From: **Roger Gough – Cabinet Member for Education and Health Reform**

To: **Kent Health and Wellbeing Board 27th January 2016**

Subject: **The new planning arrangements for health and social care**

Summary:

NHS England has issued new planning guidance requiring local areas to draft place-based five year Sustainability and Transformation Plans that will demonstrate how new models of care will be developed and full integration of health and social care will be achieved by 2020. Associated changes to the Better Care Fund have also been announced as has the financial settlement for the NHS within the Chancellor's Autumn Statement. This paper describes these changes and explores some of the implications for the Kent Health and Wellbeing Board.

Recommendations –

The Health and Wellbeing Board is asked to:

I. Agree the most appropriate "Planning Footprints" for the population of Kent

II. Consider how the pan-Kent and wider issues that lie outside the scope of individual plans will be addressed.

III. Ensure that the Board's workplan and forward agenda setting adequately reflects the requirements to consider and agree the various plans that will be produced in coming months including the evolution of the BCF in Kent to deliver the wider integration required by 2020 in conjunction with the Sustainability and Transformation Plans.

IV. Decide how the Board wishes to review and evaluate progress towards the objectives of these plans including the nine "must-do's"

1. Introduction

1.1 In recent weeks the Chancellor's Autumn Statement and NHS England have clarified expectations regarding future funding, further development of the Better Care Fund and planning arrangements for the NHS and social care for the coming year and beyond. The main thrust of all these announcements has been to improve prospects of sustainability of providers and services, especially acute hospital trusts, and to increase the pace and scale of integration and development of the New Models of Care associated with the NHS England Five Year Forward View.

2. New funding

2.1 The Chancellor's Autumn Statement included several announcements of new funding . The NHS will receive a real-terms funding increase of £10 billion between 2014/15 and 2020/21. £6 billion will be "front-loaded" into 2016/17 thereby delivering (along with additional funding for the current year) the promised £8 billion for delivery of the Five Year Forward View.

2.2 Included within this was 4% increase for GP services and £ 600 million for mental health. A Mental Health Taskforce will report in "early 2016" setting out more detail. There is an expectation that CCGs will increase spending on mental health services by at least the level of their overall increase.

2.3 A part of the overall allocation over the next five years is to be set aside for a Sustainability and Transformation Fund (STF). This will amount to £2.14billion in 2016/17, £2.9 billion in 2017/18 and rise to £3.4 billion in 2020/21.

2.4 There is still some lack of clarity about how the funds will be distributed but according to the Planning Guidance in the first year of the STF, there will be a £1.8bn 'sustainability fund' with a focus in 2016-17 to help providers turn this year's projected national £2.5bn funding gap into a surplus and "restabilising the NHS". This sustainability element is aimed at restoring the provider sector to financial balance, with a general element aimed at supporting emergency services, and a targeted element aimed at allowing providers to go faster in providing additional efficiency gains.

2.5 £340 million is for transformation on new models of care and wider policy commitments such as 7 day services, GP access, Cancer, mental health, and prevention. As previously mentioned the ratio of money for sustainability is meant to decrease, with more money available for transformation, as providers regain financial balance.

2.6 £450 million of the STF money has already been allocated for Greater Manchester over the 5 years for transformation. The Kent allocation is currently still to be confirmed but areas that will be allocated first will be those with clear economy wide structure for decision making. These areas may also be able secure a higher proportion of funding and avoid delays in payment.

2.7 Additional factors include the ability to increase local authority council tax by a 2% social care precept and the £4.8 billion of capital funding that has been allocated every year for the next 5 years. Over the next 5 years at least £500 million will be invested in building new hospitals. £1 billion will be invested in technology to aid transformation.

2.8 Another £115 million is being allocated to the Joint Work and Health Unit (a shared DWP and DH unit), £40 million of which is for a health and work innovation fund to pilot new ways to join up health and employment. A white paper on this will be issued in 2016.

2.9 The headline figures for increases in health spending have been challenged by the Nuffield Trust, The Health Foundation and The King's Fund. Whilst NHS England's budget will increase by £ 7.6 billion in real terms between 2015/16 and 2020/21 overall total health funding in

England will rise by only £4.5 billion in real terms between this year and 2020/2021, meaning the new settlement equates to an increase of 0.9% per year which is almost identical to that during the previous parliament. This is because other health spending included in previous budget definitions will reduce by more than £ 3 billion. For example there will be a reduction in public health budgets of £600 million in real terms.

2.10 This figure is substantially less than expected and results from a change in the calculation of the increase. Previous governments have defined health spending as the whole of the Department of Health's budget (£116.4 billion in 2015/16) whereas for the Autumn Statement the definition used was that of NHS England's budget (£101.3 billion in 2015/16), a significantly lower amount. The £22 billion efficiency savings required in the Five Year Forward View will also need to be delivered with an emphasis on those identified in the Carter Review.

2.11 The measures announced in the Autumn Statement relating to local authority funding are also significant for the planning of social care services. Overall local authorities can expect an ongoing reduction in funding amounting to £46 million for Kent County Council in 2016/17. These reductions can be offset to some extent by a new power to levy a 2% precept of additional Council Tax specifically to fund social care services.

3.0 New planning arrangements

3.1 The new arrangements announced by NHS England require all NHS organisations in England to develop two "separate but connected" plans detailing the strategies for their local health and care system and within their own organisation.

3.2 The plans are:

- five-year 'Sustainability and Transformation plans' (STPs), which will be place-based and focussed on delivering the Five Year Forward View
- a one-year operational plan for 2016-17, which will be organisation-based but consistent with the developing STPs.

4.0 Sustainability and Transformation plans

4.1 Every health and care system will have to work together to create an "ambitious local blueprint" to speed up delivery of the Five Year Forward View. The plans cover the period between October 2016 and March 2021 and will be subject to formal assessment in July 2016 following their submission in June. The guidance states:

"We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years."

4.2 The guidance marks a significant movement to place-based planning rather than a focus on separate organisations "that doesn't make sense to staff or patients". The plans must go further than "just writing a document" and cannot be outsourced or delegated. Guidance states that this will require strong system leadership that concentrates on several key elements:

- local leaders coming together as a team
- developing a shared vision with the local community
- involving local government as appropriate
- programming a coherent set of activities
- executing against plan
- learning and adapting.

4.3 If there are problems where "collaborative and capable leadership" cannot be established, NHS England and NHS Improvement will "help secure remedies" through joined-up and effective system oversight.

4.4 These linked Sustainability and Transformation Plans will need to be produced for each local system for the five year period and signed off by July 2016, with a one year plan for each organisation for 2016/17, reflecting the strategy. These plans will be the sole route of access to transformational funding for 2017-18 onwards. Areas with the "most compelling and credible" plans can secure the extra funding from April 2017.

4.5 Additionally plans must demonstrate how the 9 "must do" priorities identified by NHS England for 2016/17 will be delivered:

1. Develop a high quality and agreed 'sustainability and transformation plan' that will identify the most locally critical milestone that has to be achieved in 2016-17.
2. Providers must return to aggregate financial balance, including secondary care providers delivering efficiency savings through the Carter review's £5bn productivity savings programme. They must also comply with the maximum total agency spend and hourly rates determined by NHS Improvement.
3. All organisations will be expected to develop and implement a local plan that addresses the sustainability and quality of general practice, including existing workforce and workload issues.
4. A&E access standards and ambulance waiting times must "get back on track" to ensure at least 95% are seen within four hours, and that all ambulance trusts respond to at least 75% 'Category A' calls within eight minutes. This will require progress towards implementing the urgent and emergency care review and associated ambulance standard pilots.
5. There must be improvement against standards that require more than 92% of patients on non-emergency pathways to wait no longer than 18 weeks from referral to treatment, whilst continuing to offer patient choice.

6. The 62-day cancer waiting standard must be met, including the safeguarding of better diagnostic capacity, and improvement to the two-week and 31-day cancer standards must continue. Providers should also make progress towards ensuring one-year survival rates are kept through a year-on-year improvement in the proportion of cancers diagnosed at an earlier stage.
7. Two new mental health access standards must be achieved and maintained: more than 50% of people experiencing a first episode of psychosis will start treatment with a NICE-approved care package within two weeks of referral, and 75% of those with "common mental health conditions" will be referred to the Improved Access to Psychological Therapies (IAPT) programme, treated within six weeks of referral (with 95% treated within 18 weeks).
   At least two-thirds of the estimated number of people with dementia must be diagnosed.

8. Local plans must seek to transform care for those with learning disabilities, including the implementation of better community provision, reduction of inpatient capacity and extending treatment reviews.

9. All NHS organisations must develop and introduce an affordable plan to improve quality, particularly for those currently in special measures. Avoidable mortality rates will also be published annually.

4.6 Provider access to Sustainability and Transformation Funding will be dependent on them agreeing local plans. Funding for the sustainability elements will be released on a quarterly basis and will be based on individual providers' performance against financial, access and transformation eligibility criteria. Funding does currently go directly to providers to support them and the STF will include this funding, consolidate it and provide a single process for funding to go to providers. The Investment Committee of NHS England will, in partnership with NHS Improvement, have delegated authority to allocate money to specific organisations. The full planning guidance will be required to tease out the details of exactly how this will work and this is due shortly. Providers will have access to the sustainability part of the fund directly, but the intention seems to be that commissioners can access the transformation element of the funding to develop new care models. The intention is that as system sustainability is achieved the relative sizes of the two elements of funding will change and transformation will grow as a proportion of the money pot.

4.7 STPs must cover all areas of CCG and NHS England-commissioned activity, including specialised services, plans for which will be led from the 10 collaborative commissioning hubs, and primary medical care. Plans must also ensure better integration with local authority services, especially prevention and social care. The "units of planning" may vary and are yet to be decided but indicative "footprints" need to be submitted to NHS England by the 29th of January.

5.0 The Planning Footprint

5.1 The planning area selected will be of great importance to how the plans develop over the next five years as it will define the populations that the plans refer to. The guidance states that the plans must be "placed based" and produced for a defined 'Planning Footprint'. This is a significant departure from the normal organisation based plans that have been produced in previous years and develops further the approach taken in 'Success Regimes' and some 'Vanguards'. The plans have to be developed by June 2016 and agreed by all parties in the system (providers and commissioners) including Local Authorities. The 'Planning Footprints' must be agreed by local systems and NHS England and proposals for the shape of local 'Planning Footprints' need to be submitted to NHS England by 29th January. In Kent, Surrey, and Sussex plans need to be submitted to the NHS England team by 25th January 2016, before being submitted to NHS England nationally.

5.2 Determination of the planning footprint should include a number of considerations.

- CCGs, NHS Trusts, FTs and local Authorities remain the statutory bodies and all have a series of financial duties that they will continue to be required to meet.
- Individually organisations must return to financial balance in 2016/17 and achieve this sustainably by 2020.
- There is an option for all organisations in a Planning Footprint to pilot arrangements whereby they pool budgets. However, the intention for the majority of Planning Footprints is that all statutory bodies must meet their financial duties as individual organisations as well as across the whole system in the 'Planning Footprint'
- Planning Footprints must cover all services provided for their populations. There is no option to create different planning footprints for different services.
- Planning Footprints cannot be smaller than a CCG footprint.
- NHS England, and NHS Improvement (The Trust Development Agency (TDA) and Monitor) have a preference for larger footprints with sub-systems within them rather than smaller footprints that work within other larger planning arrangements

5.3 Other issues that are pan-Kent or wider also need to be considered including:

- There are some services that need to be planned at a Kent wide level in partnership. Such as Learning Disability Services and Children's services, including Children and Adolescent Mental Health Services.
- Emergency and Urgent Care Services that are planned across Kent and Medway.
- Specialist services that are planned across a range of national footprints. If commissioning of these services is devolved from NHS England to CCGs these services will continue to need to be planned across these national footprints.

5.4 Within Kent there would be a number of options for planning footprints. Those include footprints at a Kent level, at CCG level, at joint CCG level such as "East Kent", or on a "Health Economy" level of North, East and West Kent.

5.5 Other options that have been mooted include those designed to concentrate on ensuring the viability of acute providers such as an "A21 Corridor" that would be based around the acute trusts in Medway, Maidstone & Tunbridge Wells, and the Conquest hospital in East Sussex, although it is unclear how these reflect the requirement in the planning guidance to move away from organisationally based plans to a "place based" approach.

6.0 Operational plans

6.1 Operational plans should be regarded as 'year one' of the five-year STP, and therefore should deliver "significant progress on transformation". Local system leaders will undertake a "shared and open-book" process for 2016-17 to cover activity, capacity, finance and deliverables based on the emerging STP, for the next financial year. All operational plans must demonstrate how providers "intend to reconcile finance with activity", and how any deficits will be addressed and outline their plans to deliver the 'key must-dos' (see below) as well as their contribution to efficiency savings.

6.2 Risks embedded in the local health economy plans must be jointly identified and mitigated through an agreed contingency plan, and organisations will be asked to show how they link with, and support, the local emerging STPs. Commissioner and provider plans must be agreed by NHS England and NHS Improvement , by April 2017, based on local contracts that must be signed by March 2016.

6.3 The timetable

A more detailed timetable and milestones will be in the technical guidance published in January.

	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	29 March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

7.0 The Better Care Fund

7.1 The Better Care Fund has now been fully in place since April 2015. Kent's BCF plan was cited as an example of good practice and is now operational. The s75 agreement has been signed (some other areas have still not completed theirs). However the evaluation of the success of

the BCF has proved problematic as it has been difficult to establish base line data for non-elective admissions across the Kent health economy to enable comparisons over time to be made. A change of the data set used to establish the baseline and calculate activity has been positive and there is some confidence that we will attain the 1% reduction target for non-elective admissions. Comparisons with other areas are difficult as some are continuing to use the original data sets to establish their performance.

7.2 In addition changes to the BCF during its initial development may have compromised its ability to drive transformation in the way originally hoped. For example although initially designed to introduce pooled budget arrangements to achieve a range of locally designed outcomes the BCF was modified primarily to target reductions in the number of non-elective admissions to acute hospitals and funding streams within the "pooled" arrangements retained designated focus.

7.3 A position statement on the current state of the BCF in Kent is appended to this report for information.

8.0 Future Better Care Fund

8.1 The government has announced it intends to continue with an expanded BCF. Going forward the BCF requires an agreed plan for better integrating health and social care by March 2017. It is intended that the BCF will be an integral part of the progress towards the requirement of full integration of health and social care by 2020. Together with the Sustainability and Transformation Plans the BCF going forward must be able to demonstrate how this will be achieved.

8.2 The mandated minimum spend to be deployed locally on health and social care through pooled budget arrangements between local authorities and CCGs will be increased to £3.9 billion nationally. Local flexibility to pool more than the minimum remains. Extra government funding will be provided to local authorities through the BCF from 2017/18 which will amount to £1.5 billion by 2019/20. The BCF should be aligned to other work programmes including the development of the new models of care set out in the Five Year Forward View and delivering 7-day services.

8.3 The £1 billion Payment for Performance element of the BCF will be removed to be replaced by two national conditions that will require local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focussed action plan for managing delayed transfers of care (DTOCs).

8.4 Nationally £3.519bn of NHS England budget needs to be ring-fenced via the CCGs for the BCF. The Disabled Facilities Grant will amount to £394 million in 2016/17 rising to over £500 million in 2019-20. £ 2.519 billion will be available to Health and Wellbeing Boards for funding the BCF plans. The other £1 billion will be paid as national conditions are met as described above.

8.5 As before the BCF will include elements to support implementation of the Care Act (£135 million in 15/16, funding for reablement (£300 + million) and provision of breaks for carers (£130+ million)

8.6 From 2017, funding will be made available to local government as part of the BCF worth £1.5 billion in 2019-20. As before, there will need to be consultation with the Department of Health and DCLG over BCF spending plans and what will happen in the event of failure to meet BCF conditions.

8.7 At the time of writing the actual allocations for the BCF have yet to be announced.

8.8 The metrics applied to the BCF remain the same as for this year.

8.9 BCF plans will be subject to regional moderation and assurance with brief narrative plans developed locally and submitted to regional teams through a short, high level, template, setting out the overall aims of the plan and how it will meet the national conditions. A reduced amount of finance and activity information relating to BCF plans will be collected alongside CCG operational planning returns and submitted to NHS England. However it will be important to ensure that local oversight of the BCF maintains a rigorous focus on the contribution the BCF is making towards integration and transformation in Kent.

8.10 An additional change to current practice that has the potential to change the scope of the BCF is the recent announcement from NHSE that their budgets relating to the commissioning of primary care services can now be included in pooled arrangements alongside those of CCGs and local authorities.

8.11 Local areas are meant to be able to 'graduate' from the BCF if they demonstrate they have moved beyond its requirements and meet the government's key criteria for devolution in health and care. Examples given of approaches approved by the Government are ACOs (Northumberland), Lead Commissioners (NE Lincolnshire) and devolution (GM). Simon Stevens has recently said that Greater Manchester, London and the North-East are the only clear examples of devolution deals in health and social care. This gives scope to develop the BCF and increase its contribution towards greater integration and more devolved arrangements. The Planning Guidance states that 20% of the country will be designated as transformation areas pursuing accelerated integration although clarification on how this will be decided is still awaited. Further guidance on how areas can graduate beyond the BCF will be issued shortly.

8.12 Significant amendments have been made to the BCF but increasingly it is being regarded as an element supporting wider integration whilst acknowledging that of itself it will not generate the momentum required for the scale of transformation that is necessary. The BCF now needs to be considered within the overall planning processes that have been announced, in particular the 5 year Sustainability and Transformation Plans that are now required to be produced by the Summer, and also the operational plans for 2016/17.

9.0 Better Care Fund Policy Framework 2016-17

9.1 In November the Comprehensive Spending Review confirmed the continuation of the Better Care for 2016-17. A total of £3.9 billion has been identified from its different elements to fund health and social care through pooled budget arrangements between local authorities and CCGs. The framework intends that planning and approval process for the BCF in 2016-

17 will be more streamlined and integrated into the usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities. BCF planning guidance is expected to be issued in early January 2016 with the following deadlines:

- Initial draft – 8 February 2016
- Refresh – mid-March 2016
- Final submission (signed off by Health and Wellbeing Boards) - mid-to-late April 2016

9.2 Because of the short timescales involved, the first draft submission of BCF plans on 8 February will be expected to be high-level with a focus on finances and core principles but with sufficient detail to inform the budget setting processes of local authorities. Details for submissions and timings for the March and April resubmissions will be confirmed in January.

9.3 It remains to be clarified exactly how the BCF fits with the STP but logically it should form a part of the overall picture rather than a stand-alone component.

10.0 Changes to resource allocation

10.1 NHS England confirmed significant changes to resource allocation for providers and the commissioning sector for 2106-17 until the end of the decade to ensure greater equity across CCGs, faster progress towards NHS strategic goals and stronger long-term collaboration. NHS England has stated that no CCG will be more than 5% under target for their commissioned services in the next financial year. All CCGs (except those 10% or more above target) will receive a minimum cash growth equal to real-terms growth, plus specific non-routine policy pressures, predominantly linked to pensions and provision of seven-day services.

10.2 A new 'inequalities adjustments' for specialised care and "more sensitive adjustments" for CCGs and primary care will be introduced, along with a new 'sparsity adjustment' to ensure closer alignment with population need in remote areas.

10.3 Commissioners and providers will be asked to integrate strategic planning to stimulate and strengthen long-term collaboration between them. There will also be opportunities to pilot shared financial control totals. NHS England's chief financial officer, Paul Baumann, has said they will move to multi-year allocations in the form of three-year firm allocations and two-year indicative allocations to help providers plan ahead.

10.4 Changes in contractual arrangements including the "GP plus" options and MCP (Multi Specialty Community Providers) contracts that cover a number of services may also be significant.

10.5 The emphasis on integration and transformation inevitably overlaps with the Kent Health and Social Care Integration Pioneer Programme and the contribution that the Pioneer programme can make to supporting the aspirations of the Sustainability and Transformation Plans is under consideration.

11.0 CCG "OFSTED"

11.1 In another development within NHS England's new mandate for 2016-17, the results of the CCG assessment framework for 2015-16 will be published by June. This will provide CCGs with an "aggregated Ofsted-style assessment" of their performance and allow them to benchmark their performance against other commissioning bodies and thereby determine whether national intervention is needed. The new Ofsted-style CCG framework for next year will include metrics to measure progress on NHS planning guidance priorities, including overall assessments for each cancer, dementia, maternity, mental health, learning disabilities and diabetes – as well as for efficiency, core performance, technology and prevention. By the end of the first quarter in 2016-17, NHS England will publish the first overall assessment for each of the six clinical areas.

12.0 Implications for the Kent Health and Wellbeing Board

12.1 The Health and Wellbeing Board needs to be appraised of the timetables for the submission of the various plans – Operational, STP, and BCF, how they inter-relate and the Board's role in considering them. This needs to be reflected in the annual workplan for the Board which is also being discussed at this meeting.

12.2 As the plans are implemented the Kent Health and Wellbeing Board will need to consider its role in ensuring that integration and the development of new models of care across the area is progressed at the pace and scale necessary to deliver a coherent and sustainable health and social care economy across the County.

12.3 The business of the Board will also be shaped by the new planning footprints that will be adopted for the STPs. These should be agreed and submitted to NHS England regionally by 25th January, and to NHS England nationally by 29th January 2016. It is important for the Board to understand how the planning footprints adopted can demonstrate the greatest benefit for Kent residents and promote the integration we need to achieve.

13.0 Recommendations:

13.1 The Health and Wellbeing Board is asked to:

I. Agree the most appropriate "Planning Footprints" for the population of Kent

II. Consider how the pan-Kent and wider issues that lie outside the scope of individual plans will be addressed.

III. Ensure that the Board's workplan and forward agenda setting adequately reflects the requirements to consider and agree the various plans that will be produced in coming months including the evolution of the BCF in Kent to deliver the wider integration required by 2020 in conjunction with the Sustainability and Transformation Plans.

IV. Decide how the Board wishes to review and evaluate progress towards the objectives of these plans including the nine "must-do's"

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Background documents:

NHS Shared Planning Guidance
https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

2016/17 Better Care Fund Policy Framework
https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

The spending review what does it mean for health and social care ?
http://www.nuffieldtrust.org.uk/publications/spending-review-what-does-it-mean-health-and-social-care

APPENDIX 1

Subject: **Better Care Fund Position Statement**

1. Introduction

1.1 Kent's Better Care Fund (BCF) plan was agreed by the Health & Wellbeing Board in January 2015 and had previously been approved through the national assurance process.

1.2 At the same meeting of the Health and Wellbeing Board, it was agreed that the NHS Area team would lead a group with CCG CFOs and other senior KCC finance leads ("CFO Group") to discuss and recommend options for pooled fund arrangements with the ultimate aim of producing a s75 pooled budget agreement(s) to support and deliver the Kent BCF plan.

1.3 The purpose of position statement is to provide an update on progress to date. The draft agreement was presented at the March 2015 Health & Wellbeing Board, and funds released in line with the terms of the signed s75 agreement.

2. Flow of funds

2.1 Although the BCF in theory operated as a pooled budget as required by the technical guidance, there were conditions attached to several of the funding streams which will had to be met e.g. part of the money was earmarked as disabled facilities grant and could only be used for that purpose. Hence the funding did not entirely lose its identity as more often is the case in pooled budgets.

2.2 Where there were specific conditions, the agreement was drafted to reflect these requirements. The guidance confirmed that the accountable body was the organisation from where the money originated.

3. The flow of funds within the agreement was as follows:

Source of Funds	**Pooled Fund**	**Application of funds**
KCC £10.640m	£101.404m	KCC Protection of social care £28.254m
CCGs £90.764m		KCC Care Act implementation £3.566 m
Total £101.404m		KCC Social Care Capital grant £3.432 m
		Districts Disabled facilities grant £7.208m
		BCF schemes (Ringfenced CCG out of hospital commissioned services) £24.049m
		BCF Payment for performance £2.183m
		CCG carers' break schemes £3.443m
		BCF schemes £29.269m
		Total £101.404 m

4. Risk share

4.1 In line with the series of meetings hosted by Roger Gough, Chairman of Kent HWB, with the CCGs as well as discussion at the HWB in September 2014 it was agreed not to share risks across CCG's at this time. The agreement was therefore drafted in light of this as follows:

4.2 ***Performance element*** - The £2.183m performance payment linked to achievement of the 1% target reduction in emergency admissions was calculated quarterly with no cross subsidy across CCG's for under-performance. Amounts reflecting under-performance have been retained by CCG's to address the resulting pressures (in consultation with the Health & Wellbeing Board).

4.3 ***Over and Underspends*** - the s75 agreement ensured that there was no cross subsidy across locality for under or overspends. Overspends remain the responsibility of the relevant body to which the funds had been applied and the agreement ensures mitigation of this risk to the host and fund as a whole. Proper forecasting of underspends was required by relevant bodies to ensure that they comply with the necessary regulatory requirements.

5. Commissioning arrangements

5.1 The nature of the schemes within the Better Care Fund plan has meant that the current s75 arrangements are tailored around joint commissioning principles (i.e. two or more commissioning bodies acting together to coordinate their commissioning, taking joint responsibility for how the care is commissioned to meet the agreed list of agreed objectives within the Better Care Fund plan). In the initial year of this agreement physical contracting arrangements did not change from the previous arrangements, however in time, as commissioning plans are reviewed and consulted upon, this approach could still change to reflect a more integrated way of commissioning services to achieve the BCF outcomes.

6. S75 Governance arrangements

6.1 Although the pooled budget is created from allocations to CCGs and local authorities, the arrangements do not constitute a delegation of statutory responsibilities. These are retained by the CCG Governing Body and the local authority Cabinet/executive.

6.2 In practice this means CCG Governing Bodies and KCC Cabinet or executive operating through Executive delivery groups reporting to County & Local Health and Wellbeing Boards (or equivalent local groups) for oversight.

7. Monitoring of the performance metrics

7.1 The BCF identifies six key performance indicators from which to monitor that the primary objectives of the fund are being met. These are;

i. Total non-elective admissions into hospital (general and acute), all ages, per 100,000 population

ii. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

iii. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

iv. Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)

v. Patient user survey: percentage of people feeling supported to manage their long term condition

vi. Injuries due to falls in people aged 65 and over

7.2 Of the above, non-elective admissions data is the most high profile as it drives the release of the payment for performance element funding to the CCGs.

7.3 Data on non-elective admissions is still being collected and the results validated by the CCGs. Due to a change in the agreed data sets the indication is that the 1% target for reducing non-elective admissions is largely being met based on the first three quarters of 2016.

7.4 The Performance Element of the fund has been adjusted to reflect this and the final adjustment will be made in final quarter payment.

7.5 A "Finance and Performance Dashboard" has been developed from which these six indicators can be monitored in conjunction with contributions into and out of the fund across the primary categories of revenue.

7.6 Quarterly returns are submitted to the NHS England BCF Fund Team. Quarter four 2014/15 was submitted in May and quarter one 2015/16 was submitted in August. Quarter two 2015/16 was submitted on 27th November 2015.