Ministry of Housing,
Communities &
Local Government

Improved Better Care Fund (iBCF): Quarterly and year-end reporting 2017-18

Local Government Finance

Management Information Release

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At Spring Budget 2017, local government was provided with an additional £2 billion funding for adult social care. This funding was to be spent through the Improved Better Care Fund (iBCF) over the period 2017-18 to 2019-20. This publication reports on data collected from local authorities[a] outlining how the £1.01 billion allocated for 2017-18 has been used.

- At Quarter 4, local authorities reported that they had, on average, assigned 40.9% of their additional 2017-18 iBCF funding on meeting adult social care needs, 29.0% on reducing pressures on the NHS and 29.3% on ensuring the social care market was supported.[b]

- Local authority feedback indicates that the additional iBCF has enabled fee uplifts. Over 90% of authorities stated at Quarter 2 that they would be increasing the fees they pay to external providers for home care, residential care and nursing care. On average, local authorities reported that home care fee rates would increase by 5.5% while residential and nursing home fee rates would rise by 4.1% and 4.6% respectively when compared to 2016-17.[c]

- At Quarter 2, 65% of local authorities stated that they planned to increase the number of home care packages they would be providing over the course of the year as a result of the additional funding. Furthermore, 66% of authorities reported that their provision of home care hours would increase.[c]

- Local authorities provided details of 785 projects that had been supported by the additional funding over the course of the reporting year. Reflecting the purpose of the iBCF, the leading project themes related to increasing capacity, stabilising the care market and reducing delayed transfers of care.

- The narrative and quantitative feedback received shows that the additional funding has been valuable in delivering impact in areas of interest to both local and central government. By Quarter 4, local authorities reported that over half (53%) of the metrics they had identified as being used to monitor progress had shown improvement over the course of the reporting year; just 11% were reported to have deteriorated.

[a] 152 single tier and county councils responsible for the provision of adult social care services.

[b] Percentages represent the unweighted arithmetic mean of local authority responses and not overall proportions of the total additional iBCF funding for 2017-18.

[c] Findings should be treated as indicative.

Introduction	2
Key findings	4
Conclusion and next steps	22
Annex A: iBCF allocation methodology	23
Annex B: Data collection, quality and analysis	24
Annex C: Voluntary compliance with the Code of Practice for Statistics	26
Accompanying tables	27
Enquiries	27

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Next publication:
Improved Better Care Fund: Quarter 2 Reporting 2018-19 - Provider Fees

Introduction

Adult social care provides support for older people and working age adults with personal and practical care needs, as well as support for their carers. In England, adults may be cared for informally by family, friends and neighbours, or formally through services they or their local authority pay for. Publicly funded adult social care is means-tested and primarily funded through local government; those with eligible needs, assets of less than £23,250 and low incomes can receive help towards their care and support costs.

Adult social care currently constitutes the largest area of discretionary expenditure for local authorities. To help address the pressures of an ageing population with increasingly complex care needs, as well as rising care costs, additional dedicated funding for adult social care has been made available to local authorities in recent years. This funding has comprised of: the Adult Social Care Support Grant; investment to ease NHS winter pressures; the Adult Social Care Precept (flexibility to raise council tax) and the Improved Better Care Fund (iBCF).

This Management Information release relates to the iBCF funding announced at Spring Budget 2017, and specifically reports on data collected from local authorities detailing how they have used the £1.01 billion they were allocated for 2017-18.

Background to the iBCF

The iBCF was created in Spending Review 2015 and provided local government with new funding for adult social care.

> *From 2017 the Spending Review makes available social care funds for local government, rising to £1.5 billion by 2019-20, to be included in an improved Better Care Fund.*[1]

At Spring Budget 2017, a further £2 billion was announced for adult social care.

> *The Government will provide an additional £2 billion to councils in England over the next 3 years to spend on adult social care services.*[2]

The £2 billion was added to the iBCF and, as with the original funding, was required to be pooled into the Better Care Fund[3]. The combined funding profile for the iBCF is shown in Table 1.

Table 1: iBCF funding profile, England 2017-18 to 2019-20

£ millions	**2017-18**	**2018-19**	**2019-20**
Spending Review 2015: Original iBCF	105	825	1,500
Spring Budget 2017: Additional iBCF	1,010	674	337
Total iBCF	**1,115**	**1,499**	**1,837**

[1] HM Treasury (2015) Spending Review and Autumn Statement 2015
[2] HM Treasury (2017) Spring Budget 2017
[3] The Better Care Fund (BCF) is a national programme which requires local health bodies and local authorities to pool funding and produce joint plans for the delivery of integrated health and care services.

Purpose of the iBCF

The iBCF is passed to local authorities with social care responsibilities as a Section 31[4] grant, with conditions. The grant determination required the money to be used only for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the social care provider market is supported.

In addition, conditions were placed that a recipient local authority must:

- Pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;
- Work with the relevant Clinical Commissioning Group (CCG) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
- Provide quarterly reports as required by the Secretary of State.

Allocation of the iBCF

At Spending Review 2015, the Government also gave local authorities with social care responsibilities the flexibility to raise council tax in their area by up to 2% above the referendum threshold for each year between 2016-17 and 2019-20, to fund adult social care services.[5] In combination, the Adult Social Care Precept and iBCF were designed to provide resources to help local authorities address the demographic pressures facing the social care system. Details of the methodology for allocating the iBCF to local authorities are contained in Annex A.

Quarterly reporting

In setting the requirements for local areas to report quarterly on how the money was being spent, the Government determined this was only necessary for the additional iBCF funding; that is, the £2 billion funding announced at Spring Budget 2017.

Both central and local government were keen to understand whether and how the additional funding was making an impact, and what it meant local authorities could deliver over and above the services they had already planned for - particularly in relation to the number of care packages and hours of care provided, and the fees paid to providers. In addition, the reporting covered the types of projects which were being funded through the additional money and the metrics which local areas were using to assess their own progress. The questions took a lead from the three purposes of the grant and comprised both open questions seeking narrative responses as well as closed questions.

Details of the methodology for data collection and approach to data analysis are presented in Annex B. The questionnaires used for each quarter of 2017-18 are published on Gov.uk.

[4] Section 31 of the 2003 Local Government Act gives ministers powers to make direct grants to local authorities.

[5] The adult social care precept allowed local authorities to raise funds for adult social care through an additional 2% on council tax above a threshold of 1.99% (above which a referendum is required to approve higher increases). The 2017-18 Local Government Finance Settlement subsequently allowed local authorities to levy up to 3% in 2017-18 and 2018-19, provided their increases do not exceed 6% in total over the three-year period to 2019-20.

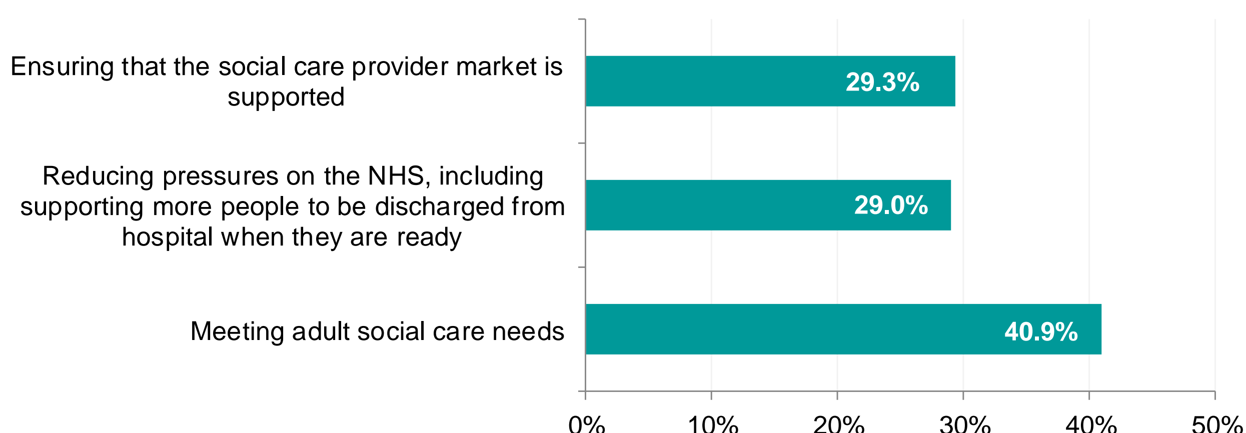
Key Findings

Distribution of funding by purpose

Local authorities were given flexibility as to how to spend their iBCF allocation within the overarching purposes of the grant. At Quarter 4, local authorities were asked to show how they had distributed their additional funding for 2017-18, specifically the amount they had designated for each purpose as a percentage of their additional iBCF allocation for the year.[6]

Of the 150 local authorities that provided a valid response, 145 provided percentage figures which summed to 99% or more. On average[7], local authorities reported that they had assigned 40.9% of their funding on meeting adult social care needs, 29.0% on reducing pressures on the NHS and 29.3% on ensuring the social care market was supported (see Figure 1). The fact that the funding was more likely to be allocated to meeting adult social care needs is perhaps unsurprising given that this purpose could be viewed as encompassing both the other purposes as well as wider social care requirements.

Figure 1: Local authority average proportions of additional 2017-18 iBCF funding allocated to each of the three purposes for which it was intended, as at Quarter 4 2017-18



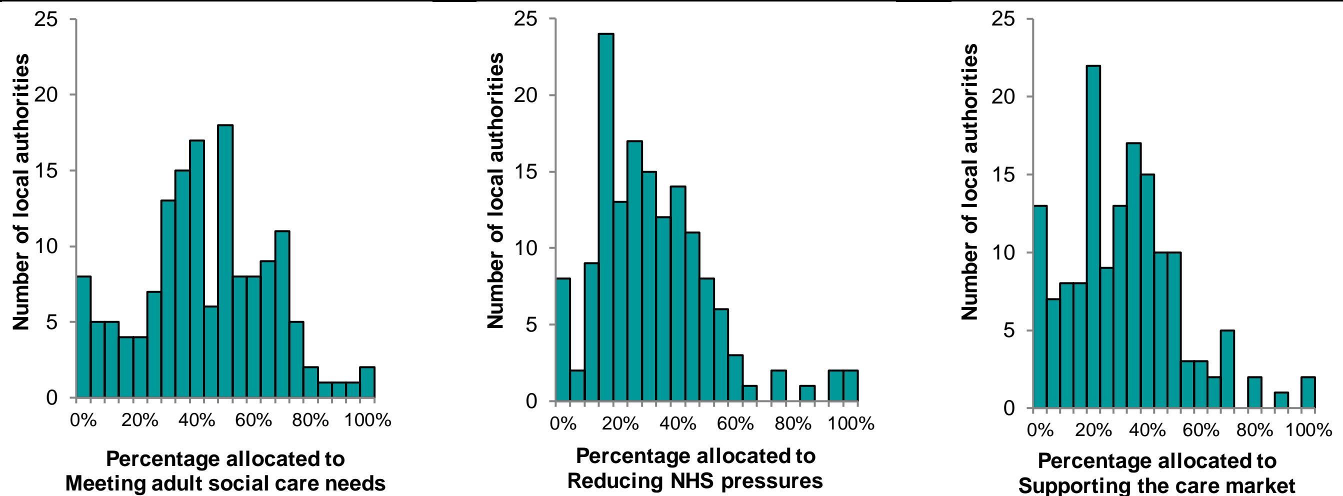
Based on responses provided from 150 out of 152 local authorities
Local authority average = unweigted mean

In explaining the allocations, the distribution of local authority responses was explored as illustrated in Figure 2. While the majority of local authorities split their funding across all three purposes, the range of responses varied from 0% to 100% for each purpose. This was a primarily a result of a handful of authorities concentrating all their funding in one or two areas. Thirteen authorities, for example, did not allocate any funding to supporting the social care market. In contrast, two authorities designated 100% of their allocation to meeting adult social care needs. Again, this could reflect the fact that the other purposes can be interpreted as a sub-set of the wider 'meeting adult social care needs' purpose.

Individual local authority responses can be found in Table A of the workbook accompanying this report.

[6] Local authorities were asked to categorise their funding by its primary purpose if it covered more than one purpose.
[7] Local authority average = unweighted mean

Figure 2: Distribution of additional 2017-18 iBCF funding allocated to each purpose for which it was intended, by local authority, as at Quarter 4 2017-18



Based on responses provided from 150 out of 152 local authorities

Fees paid to external care providers

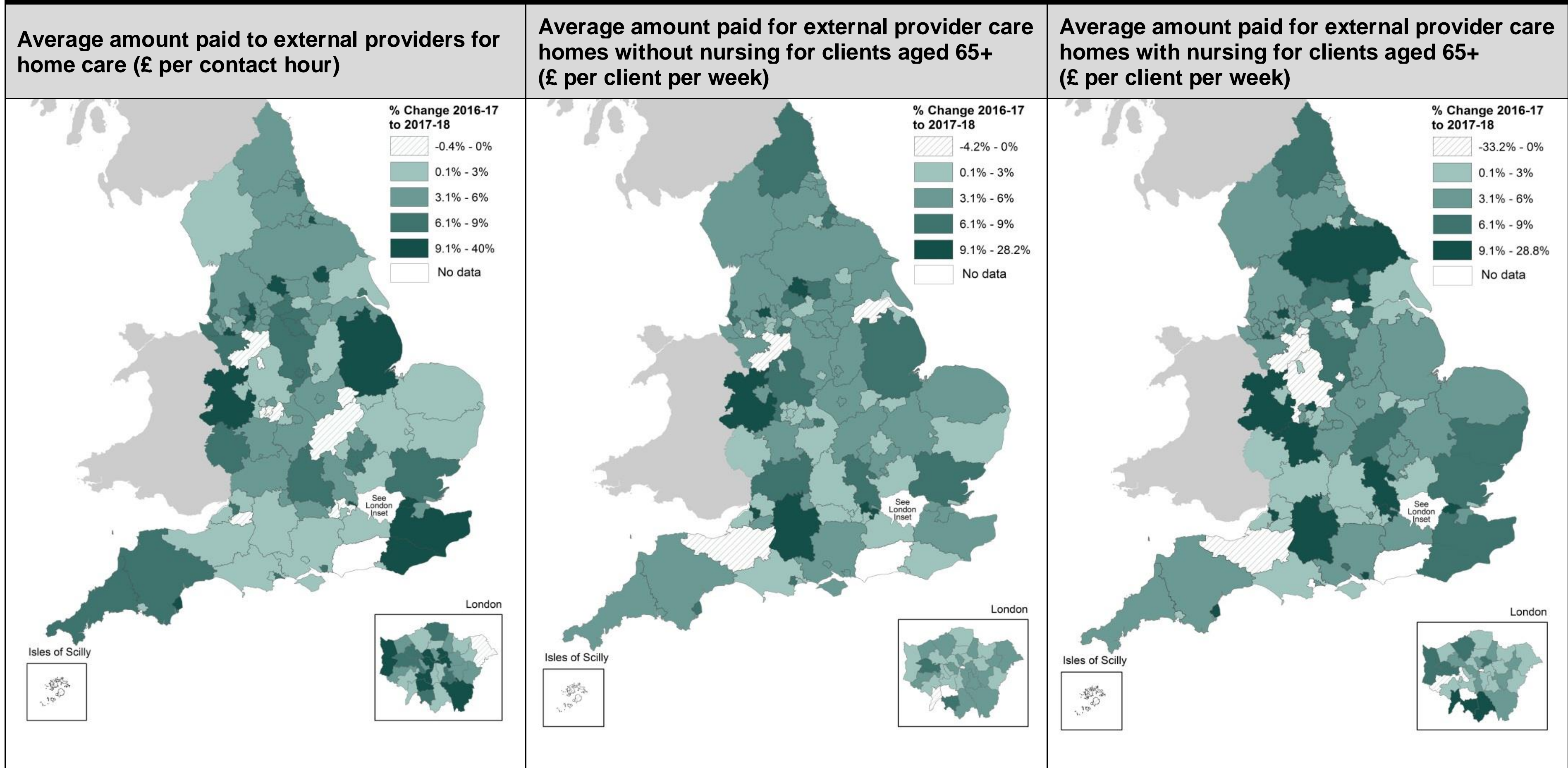
Questions on provider fees were included to ascertain whether or not the additional iBCF funding was having an impact in helping local care markets through fee uplifts. Fees questions were first posed at Quarter 1. However due to inconsistencies in the responses received, the questions were refined with more precise definitional detail and asked again in Quarter 2. While the response was greatly improved in terms of response rate and coherence, it should be noted that there were still some inconsistencies in the returns. The findings in this section of the report should therefore be treated as indicative. However, it is worth noting that NHS Digital collates outturn data on unit costs through the Adult Social Care Finance Return (ASC-FR) and publishes the results in its annual Adult Social Care Activity and Finance Report. This is a National Statistic publication, the 2017-18 edition of which is scheduled for publication in October 2018.[8]

As presented in Table 2, the returns showed that, on average, local authorities were increasing the average hourly fees paid to external providers of home care by 5.5% in comparison to 2016-17. With respect to residential care without nursing, and with nursing, the average annual percentage uplifts were 4.1% and 4.6% respectively. For each of the three fee types for which data was collected, the vast majority of local authorities (over 90% in each case) reported that their average fees were increasing in comparison to 2016-17. For the small number of cases where unit costs were reported to be falling and additional commentary provided, one of the explanations included having fewer high cost packages of care in 2017-18. Maps illustrating the range of local authority responses are shown in Figure 3.

Full details of the fees data provided can also be found in Table B of the workbook accompanying this report.

[8] NHS Digital: Adult Social Care Activity and Finance Report series/collection

Figure 3: Percentage change in average fees paid by local authorities to external care providers, 2016-17 to 2017-18



Data sources: OS Boundary Line and iBCF reporting data, at Quarter 2 2017-18
Underlying data should be treated as indicative.
See Footnote 9 for details of inclusions and exclusions

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Table 2: Change in average fees paid to external care providers 2016-17 to 2017-18, as at Quarter 2 2017-18 [9]						
	Average amount paid to external providers for home care		Average amount paid for external provider care homes without nursing for clients aged 65+		Average amount paid for external provider care homes with nursing for clients aged 65+	
	2017-18 £ per contact hour	% change since 2016-17	2017-18 £ per client per week	% change since 2016-17	2017-18 £ per client per week	% change since 2016-17
Local authority average	15.79	5.5%	561.08	4.1%	598.67	4.6%
	Number and percentage of local authorities					
Increase (uplift)	139	91.4%	143	94.1%	138	90.8%
No change	11	7.2%	4	2.6%	4	2.6%
Decrease	1	0.7%	3	2.0%	6	3.9%
Missing/Invalid data	1	0.7%	2	1.3%	4	2.6%
Figures should be treated as indicative and with caution due to quality and coherence issues with the underlying data.						

Impact on home care packages, care home placements and hours

At Quarter 1, local authorities were asked about the impact the additional funding would have on the planned number of home care packages, hours of home care and number of care home placements provided over the course of the year. However, given the low and inconsistent response, these questions were refined and asked again at Quarter 2. While the response rate improved somewhat, it was clear that local authorities were still taking different approaches and experiencing difficulties in estimating the requested figures. As such, the responses to these questions should be treated as indicative given the data quality concerns. In particular, the figures should not be aggregated or used to make direct comparisons between local authorities.

Despite the data limitations, the responses provide an insight into the general direction of travel regarding the provision of both home care and residential care. As shown in Table 3, the returns indicate that around two-thirds of local authorities planned to increase the number of home care packages they would be providing over the course of the year as a result of the additional money. A similar proportion reported that their provision of home care hours would increase. In contrast, 41% stated that they would increase the number of care home packages as a result. While the proportion stating there would be no change for each measure was also substantial, this is in part reflective of some local authorities experiencing difficulty in trying to quantify the impact of the additional funding.

[9] In calculating the fees underlying the figures in Table 2, local authorities were asked to exclude:
- Any amounts usually included in fee rates but not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places
- Any amounts that are paid from sources other than the local authorities' funding i.e. third party top-ups, NHS funded Nursing Care and full cost paying clients

Local authorities were asked to include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by local authorities and fees commissioned by the local authorities as part of a managed personal budget.

Notably, several authorities stated that as the additional money was being used on preventative work and actively pursuing a strategy of reducing demand and maintaining independence, it was anticipated that the level of provision would fall. This was particularly the case for care home placements where nearly a fifth of local authorities said they anticipated that their provision would reduce as a result of the extra funding. Complete local authority responses can be found in Table C of the accompanying workbook.

Table 3: Planned change in home care and care home provision in 2017-18 as a result of additional iBCF funding, as at Quarter 2 2017-18

Number and percentage of local authorities reporting a planned change in the:						
Direction of travel	**Total number of home care packages provided**		**Total number of hours of home care provided**		**Total number of care home placements provided**	
	Count	**%**	**Count**	**%**	**Count**	**%**
Increase	99	65%	101	66%	63	41%
No change	30	20%	27	18%	51	34%
Decrease	10	7%	9	6%	27	18%
Missing/Invalid data	13	9%	15	10%	11	7%

Figures should be treated as indicative and with caution due to quality and coherence issues in the underlying data.

Projects being supported

In each quarter, local authorities were asked to provide details of the projects that were being supported in 2017-18 by the additional iBCF funding they had been allocated. As shown in Table 4, details of 785 projects had been provided in total (an average of just over 5 projects per authority) by Quarter 4. This compares to a total of 696 projects reported at Quarter 1. There was considerable variation in the number of projects reported, with authorities reporting as few as one to as many as 29 projects by Quarter 4 (although some of this variation was due to differences in how local authorities defined an individual project).

Table 4: Number of projects supported by additional iBCF funding, 2017-18

Cumulative number of projects reported by quarter			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
696	746	752	785

At Quarter 4, local authorities were asked to categorise their projects by a primary theme[10]. In total, 780 out of the 785 projects were categorised. Reflecting the key purposes for which the funding had been provided, the leading project themes were: DTOC: reducing delayed transfers of care; Capacity: increasing capacity; Stabilising social care provider market - fees uplift and; NHS: Reducing pressure on the NHS. Combined, these themes accounted for half of all categorised projects. Prevention also featured prominently (see Table 5).

[10] The list of pre-coded themes was compiled by the Department of Health and Social Care (DHSC) by categorising project information provided in Quarters 1 and 2

Table 5: Projects supported by additional 2017-18 iBCF funding by theme, as at Quarter 4 2017-18		
Theme	**Number of categorised projects**	**Percentage of categorised projects**
DTOC: Reducing delayed transfers of care	121	16%
Capacity: Increasing capacity	121	16%
Stabilising social care provider market - fees uplift	77	10%
NHS: Reducing pressure on the NHS	72	9%
Prevention	72	9%
HIC: High Impact Change	57	7%
Expenditure to improve efficiency in process or delivery	49	6%
Other	40	5%
Integration	34	4%
Home care	29	4%
Reablement	27	3%
Stabilising social care provider market - other support	21	3%
Technology	18	2%
Protection	13	2%
Leadership	10	1%
Workforce: Stabilising workforce	10	1%
Carers	9	1%
Total	**780**	**100%**

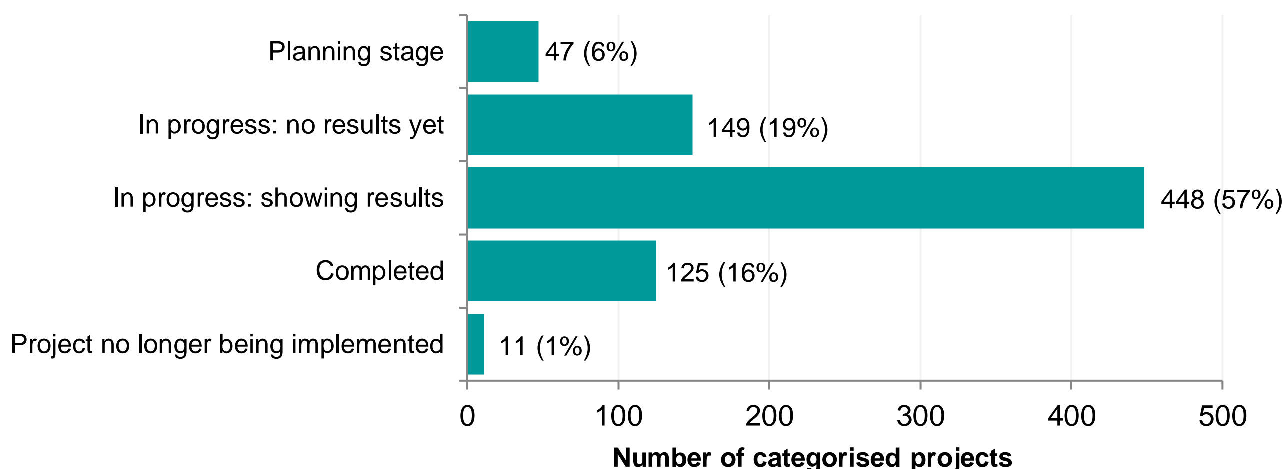
In addition to the pre-coded themes, respondents were asked to provide some additional descriptive information about their projects using free text. Data science techniques were employed to explore what themes the projects clustered around. This method aimed to find clusters by grouping texts that use similar words.[11] This helped provide some context to the purpose of projects. Table 6 summarises the categories around which projects were grouped as defined by the data science analysis. These findings can be seen as reinforcing the results obtained through other methods. In particular, the clusters discovered aligned with the three themes of community, market, and health categories.

[11] For further information on the Data Science methods used see Annex B.

Table 6: Topic clustering for projects supported by additional 2017-18 iBCF funding based on project descriptions
(Size of word indicates relative importance)
Community type categories
1: support care service home reduce term people provide hospital capacity admission provision reablement increase long discharge outcome community include
2: need have service sc funding home people level ensure current meet
3: home improve investment capacity quality bed technology use resource additional system enhance
4: work community social team base improve service people model capacity enable include
Market type categories
5: care market provider increase residential home_care local rate package cost ensure quality sustainability care_home stabilise
6: capacity asc additional sc increase demand service assessment investment market new use development include pressure homecare
Health type categories
7: discharge hospital admission assessment d2a day patient increase team care improve home work dtoc model reablement flow assessor reduction
8: service care reduce community health increase reablement prevention user admission
9: care health support sc system develop new model work need staff integrated
10: people need reduce number increase meet pressure admission asc hospital disability demand more community independence complex

At Quarter 2, local authorities were able to report on the progress of 731 projects. Of these, 296 (40%) were described as 'in progress: showing results'. By Quarter 4, local authorities were able to report on the progress of 780 out of 785 projects. At this latter point, the majority (448 or 57% of categorised projects) were described as being 'in progress: showing results'. In contrast 11 projects (1%) were categorised as 'no longer being implemented'. 125 projects (16%) were reported as 'completed' (see Figure 4).

Figure 4: Projects supported by additional 2017-18 iBCF funding by stage of progress, as at Quarter 4 2017-18



780 initiatives and projects categorised in total. Percentage of categorised projects shown in brackets.

A breakdown of the 780 categorised projects by both theme and stage of progress as reported at Quarter 4 is shown in Table 7. While a third of technology projects were still in the planning stages, nearly half of protection projects were reported as complete. For the majority of themes, over 50% of the projects were reported as being 'in progress: showing results'.

Table 7: Categorised projects supported by additional 2017-18 iBCF funding by theme and stage of progress, as at Quarter 4 2017-18

Theme	Number of projects within theme	Percentage of projects within theme by stage of progress: Planning stage	In progress: no results yet	In progress: showing results	Completed	Project no longer being implemented	Progress not reported
Capacity: Increasing capacity	121	4%	20%	51%	22%	2%	1%
DTOC: Reducing delayed transfers of care	121	2%	11%	75%	11%	2%	0%
Stabilising social care provider market - fees uplift	77	0%	10%	52%	38%	0%	0%
NHS: Reducing pressure on the NHS	72	7%	18%	63%	11%	1%	0%
Prevention	72	10%	29%	47%	11%	3%	0%
HIC: High Impact Change	57	5%	12%	79%	2%	2%	0%
Expenditure to improve efficiency in process or delivery	49	8%	27%	53%	12%	0%	0%
Other	40	10%	25%	43%	20%	3%	0%
Integration	34	6%	38%	41%	15%	0%	0%
Homecare	29	3%	7%	69%	17%	3%	0%
Reablement	27	15%	19%	56%	11%	0%	0%
Stabilising social care provider market - other support (training, property maintenance)	21	5%	38%	43%	14%	0%	0%
Technology	18	33%	6%	56%	0%	6%	0%
Protection	13	8%	15%	31%	46%	0%	0%
Leadership	10	10%	30%	60%	0%	0%	0%
Workforce: Stabilising workforce	10	10%	30%	40%	20%	0%	0%
Carers	9	0%	33%	67%	0%	0%	0%

Key: Deeper shading represents higher percentage of projects

0%	25%	50%	75%	100%

Local authorities chose to use their additional iBCF resources in a variety of ways. The following section provides some illustrations of the types of projects undertaken during 2017-18. These illustrative examples are based on the individual returns provided by local authorities throughout the reporting year.[12]

[12] Impacts and figures are based on self-reported local authority returns and have not been verified by MHCLG.

DTOC: Reducing Delayed Transfers of Care

Shropshire: Integrated Community Services (ICS) Increase in hospital social work capacity
Staffing levels were increased to enable the timely review of care and rapid and safe assessments. The aim was to improve the flow through the system to support the achievement of the DTOC target. By the end of the reporting year, all posts (except one) were recruited to and had commenced employment. Shropshire reported that this contributed to consistent improvement in the DTOC figures, considerable increase in the number of complex discharges from both acute and community hospitals, and an improved flow through the system.

Reading: 'Willows' / Discharge to assess
The aim of this discharge to assess service (part of the Willows residential care complex operated by Reading Council) was to reduce the number of patients on the fit to go list, reduce the length of stay for individuals who were fit to leave acute hospital care, reduce permanent admission to residential and nursing care, improve service user satisfaction, further enhance the number of service users at home 91 days post discharge from hospital and to avoid hospital admission. By Quarter 4, it was reported that the service had engaged with 78 clients referred by acute hospital settings and may have prevented and/or reduced the impact of 78 delayed transfers of care. Given an average length of stay of 4.5 weeks (or 31.5 days), it was estimated that this could equate to 2,457 delayed days avoided. Assuming a cost of £400 per NHS bed/day, Reading reported this could equate to potential cost avoidance of £982,800.

Poole: Intensive packages to support complex needs and behaviours including dementia
In 2017-18, £227 thousand of iBCF money was used to support adults with high intensity and high cost care home placements, in particular for those patients difficult to place in residential settings from community hospitals. This project supported high impact changes in relation to early discharge planning and patient flow and the supplementary funding enabled complex packages to be put in place to expedite discharge from hospital. Poole reported that this had enabled social care to support early hospital discharge and meant that they were able to exceed their DTOC target.

Prevention

Nottinghamshire: Prevention services to build community resilience and offer early interventions (Brighter Futures, Connect, Co-Production, Moving Forward)
This project concerned the maintenance of programmes that were providing evidence of positive outcomes for service users. By the end of Quarter 4, Co-Production had delivered 37 support groups running across the county and Connect had helped 3,587 predominantly older people year-to-date with issues relating to maintaining independence. Moving Forward had helped 833 service users year-to-date to address housing and money issues, improve mental well-being recovery and maintain independence while Brighter Futures had helped 492 service users year-to-date with a learning disability, Autism Spectrum Disorder or acquired brain injury to develop skills and confidence for independence.

Wandsworth: Preventative services
Wandsworth undertook a review of the preventative offer from the voluntary sector, and enhanced the range of services offered including open access day services to help manage demand and keep people as independent as possible and away from mainstream services. Through the year they consulted with voluntary organisations on the proposals to implement an integrated approach to commissioning and a strengthened preventative offer from the local voluntary sector. By the end of the year, the consultation had been completed and proposals were in development. Additional resources enabled the stabilisation and strengthening of key open access day services.

Warwickshire: Transformation to support longer term sustainability
This project aimed to improve community and voluntary sector capacity and resilience to reduce the demand for statutory services; including focussed support services to help people make the right choices for themselves (self-care and support). By the end of Quarter 4, Warwickshire reported that six proof of concept community hubs were in place across the county. These hubs are now supporting community capacity building and reducing demand for statutory and council services.

Technology

Southampton: Promoting Use of Care Technology
Southampton employed a dedicated Care Technology Coordinator to sustain an increase in referrals and help support independence, prevent admissions and support timely discharges. A focus on referral routes helped to monitor their success around increasing and promoting Care Technology. After beginning in post, referrals improved significantly and have since maintained a consistent level. The primary referral route from health came through a falls pathway (rehabilitation and reablement). Hospital discharges were also linked in with the referral process for the City Council. Southampton is now looking at potential referral routes from the dementia pathway to introduce GPS technology to appropriate clients.

Bristol: Collaborative use of technology
This project had two elements aimed at increasing collaborative use of technology: 1) to implement mobile technology for front line staff to be able to operate more efficiently and effectively away from the office; and 2) to implement more extensive solutions to keep service users safe in their own home. By the end of Quarter 4, on the first, the new technology was being piloted. On the second, increased and more creative use of Assistive Technology (AT) had led to better outcomes and opportunity to discharge more quickly from hospital. The Council is now working on a strategic plan for an increased Assistive Technology offer in Bristol.

Details of the project information as submitted at Quarter 4 can be found in Table D of the workbook accompanying this report.

Locally used metrics

Throughout the reporting process, local authorities were asked about the metrics they were using locally to assess progress. This was monitored in order to provide a view of what impact local authorities thought that the projects and additional iBCF funding would have.

By Quarter 4, local authorities had cumulatively provided details of 574 metrics (or groups of metrics). This averaged out to 3.8 per local authority. However, 30 authorities failed to provide details of any metrics at all, while the maximum submitted by a single authority was ten.

The metrics collated at Quarter 4 were subsequently categorised by broad theme based on the titles and descriptions provided.[13] As shown in Table 8, the leading theme related to delayed transfers of care (DTOCs) and discharge activity. A similar proportion (nearly a fifth of reported metrics) were categorised as measures relating to reablement and rehabilitation activity. This was followed by metrics relating to care home admissions. These results are not surprising given the focus of activity on reducing DTOCs over the reporting year. Moreover, these leading themes represent three of the four national performance metrics for the Better Care Fund for 2017-19.[14]

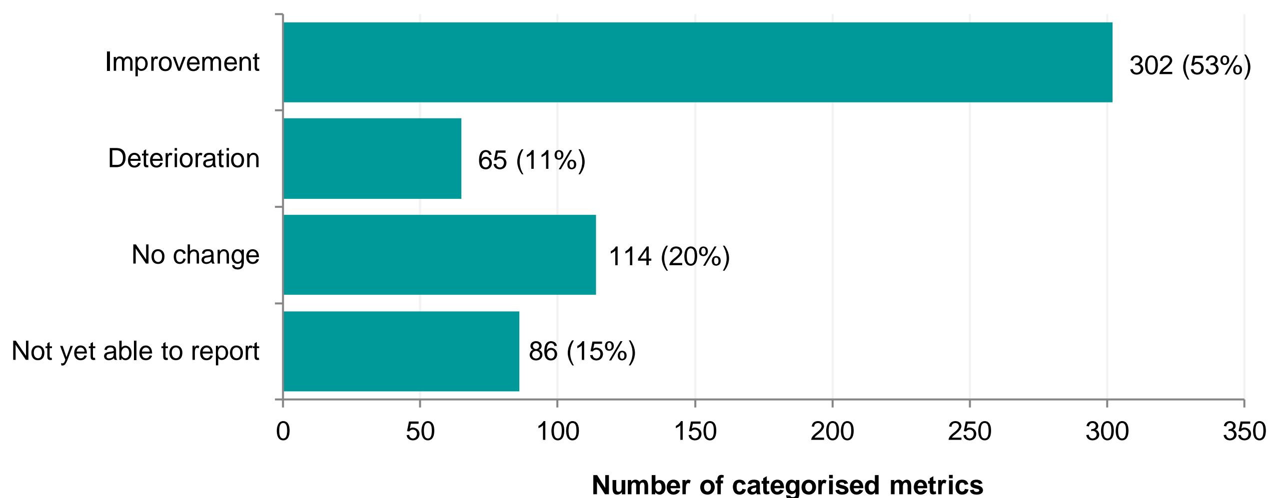
Table 8: Metrics used locally to monitor impact of additional 2017-18 iBCF funding by theme, as at Quarter 4 2017-18

Theme	Number of metrics	Percentage of metrics
DTOC/Discharge	129	22%
Reablement & Rehabilitation	109	19%
Residential/Nursing Care Admissions	51	9%
Assessment & Reviews	42	7%
Capacity - Domiciliary	41	7%
Reducing NHS Pressures	40	7%
Capacity - Activity	26	5%
User Satisfaction/Outcomes	19	3%
Other	18	3%
Workforce	16	3%
Capacity - Residential & Nursing Care	13	2%
Performance (including CQC ratings)	13	2%
Carers	11	2%
Housing & Supported Living	10	2%
Direct payments/Personalisation	9	2%
Prevention/Early intervention/Signposting	8	1%
Technology/Telecare	7	1%
Market Support	5	1%
Integration	4	1%
Market failure	3	1%
Total	**574**	**100%**

[13] For metrics falling under multiple themes, a primary theme was selected based on the descriptions provided.
[14] BCF metrics: Non-elective admissions; Admissions to residential and care homes; Effectiveness of reablement; and Delayed transfers of care.

At Quarter 4 local authorities also provided details on the overall direction of travel over the course of the year for 567 of their metrics. As shown in Figure 5, 302 (53% of categorised metrics) were reported as showing improvement. In contrast, just 65 (11%) were said to have deteriorated. It should be noted that these figures are based solely on self-reported returns which have not been subject to additional validation. It is also not possible to be clear about causality, in that changes in metrics may not be due (entirely) to the interventions themselves. Official and National Statistics relating to the metrics provided may be available elsewhere.

Figure 5: Locally used metrics by direction of travel during 2017-18, as at Quarter 4 2017-18



567 metrics categorised in total. Percentage of 567 categorised metrics shown in brackets.

A further breakdown by theme and direction of travel is shown in Table 9. Significantly, this breakdown shows that for the leading themes, the majority of metrics were reported to be showing improvement. In the case of DTOCs/Discharge, Residential and Nursing Care Admissions and Assessment and Reviews, around two-thirds of metrics were reported as showing improvement. The theme with the largest proportion of metrics which fell into the deterioration category was Reducing NHS Pressures. This theme excludes DTOCs but notably includes metrics relating to non-elective admissions. These broad trends chime with what has been shown in published statistics over 2017-18. For example, nationally, social care DTOCs fell by 32% between April 2017 and March 2018.[15] In contrast, total emergency admissions rose by 8% over the same period.[16]

Full details of the metrics can be found in Table E of the workbook accompanying this report.

[15] NHS England Delayed Transfers of Care Data 2017-18 (Based on figures adjusted for the varying length of calendar months)
[16] NHS England A&E Attendances and Emergency Admissions 2017-18 (Based on figures adjusted for the varying length of calendar months)

Table 9: Locally used metrics by theme and direction of travel during 2017-18, as at Quarter 4 2017-18						
Theme	**Number of metrics within theme**	**Percentage of metrics within theme by direction of travel**				
		Improvement	**Deterioration**	**No change**	**Not yet able to report**	**Direction of travel not reported**
DTOC/Discharge	129	66%	5%	19%	10%	0%
Reablement & Rehabilitation	109	56%	14%	15%	15%	1%
Residential/Nursing Care Admissions	51	65%	8%	18%	8%	2%
Assessment & Reviews	42	64%	0%	14%	14%	7%
Capacity - Domiciliary	41	39%	20%	27%	12%	2%
Reducing NHS Pressures	40	28%	35%	15%	23%	0%
Capacity - Activity	26	42%	8%	23%	27%	0%
User Satisfaction/Outcomes	19	16%	16%	21%	47%	0%
Other	18	39%	6%	39%	11%	6%
Workforce	16	69%	6%	0%	25%	0%
Capacity - Residential & Nursing Care	13	31%	15%	38%	15%	0%
Performance (including CQC ratings)	13	54%	8%	31%	8%	0%
Carers	11	55%	18%	9%	18%	0%
Housing & Supported Living	10	40%	20%	40%	0%	0%
Direct payments/Personalisation	9	11%	22%	67%	0%	0%
Prevention/Early intervention/Signposting	8	50%	0%	13%	38%	0%
Technology/Telecare	7	71%	0%	29%	0%	0%
Market support	5	100%	0%	0%	0%	0%
Integration	4	0%	25%	0%	75%	0%
Market failure	3	33%	0%	67%	0%	0%

Key: Deeper shading represents higher percentage of metrics

0%	25%	50%	75%	100%

Engagement with external care providers

At Quarter 1, local authorities were asked whether they had been engaging with their care providers in light of the new money they had received. 133 (87.5%) of authorities confirmed that they had engaged, while 19 local authorities (12.5%) reported that they had not. However, all the authorities that had not yet engaged with providers, stated their intention to do so. For example, a number of these authorities outlined their plans for consultation through the use of established provider forums or reported that they were waiting for final spending plans to be agreed before starting formal engagement. Full details can be found in Table F of the accompanying workbook.

Views on the purpose and impact of iBCF funding

At Quarter 1 local authorities were given the opportunity to provide some background and context to their responses about their intended use of their additional iBCF allocations. Specifically, they were asked to provide a *scene-setting narrative*, and an explanation of how they anticipated the allocation would impact on their budget. The latter question reflected the fact that the additional iBCF funding was announced after most local authorities had already set their 2017-18 budgets. This question was therefore included to help understand what the additional money meant local authorities could do, in comparison to their planned activity. This scene-setting and impact on budget-setting was only relevant to the start of the reporting year and therefore not followed-up in subsequent quarters.

Scene-setting narratives

A closer analysis of a sample of local authority returns revealed a number of commonly mentioned themes.[17] These included the challenges and pressures local authorities were facing, the efforts they had already made to tackle demand and manage service delivery on reducing budgets, as well as working together with colleagues in the health sector towards achieving better integration.

The three purposes of the iBCF funding were often cited, and the fragility of the care market was referenced frequently. This was noted not only with regard to market capacity and increased costs, but also in reference to workforce resilience, recruitment and retention issues. The need to address delayed transfers of care was also a common theme.

However, in addition to the short to medium term pressures and challenges, local authorities also mentioned the need to invest in prevention and transformational activity in order to achieve sustainability for the future.

> *The employment market in the area is buoyant. Whilst positive for local people, this means that the entire health and care market struggles to compete to recruit and retain capability to maintain capacity in care services across rural and urban geography.*
>
> *Hampshire*

> *The iBCF means that we can meet the additional transitional costs associated with developing new community-based activities, whilst running the existing traditional services.*
>
> *Bexley*

[17] See Annex B for further information on the manual reading of narrative returns. The narrative-based findings in this report should be viewed as illustrative rather than representative of the dataset.

> *The Council has taken a view that the iBCF investment, albeit time limited, will be used to 'transform' the health and social care system in Central Bedfordshire and therefore will not be used to offset the underlying over spend within Adult Social care…*
>
> *Central Bedfordshire*

> *There are opportunities to do things differently; prevention and early intervention approaches to managing demand are a crucial component of both the Council and NHS' sustainability strategies. Shifting a focus to earlier interventions to prevent escalation of need, improved information and advice at access points into services, more effective integration of assistive technology, equipment and housing solutions, self-management approaches to maintain independence and effective commissioning of the market are fundamental aspects of the forward approach.*
>
> *Cambridgeshire*

Impact of iBCF allocations on budget decisions

Based on the sample of returns that were reviewed more closely, three messages came across clearly:

- **A more strategic approach to service planning:** A number of local authorities had experienced consistent over-spending against adult social care budgets and while the money had not halted the need to deliver savings and cost reductions, it meant they felt able to take a more deliberative and realistic approach;
- **Protecting service delivery:** Without the additional funding, a number of local authorities would have needed to find additional savings or cut services; and
- **Supporting additional services:** The money had allowed investment in activities which otherwise would not have been able to be supported.

> *Additional funding has been used to fund the year on year growth thus meeting increased demand without requiring offsetting cuts in services.*
>
> *Bedford*

The financial pressure from an increasing demand and market pressures means the iBCF only partially helps address the pressures being experienced across health and social care.

Cheshire East

There is a £9m gap in the Council's medium term financial plan due to pressures on Adult Social Care costs and consequently the additional funding is also being utilised to maintain service provision, which has replaced the need to use reserves to meet adult social care spending in the short term.

East Riding of Yorkshire

The iBCF has allowed the Council to invest in services that are preventative and otherwise may not have been funded…

Croydon

Full details of all Quarter 1 narratives can be found in Table G of the workbook accompanying this report.

Key successes and challenges

In subsequent quarters, local authorities were asked about the key successes they had experienced and challenges faced in relation to the additional iBCF funding they had been given for 2017-18.

Successes

A keyword count analysis[18] of the narrative responses provided in Quarter 4 showed that by theme, DTOCs and Capacity were most likely to be mentioned in the narratives relating to successes (see Table 10).

[18] Information on the keyword count approach and its limitations can be found in Annex B.

Table 10 : Top 10 themes based on keywords mentioned in Key Successes narratives, as at Quarter 4, 2017-18		
Theme	**Number of local authorities reporting keywords related to theme**	**% of local authorities reporting keywords related to theme**
DTOC	117	77%
Capacity	89	59%
Stabilising market	78	51%
Finance	77	51%
Reablement	77	51%
NHS	74	49%
Reducing Demand	66	43%
Integration	61	40%
Workforce	59	39%
Prevention	40	26%

Closer reading of a sample of the returns from Quarter 4 largely bore out the keyword findings from Table 10.[19] Improved performance and reductions to social care DTOCs were consistently referenced. In relation to the market and providers, there were a number of comments about successfully managing provider contracts and price negotiations to support market sustainability. Related to this, comments about increasing capacity at the interface of health and social care in order to develop a joint approach to managing the care home market were also mentioned.

Though not featured as a leading theme in the keyword count, comments about strong partnership working were commonly identified when examining the narrative detail. Such commentary related to partnership working between the NHS and the council, joint leadership delivering whole system outcomes, and systems taking and developing co-ordinated or joint responses.

> *One of the key areas of successes in this area has been the benefit of working together as a local system.*
>
> *City of London*

> *The funding has assisted to stabilise the care market by giving the flexibility to the local authority to fund genuine additional cost pressures faced by providers.*
>
> *Hackney*

> *The investment from the iBCF has stabilised the local health and social care economy. No contracts have been passed back by the external provider market and we have been able to maintain our investment in home care packages which would not have been the case without this additional funding.*
>
> *York*

[19] Findings based on the reading and manual coding of narrative returns should be viewed as illustrative.

Challenges

As well as being identified as leading themes in the success narratives, DTOCs and Capacity also featured prominently in the keyword count of the challenges narratives (see Table 11).

Table 11 : Top 10 themes based on keywords mentioned in Key Challenges narratives, as at Quarter 4, 2017-18

Theme	Number of local authorities reporting keywords related to theme	% of local authorities reporting keywords related to theme
DTOC	59	39%
Workforce	56	37%
Capacity	53	35%
Stabilising market	52	34%
Finance	49	32%
Reducing Demand	43	28%
Reablement	36	24%
NHS	34	22%
Integration	24	16%
Finance Pressure	22	14%

From the sample of returns examined in detail, the narrative on challenges was very clear in suggesting that although the additional iBCF had enabled improved delivery and performance, risks remain. There was, for example, frequent reference to the ongoing challenge of increasing demand and complexity and therefore continued associated financial pressures.

The difficulty of recruiting to social care - and particularly to specific project roles or occupations - was highlighted. It was mentioned that delays in recruitment could lead to delays in being able to implement initiatives and this also impacted timescales. The limited and tight timeframe for planning and delivery, the time-limited nature of the funding and opportunities for investment, and the ability to sustain performance improvement were all noted.

In recognition of the challenges of partnership working, some comments expressed frustration with managing NHS and other partner expectations about funding, and the need to get agreement across organisations.

Demand and complexity of need continues to rise putting further pressure on placement budgets and commissioning protocols.

Ealing

Budgetary pressures still remain a challenge at present with the Health and Wellbeing Department needing to make significant savings by 20/21.

Bradford

Delays in processing and transferring funds to partner organisations due to approval and procurement process for due diligence. Delays due to recruitment and retention in a number of the new initiatives.

Bolton

Challenges have been in operationalising services given the tight timescales between funding agreement and service delivery. Whilst additional funding is welcomed, time limited investments provide challenge in supporting long term strategies.

Coventry

Complete local authority responses on the key successes and challenges reported at Quarter 4 are presented in Table H of the workbook accompanying this report.

Conclusion and next steps

It is clear that the additional funding provided at Spring Budget 2017 has been valuable to local authorities in delivering impact in the areas of interest to the Government during 2017-18. Key messages about the purposes of the funding, especially in relation to stabilising the market and reducing pressures on the NHS featured strongly in the reporting over the year. It is also clear that the investment in projects through the additional iBCF has helped to deliver positive change, particularly in relation to the substantial fall in DTOCs over the course of 2017-18.

The information received from local authorities supports the national understanding about the fragility of the care market and the need to support providers. Notably, the feedback indicates that the additional iBCF has enabled fee uplifts across home care, nursing and care home provision, despite concerns about the non-recurrent nature of the funding.[20] However while increased fees can go some way to address these issues, it is clear that challenges surrounding the social care workforce, including recruitment and retention, remain.

In 2018-19, data will continue to be collected from local authorities on a quarterly basis. The aim for 2018-19 is to reduce the reporting burden, and the narrative information collected. A greater focus will therefore be placed on the quantitative responses.

A short report will be published following the 2018-19 Quarter 2 collection in order to present the fees information collated. An end-of-year report following the Quarter 4 2018-19 collection will then be published during 2019.

Acknowledgements

The Ministry of Housing, Communities and Local Government (MHCLG) would like to thank all 152 local authorities with social services responsibilities for providing the wealth of material which has been drawn on for this report. The iBCF quarterly data collection is managed by MHCLG working in collaboration with the Department of Health and Social Care (DHSC).

[20] As with other funding, the Government has taken no decisions about this funding beyond 2019-20.

Annex A: Allocation methodology for the iBCF

The Government set out its proposed approach to allocating the original iBCF alongside the provisional Local Government Finance Settlement 2016-17[1] and confirmed this approach as part of the final Settlement in 2017-18. The approach recognised that local authorities have varying capacity to raise council tax, and therefore used a methodology which, relative to need, provided more funding to those authorities that benefit less from the adult social care council tax precept.

The methodology was based on the following steps:

1. Calculating the dedicated funding available to spend on adult social care at a national level by combining the council tax flexibility for adult social care and the original iBCF.

2. Calculating the share of that national amount each authority with responsibility for social care would receive if it were distributed according to the 2013-14 adult social care relative needs formula (RNF)[2].

3. Calculating how much each authority with responsibility for social care could raise from the additional council tax flexibility for adult social care.

4. Allocating the original iBCF in such a way that, when combined with the money which could be raised from the council tax flexibility, each authority would receive its share of the combined national amount as calculated by the adult social care RNF.

5. These allocations are then adjusted so that, where an authority could receive more from the additional council tax flexibility for social care than its share of the national amount calculated in step 2, its allocation for the improved Better Care Fund is set to zero rather than a notional negative figure.

6. The remainder of the allocations are then reduced proportionately, so that the combined totals sum to the national total for additional funding available to spend on adult social care, as calculated in step 1.

In distributing the additional iBCF from Spring Budget 2017, 10% of the funding in each year was allocated using the 2013-14 adult social care RNF. This was done in recognition that all 152 responsible local authorities were facing pressures on the provision of adult social care. The remaining 90% of the funding in each year was allocated using the original iBCF distribution methodology. Allocations for the additional iBCF from 2017-18 to 2019-20 for all local authorities with social care responsibilities were published in March 2017.[3]

[1] DCLG (2015) The provisional Local Government Finance Settlement 2016-17 and an offer to councils for future years Consultation
[2] DCLG (2013) Methodology Guide for Adults' Personal Social Services Relative Needs Formulae 2013/14
[3] DCLG (2017) The allocations of the additional funding for adult social care

Annex B: Data collection, quality and analysis

Collection

Quarterly reporting data was collected using Excel-based forms which were distributed to all 152 local authorities in receipt of additional iBCF funding. The data collection process was administered by email for each quarter, with the forms initially sent to senior officials responsible for adult social care services or the Better Care Fund in each local authority. The timetable for collection is shown in Table B1 below.

Table B1: 2017-18 iBCF quarterly reporting timetable

Quarter (2017-18)	Main collection period	Form return response rate[1]
Quarter 1	26 May to 21 July 2017	100%
Quarter 2	25 September to 20 October 2017	100%
Quarter 3	13 December to 19 January 2018	100%
Quarter 4	20 March to 27 April 2018	100%

Over the year, the questions were refined and honed, particularly to provide greater clarity of what was required and to reduce the extent of the narrative information required. The questionnaires used for each quarter of 2017-18 are published on Gov.uk.

Data quality

The status of the data was assessed prior to publication. Much of the information was qualitative, based wholly on self-reported local authority returns, and the data collected changed quarterly meaning that there was limited scope to publish a consistent time series. In addition, although some cleaning took place to exclude invalid returns, the datasets were not subject to additional quality assurance. Local authorities were not, for example, contacted for clarifications. Taking these factors into consideration, the decision was taken to release the reporting data as Management Information. Further information about the basis of this decision, and the ways in which the data was judged to be Management Information is contained in Annex C.

Data analysis

The analysis was undertaken by the Ministry of Housing, Communities and Local Government (MHCLG) with input from the Department of Health and Social Care (DHSC). Once the data had been collated for each quarter, it underwent a series of basic validation checks to exclude any invalid returns. However, as noted above, further clarifications from local authorities were not sought. Local authority level datasets are published on Gov.uk.

[1] In some instances completed forms were submitted by a partner organisation representative (e.g. CCG) rather than the local authority. Where relevant, response rates for individual questions are indicated in the analysis.

Keyword counts

Free text responses were analysed and categorised using a list of keywords as determined by the manual inspection of returns by DHSC officials. These keywords were grouped into categories to give a number of themes. Excel-based analysis was used to count the keywords mentioned by each local authority for each of the free text responses. This method relied on exact matches to keywords and therefore may not have captured information where there were spelling errors. Another limitation of word counts is that they do not capture the context in which the word is being mentioned. For example, the approach does not distinguish whether a word is mentioned in a positive or negative way.

Data science techniques

Exploratory data science techniques were also employed to analyse some of the narrative responses. In particular the method of topic modelling was utilised to help extract insights beyond simple word counts.

Topic modelling is a clustering method which enables a collection of texts to be labelled with their common themes. The themes are discovered according to the words that are commonly used together. Since the themes are not specified in advance, this method can enable the discovery of themes and results which may be unexpected. The methods applied aim to discover the inherent structure in the text and let the data speak for itself.

There are limitations to this sort of textual analysis. In particular, this modelling can only indicate the words that are typically used in common contexts. A nuanced understanding of the meaning of the topics generally requires reading a sample of the original texts in parallel with their generated topic labels. There is no automated way of telling if a particular word is used with a different meaning by different respondents and word ordering is not taken into account. As the clustering outputs for the scene setting questions were of more limited value, only the analysis undertaken on the project descriptions is included in this report.

Manual reading

Given the limited outputs from the data science analysis, manual reading and coding of the narrative returns from Quarters 1 and 4 also took place in order to identify some common themes in relation to the scene setting context, the impact the funding had on budgets and the key successes and challenges. In each case, returns from a sample of 55 local authorities (just over a third of authorities) were reviewed in closer detail. The outputs from this exercise should not be viewed as representative of the whole dataset, but as illustrative examples. It should also be taken into consideration that the resultant topics and themes may be subject to potential confirmation bias.

Annex C: Voluntary compliance with the Code of Practice for Statistics

The Code of Practice for Statistics was published in February 2018 to set standards for organisations in producing and publishing official statistics and ensure that statistics serve the public good.

The Improved Better Care Fund (iBCF) quarterly and year-end reporting release is a Management Information release rather than an Official Statistics publication. This is due to the volume of qualitative information collected, the irregularity of the data collection (as the data collected changed from quarter to quarter), as well as some limitations in the quality assurance process. Nonetheless, where possible, attempts to adhere the Code of Practice have been made.

Trustworthiness: trusted people, processes and analysis	**Honesty and integrity** (T1): The iBCF quarterly and year-end reporting data release is managed by analysts and policy officials in MHCLG, working together with officials from the Department of Health and Social Care (DHSC). This involves the design of data collection tools and analysis. **Independent decision making and leadership** (T2): The work is jointly governed by the Local Government Finance and Analysis and Data Directorates in MHCLG, with input from DHSC. It is accountable to MHCLG's Chief Analyst and Head of Profession for Statistics. DHSC's Head of Profession for Statistics is also consulted on the publication process. **Orderly release** (T3): Access to the data before public release is limited to MHCLG, DHSC and NHS Digital staff involved in the production and the preparation of the release. The data is also accessible to the Care Quality Commission (CQC), Local Government Association (LGA) and Better Care Support Team prior to publication for operational purposes. **Transparent processes and management** (T4): MHCLG has robust, transparent, data-management processes. All data are provided by local authorities who received notification that the data would be published. **Professional capability** (T5) Analytical work is managed by professionally qualified and experienced analysts - professional members of the Government Statistical Service (including Government Data Scientists) and the Government Social Research profession. **Data Governance** (T6): MHCLG uses robust data collection and release processes to ensure data confidentiality.
High quality: robust data, methods and processes	**Suitable data sources** (Q1): Data originates from all local authorities in England responsible for providing adult social care services, with each collection in 2017-18 achieving a 100% response rate. The local authorities are ultimately responsible for the quality of their data. However, where the quality of data is unclear, the issues are clearly highlighted. National and Official Statistics are signposted where relevant. **Sound methods** (Q2): Data collection tools and processes are robustly designed and tested prior to use. The data collection has been refined over time. **Assured Quality** (Q3): While the data has been checked for errors, further validation and triangulation with additional data sources has not taken place. As such, the release clearly states that the data are self-reported, and highlights any limitations, including where data should be treated with particular caution.
Public value: supporting society's need for information and accessible to all	**Relevance to users** (V1): Understanding how the additional iBCF funding is being used is of significance to central government, local authorities and their partners, as well as in the public interest. **Accessibility** (V2): Officials have had access to the data prior to publication to monitor progress and the impact of the iBCF. The data may therefore be used for operational purposes before publication in this data release. **Clarity and Insight** (V3): Data are clearly presented and explained, with suitable visualisations and underlying local authority level datasets are made available. **Innovation and improvement** (V4): This data collection series started in Spring 2017, and has been progressively refined to provide greater clarity. Online data collection methods have also been piloted. **Efficiency and proportionality** (V5): Burdens on data providers have been considered. MHCLG has worked to streamline the collection process by combining with the Better Care Fund performance reporting process for 2018-19.

Accompanying tables

Accompanying tables and copies of questionnaires are available to download alongside this release. These are:

Improved Better Care Fund (iBCF): Quarterly and year-end reporting 2017-18
Local authority data tables

Improved Better Care Fund (iBCF): Quarterly and year-end reporting 2017-18
Quarterly reporting forms

These files can be accessed on Gov.uk at: Improved Better Care Fund 2017-18: quarterly and year-end reporting

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