just the pulling together of the overall document which was completed by 17th June 2015'

'It took a little longer to complete the documentation'

'Still agreeing terms of the agreement in respect of the performance fund element'

'There was a pre-existing S75 covering all non-BCF pooling between CCGs and County Council in place. New document, replacing existing pooling arrangements and incorporating BCF has taken longer than anticipated to pull together - some key personnel departures at County Council have not helped.'

'Too much work involved to get the plan through NHS England governance, thereby placing strain on resources available to complete s75'

At the date of completing the survey, the vast majority of respondents had a section 75 agreement in place and approved by all organisations:

	No.	Percentage
The section 75 is in place and approved with no further amendments/agreements required. Even in this instance, one respondent noted: *'The agreement is in place. Whilst nothing needs amending there are a number of ongoing actions related to things like (a) risk share (b) pay for performance impacts (c) developing year end plans with a particular emphasis on the county council's and the CCG's accounts timetable being significantly different.'*	32	68%
The section 75 is in place and approved but requires further amendment and/or agreement (see below)	9	19%
The section 75 is in place but not approved	1	2%
The section 75 is approved but not signed	1	2%
The section 75 is not in place: *'Ongoing discussions concerning the sharing of risk between health and local authority, esp. the payment for performance (P4P) element.'* *'Being taken through Boards/County Council processes currently - expected to be signed by all bodies by 16 November 2015.'* *'Section 75 agreements have been drawn up but are still waiting to be signed by all parties'* *'The S75 agreements still need to be signed. The main thing outstanding is finalising a financial and performance reporting framework for the BCF in Surrey. CCGs have refused to sign the agreements until this framework has been finalised'*	4	9%

In 9 cases where the BCF agreement has been signed but needs further amendment or agreement, the reasons varied:

'Wider debate around management of risk and pressures'

'There are some further contract variations to be agreed expenditure plan within year.'

'Final value'

'Clarification of measurement of Non-Elective activity: Monthly Activity Return v Secondary Uses Service (SUS) v Service Level Agreement Manager (SLAM). Also clarification on activity v price as deciding factor'

'Some amendments required to delegated authority limit structure as operational issues encountered. '

'Local key performance indicators (KPIs) for each workstream'

'Method of release for payment for performance funds. How Care Act funds will be applied given the delay in the implementation of the Act. Year-end arrangements.'

The S75 makes reference to the process for year-end but the detailed discussions about how this will work still need to be held locally.

We asked whether respondents had reached agreement on the allocation of funds for Care Act implementation:

	No.	Percentage
Yes	37	79%
No	7	15%
No response or don't know	4	9%

One respondent noted that there is still uncertainty in this area although they have agreed an amount:

'But not on the application of the funds, given the delay in the implementation of the Act

One of those who indicated that they have not agreed said:

'We are not in any disagreement - the question or request hasn't come up.'

Another local authority respondent said that they had been able to accommodate the demand of new duties from existing funding streams.

Better care fund arrangements

Neither section 75 of the NHS Act 2006 nor its associated regulations[4] prescribe how money should be moved between partners to a pooled fund or how the funds should be managed. Regulation 7(3) simply says:

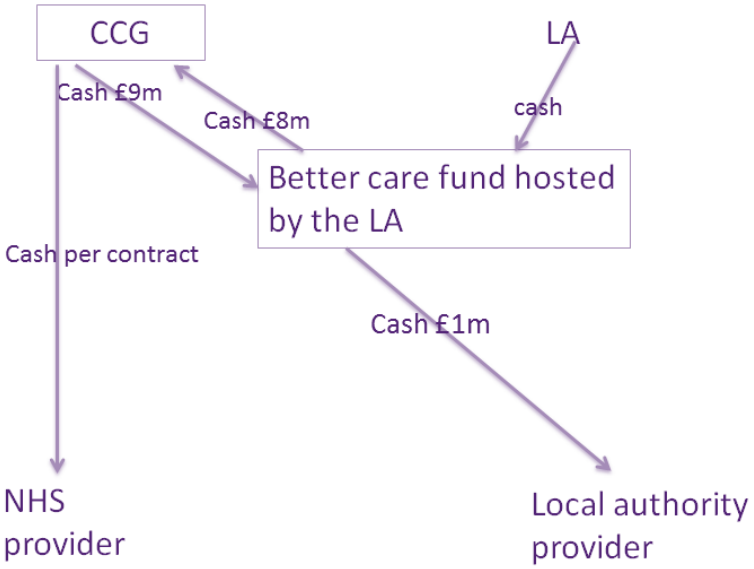
'Where the partners have decided to enter into pooled fund arrangements the agreement must be in writing and must specify—
(a) the agreed aims and outcomes of the pooled fund arrangements;

[4] SI 2000/716 www.legislation.gov.uk/uksi/2000/617/contents/made

(b) the contributions to be made to the pooled fund by each of the partners and how those contributions may be varied;
(c) both the NHS functions and the health-related functions the exercise of which are the subject of the arrangements;
(d) the persons in respect of whom and the kinds of services in respect of which the functions referred to sub-paragraph (c) may be exercised;
(e) the staff, goods, services or accommodation to be provided by the partners in connection with the arrangements;
(f) the duration of the arrangements and provision for the review or variation or termination of the arrangements; and
(g) how the pooled fund is to be managed and monitored including which body or authority is to be the host partner in accordance with paragraph (4).'

The arrangements have been discussed with NHS bodies and local authorities throughout 2015. As a result of these discussions, the HFMA identified 3 different approaches that were being considered as the BCF was being developed. These different scenarios are described in annex 3 to the annex to Chapter 2 in the DH's manual for accounts[5].

Twenty (49%) of the respondents to this question[6] indicated that their arrangement follows scenario 2, in which cash – largely from CCGs - flows to a LA host which then pays CCGs in turn so that NHS providers can be paid. This was the scenario most commonly described at the various conferences attended by the HFMA in early 2015.

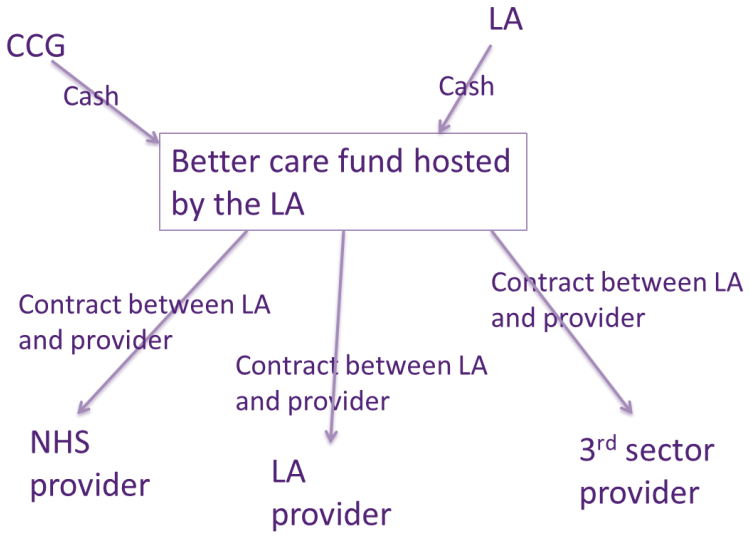


However, the guidance in the manual for accounts makes it clear that this is unnecessary, saying:

'There is no requirement to physically fund the LA host in advance of the payment being made by the CCG to its provider. A "fund" can exist under section 75 even if the cash funding actually remains in members' bank accounts until required to pay providers. The pooled fund is a concept, represented by the use of a memorandum account, rather than a discrete pool of cash held in just one account. '

[5] www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/aeda7648c62c72c680257e99004acdd6?OpenDocument
[6] 7 respondents did not answer this question

Eight (20%) respondents to this question use a variation on scenario 1 as described in the manual for accounts, in which NHS providers are paid directly by the host.



Of those eight:

- five respondents use joint commissioning where all CCG and local authority signatories pay into the pool by transferring funds to the host body, the host body places contracts for services on the basis of the decisions made by all the signatories to the agreement.
- three respondents use lead commissioning where all CCG and local authority signatories pay into the pool by transferring funds to the host body, the host body determines where contracts for services should be placed and manages that contracting process:

Seven (17%) respondents to this question have simply used existing arrangements and either added or amended an overarching section 75 agreement to pick up new funding that has to be included in the BCF such as the disabled facilities grant. Two (7%) others used their existing arrangements with multiple section 75 agreements.

Three (7%) respondents have devolved commissioning to participating bodies. This is scenario 3 as described in the manual for accounts. There are multiple section 75 agreements and each body hosts and commissions services for that agreement.

Hosting the better care fund

Most of the BCF arrangements are being hosted by a local authority:

	No.	Percentage
CCG	10	22%
Local authority	31	69%
Both the CCG and the local authority depending on the circumstance	4	9%

The reasons for deciding on a particular organisation to host can be classified as follows:

- Financial:
  - *CCG is accountable for 95% of the fund*

- *The CCG contributes the majority*
- *VAT application - reduced liability for pooled funds*
- *Financial benefits of LA hosting*
- *Value for money (VFM) audit only for CCGs*
- *Financial implications - e.g. audit fees, tax implications for the NHS*
- *Greater flexibility over any unspent amounts for LA's when compared with CCG's.*

- Geographical:
  - *Common organisation to all parties*
  - *Simplicity - the Local Authority spans the whole geographical area covered by the s.75*
  - *LA covers whole patch, CCGs don't*
  - *% of services covered.*

- Historical:
  - *Established joint commissioning lead*
  - *Consistent with pre-existing s75 arrangements*
  - *They have a track record of hosting other pooled budgets.*

- Practical:
  - *They volunteered!*
  - *Capacity*
  - *Ease*
  - *CCG financial closedown is weeks earlier than LA*
  - *Resources to manage and administer*
  - *Financial skill set*
  - *Capability*
  - *Complexity of the council paying NHS providers*
  - *LA capacity to support fund management*
  - *Willingness of the organisation*
  - *Extensive experience of hosting section 75 pooled budgets with a number currently operating.*

- Political
  - *Ownership of objectives*
  - *Health and wellbeing board (HWB) is LA dominated and made the decision*
  - *Also administers HWB.*

In terms of what being the host actually means, in most cases it is an administrative role. In only 2 cases does the host body have decision making authority:

	No.	Percentage
The host body has delegated decision making powers and runs/commissions the services covered by the BCF agreement	2	5%
The host body maintains the BCF records and produces the quarterly statements	30	70%
The host body provides additional support to the HWB and/or BCF operational groups	4	9%
A mixture of all or some of the above / joint appointments	7	16%

This is supported by the responses to the question about where decisions are being made. In the vast majority of cases, decisions are being made by a committee comprising NHS

bodies and local authorities that reports to the health and wellbeing board.

	No.	Percentage
Integrated commissioning sub-committee	30	64%
Health and wellbeing board	3	6%
No response or don't know	3	6%
Other: • Joint health and social care committee (with various names) • Commissioners • LA officers	 8 2 1	23%

Impact of the better care fund

We asked whether respondents felt that the BCF had had any positive implications and any negative implications.

Only 3 respondents could not think of any positive implications contrasting with 8 who could not think of any negative implications and 8 who could not think of either positive or negative implications.

Positive implications mostly relate to the improvement in working relations between organisations:

'Breaking down organisational boundaries'

'More dialogue across local public sector bodies (including districts), an understanding of pressures on non NHS bodies'

'LA working has to take place now, although it did before, greater understanding of some health aspects by the council members'

But others are much wider and relate to changes in provision of care and services:

'It has generated discussions around NHS funding going to social care'

'Strategic priority of integration'

'Many - improved drive to understand real links between social care provision and acute activity, improved pursuit of community provider data, real investment in upstream capacity'

'It has led to investments in innovative ways of working which may not have taken place otherwise.'

'It forced the Integration agenda, supported further development of partnership working across the health and social care economy, provided a focus on patient outcomes and allowed for further development of community provision'

'Greater collaboration, discussions on overall risks to health/social care, establishment of improved governance arrangements'

'It has led to us needing to engage with the County Council. Prior to the CCG relationships were apparently poor, although it is unclear whether they may have improved with the organisational change.'

'Still early days in terms of implementation, good discussions happening but were already established in some way in the organisation.'

'It has promoted positive joint working between the CCG and Council '

'Better joint commissioning and reduction of pressure on Trusts'

'Better joint working but the rest is already in the main annual plan'

'Clarity of ambition locally'

'Greater collaboration, discussions on overall risks to health/social care, establishment of improved governance arrangements'

'Has given more structure to local partnership working'

'It has led to investments in innovative ways of working which may not have taken place otherwise'

'LA working has to take place now, although it did before, greater understanding of some health aspects by the council members'

'Many - improved drive to understand real links between social care provision and acute activity, improved pursuit of community provider data, real investment in upstream capacity'

'More dialogue across local public sector bodies (including districts), an understanding of pressures on non NHS bodies'

'It has helped to drive integration across the whole system. It just would have been more helpful if the funding arrangements had been structured differently'

'The BCF has provided a valuable opportunity to review the health and social care system finances and consider how savings in one area might impact on other areas of the system. The BCF has accelerated and deepened our approach to integration and enabled us to co-ordinate and align our system improvements to realise maximum impact. This means health and social care staff are communicating regularly with each other as they design and change services to ensure the system as a whole improves. Regular communication means there is a better understanding of the wider system. It also improves and strengthens relationships and we are increasingly seeing a culture of improved communication and trust between organisations.'

The reasons for the worsening of relations can be categorized as follows:

- The level of bureaucracy surrounding the BCF and the amount of management time it has consumed:

  'Only national reporting requirements - the national arrangements have been quite unwieldly with duplication and numerous reporting requests – would be useful if that could be streamlined for 16/17 '

  'A significant diversion of management time away from delivery of the main CCG and LA plans'

  'Too much bureaucracy, a risk of putting existing good relationships at risk by an

inflexible model'

'The level of bureaucracy and the method of funding has presented challenges which have not added value'

'The overall process though has been a frustrating one, and without careful management could have perversely put at risk our joint working. The bureaucracy involved with the Better Care Fund has taken valuable resource out of improvement work.'

- Unrealistic expectations

'It has put financial pressure on the NHS, which is largely not well understood (by NHSE, TDA and Providers)'

'Unhelpful focus on pressures and funding over solutions'

'In the current challenging financial environment, partners are seeking to preserve their own positions irrespective of the joint working envisioned by the BCF'

'Expectation of what the fund could achieve was set too high and this leading to the Local Authority blaming the NHS whether providers or the CCG.'

'Has given integration a bad name. The BCF is ill conceived as there is no 'fund', it is reusing existing funding, which, even if demand does reduce, is tied up in hospital costs.'

'BCF neither helps local government or CCG's. It has been an elaborate process that has not to date delivered system change and since its inception financial pressures have increased on both local government and health.'

- Increased pressure on stretched finances:

'Has absorbed ALL our CCGs growth. We had nothing left.'

'All parties risk adverse so real pooling of budgets impossible to achieve'

'Limited investment opportunities in other areas'

Accounting for the better care fund

The joint HFMA/CIPFA briefing published in October 2014 identified accounting for the BCF as a risk. The briefing also raised concerns about the flow of cash between NHS bodies and local authorities and, in particular, the impact on CCGs cash management requirements.

The DH issued guidance on accounting for the BCF in their manual for accounts which was published on 6 August 2015. NHS England has issued guidance[7] to CCGs on the cash implications of the BCF. Not all respondents were aware of the guidance and more had not read it:

[7] This guidance is available to CCGs only via the NHS England Finance Guidance library section 16 "Better Care Fund" on SharePoint.

	No. aware of the guidance	No. of those who are aware of it who have read it	No. of those who are aware of it have shared the guidance with partners
DH Manual for Accounts	30	19	12
NHS England guidance	29	17	10

Some organisations are already thinking about the year end. Twenty six respondents have already discussed year end agreements with their partner organisations. Encouragingly, thirty one respondents have discussed the BCF with their auditors. Seven bodies have discussed the year-end with their auditors but not partner bodies, two with partner bodies but not their auditors.

The topics discussed include:

	With partner bodies	With auditors
Year-end assurance arrangements	21	20
Year-end cash balances	18	7
Agreement of balances with NHS bodies	14	7
Treatment of over and underspends	24	8
Agreement of performance payments at the year-end	23	6

Performance targets

The majority of respondents do not expect to meet their performance targets this year:

	No.	Percentage
Yes	8	20%
No	32	80%

The main reason for this is that non-elective (NEL) admissions are either not reducing at all or less than as planned. Other reasons include:

'The plan is currently meeting metric targets but outcome benefits were weighted to Q4 of the year as new schemes or ways of working are embedded. Also anticipating winter pressures and the denominator (population) for NEL increases significantly in Q4 which also impacts on forecast per 100,000'

'Slippages in recruitment to teams responsible for delivering integrated services. IT issues. Partnership working is still being embedded'

'in some areas, the new models of care and ways of working have taken longer to implement and embed than previously expected, meaning improvement in performance has not been realised in the planned timescales. However, progress against key indicators such as diagnosis of patients with dementia and Delayed Transfers of Care in acute settings is improving.'

Of those who are not expecting to meet their performance targets 14 expect to see a diversion of funds out of the BCF and back to providers. Overall, 9 respondents think it is still too early to say whether this will happen or not.

Lessons learned and looking forward

Finally, we asked respondents for the three lessons they had learned from implementing the BCF and operating it for six months. These are the lessons that can be used to help move the integration agenda forward.

- There needs to be clarity in designing the agreement:

'Agreement of metrics to measure the impact of schemes difficult to identify/agree'
'Parties happy to pool resources in theory, but difficult to agree in practice'
'More precise definition of terms for Performance Fund'
'Review the governance arrangements'
'Ensure guidance on BCF targets aligns with other national guidance'
'Only put into s75 services which are truly benefiting from integration'
'Openness and transparency is key to successful joint working, but sometimes transparency can have unintended consequences'
'Section 75 legal advice needed earlier'

- Implementing joint working arrangements takes time:

's.75 takes longer to agree than expected'
'Need to focus on detail.'
'Don't underestimate time needed on governance issues'
'Start early - things always take longer than expected'
'Have face to face meetings'
'Need for BCF to be business as usual'

- There needs to be clarity in terms of the financial impact of the BCF:

'Clarity about cash flows in advance'
'Clarity about use (or return) of slippage'
'Start discussions early , manage local authority perceptions of 'free cash''
'Inclusion of ring-fenced P4P schemes'
'Clear, detailed schedules of expenditure for schemes to be drawn up earlier, rather than vague scheme objectives'
'Expect late announcements from NHS England'
'It requires much more, clearer guidance on what is the DH view on how the BCF is used to protect social care.'
'The financial aspects of partnership arrangements are always likely to cause the greatest strain on relationships and so it is important to have agreed governance and risk sharing arrangements in place and be proactive in notifying all key stakeholders of financial implications'

- Working together can be difficult and trust between partners is vital:

'Sticking together when it gets difficult is hard
'Risk share means SHARE; not risk dodge'
'Integrating services is difficult, even with additional investment
'Aims are not always aligned
'Working together is fine as a concept when money is plentiful. '

‘Relationships begin to get tested when the money dries up.’
‘Don't lose sight of the end goal.’
‘Health need to work together with one voice - nominate one lead as the LA remains confused as to all the bodies in health’
‘Importance of building trust’
‘Need early principles for planning’
‘It is important to be aware of cultural differences between local authorities and the NHS and tailor approaches accordingly’
‘Have a flexible approach and be open to new ways of working’
‘ensure all who need to be involved understand what required of them and when’

- There are benefits to be had from integration:

‘The aim of the BCF is laudable and actually essential if we are serious about a free at the point of delivery NHS.’
‘Use the BCF to drive increased sharing of information from the LA on service’
‘Alignment with other major change programmes in local health and social care services’
‘Lots of small improvements are as likely to achieve success as the likelihood of one or two big ones.’
‘Build a common purpose’
‘Look to identify reciprocal investment priorities on future funded schemes’
‘Solutions lie in joint provision’
‘Early sight of the partners' plans is essential to allow strategic and operational discussions to take place in advance’
‘We have reaffirmed our conviction that the integrated nature of our commissioning arrangements delivers benefit’
‘Joint posts have been critical’
‘NEL reduction target is useful in the sense that it focuses on the system on the key activity of developing alternatives to admission’

Appendix: summary of the 2015 spending review in relation to the better care fund

On 25 November 2015, the Chancellor of the Exchequer delivered the 2015 Spending Review and Autumn Statement (2015 SR)[8].

The 2015 SR contained the following key announcements in relation to the BCF and the integration of health and social care:

- From 2017, funds will be made available to local government for social care spending. These funds will rise to £1.5bn by 2019/20 and will be included in the BCF (paragraphs 1.107, 1.111 and 1.242 of the 2015 SR)
- The BCF that these funds will be put into will be improved (paragraph 1.107). There is no indication of what this may mean in practice
- SR 15 includes over £500m by 2019/20 for the disabled facilities grant (paragraph 1.109) which is currently included in the BCF. There is no indication that this will change
- The NHS's mandated contribution to the BCF will be continued at its current rates in real terms (paragraph 1.111)
- By 2020, health and social care will be integrated across the country. Every part of the country must have a plan for this in 2017 for implementation by 2020 (paragraph 1.112)
- The BCF has started this work on integration. Areas will be able to graduate from existing BCF programme management once they have demonstrated that they have moved beyond its requirements that seems to mean meeting the government's criteria for devolution (paragraph 1.112).

Local authorities with social care responsibilities will be to raise council tax in their area by up to 2% above the existing threshold. This additional levy ('the social care precept') will be spent exclusively on adult social care (paragraph 1.107). There is no requirement in the 2015 SR for this to be included in the BCF. There is an indication it will be used, in part, to fund the additional costs of implementing the National Living Wage which is expected to benefit care workers.

[8] www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents