# Better Care Fund (BCF): Frequently Asked Questions

***Updated 29 August 2014***

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53. What types of risk share arrangements are available for use with partners including local authorities? i.e. as each pound allocated to the BCF requires an associated admission avoidance strategy to avoid duplicated spend. Should this prove not be effective, the commissioners will overspend to the amount allocated to the LAs.
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60. Is the £130m identified for Care Bill Implementation within part of the £335m?
61. Is there any detailed information available to clarify what amount of the BCF for each area is allocated for Care Bill implementation?
62. Will the "host" organisation for the pooled budget have delegated authority for the exercise of the NHS or Social Care functions? Within the pooled fund, would specific allocations be ring-fenced for respective organisations (e.g. £x to social care for DFG, £x to CCG for District Nursing etc) for payments?

63. What is the approach regarding the terms 'recurrent' and 'non recurrent'? Some people have interpreted this that the spending is NR, whereas in health we interpret that as the funding streams?
64. Is all funding other than the £1.1b transfer from NHS to LA and capital coming from CCG baseline, including Care Act implementation?
65. Of the £1.9bn additional NHS contribution, £1bn goes on payment by performance and NHS out-of-hospital services. How is the other £0.9bn to be spent?

## SECTION SIX: PLANNING TEMPLATES

66. Do we need to fill out Annex 1 (detailed scheme description) only for schemes directly related to our target for reduced admissions, or also for other uses of the BCF funding (e.g. Care Act implementation, etc.)?
67. For completing Annex 1 of Template 1, should smaller schemes be aggregated together and is there any further guidance on this – for example is there a fixed threshold in terms of the value of each scheme, below which they should be aggregated?
68. Is there a specific process local areas are expected to adhere to in engaging providers in the BCF planning?
69. Do the 2 year operational and 5 year strategic plans also need to be signed off by Health and Wellbeing Boards?

## SECTION SEVEN: OTHER METRICS

70. On the Patient Experience Metric, is there any expectation that, if an area decides to use the menu of existing survey questions, that multiple questions are needed, taken from a number of surveys? Or is the intention that just one survey question be selected for the metric?
71. Can you clarify if there is an expectation to provide baseline data for our patient experience metric by 19th September if the approach taken is to introduce a new survey?
72. For delayed transfers of care should we use the 'Patient snapshot' or the 'total delayed days', both of which are published by NHS England
73. For all metrics in the BCF the rates used are crude rates rather than standardised rates. Why is that?
74. For delayed transfers of care why was it decided to use the 'total delayed days', rather than the 'Patient snapshot'?
75. Delayed transfers of care data include breakdowns by the organisation responsible and also the reason for the delay. Why was it decided to simply use the total number of delayed days?
76. Patients can be treated in hospitals within local authorities where they are not resident. For delayed transfers of care is it not therefore possible that a local authority could be penalised because of a delayed transfer attributable to a hospital in a different local authority?
77. For delayed transfers of care and avoidable emergency admissions exactly what figures should be inserted in to the metrics table in the planning template?

78. **The residential care admissions metric concerns admissions for those aged 65 and over. However, in the Adult Social Care Outcomes Framework there are also 18-64 admissions relating to disability and mental health problems, which seem relevant to health and social care. Why are these not included?**
79. **The residential care admissions metric only includes council-supported admissions, but this will not include all admissions in to residential care?**
80. **Why is the effectiveness of reablement after 91 days being used in the scheme rather than the rate of those offered the service?**

## COMMUNICATIONS

1. **How do I get added to the circulation list for the weekly communications from Andrew Ridley, BCF Programme Director?**
   Please email bettercarefund@dh.gsi.gov.uk to be added to the list.

2. **I was unable to join the recent webinar on the updated guidance. Where can I find a note of the discussions?**
   Past webinars are available on the main BCF planning pages:
   http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/bcf-web/

3. **When will the exemplar plans be available?**
   We expect the exemplar plans to be available on the BCF planning website by the second week of September.

## BCF POLICY

4. **What requirements are there for areas to properly engage the voluntary and community sector (VCS) in developing their BCF plan?**
   The planning guidance document sets out the requirements of local areas as they revise and resubmit BCF plans. As a result of consultation with national VCS bodies such as the Care and Support Alliance and others, the planning template (part 1) was amended to explicitly reference the VCS at section 8b, in recognition of the role that VCS organisations can play in provision of local health and care services.

5. **Can multiple HWBs develop their BCF plan together?**
   Each Health and Wellbeing Board (HWB) needs to sign-off the performance measures for their area – multiple HWBs can plan together providing the data can be disaggregated and signed off at individual HWB level. Any differences will need to be worked through and separate plans and separate objectives will need to be agreed. If you have any queries regarding this and would appreciate a Unit of Planning workshop in your local area, please contact your Area Team.

6. **There are inherent difficulties when comparing data due to the use of ONS resident data vs GP practice versus registered population - the apportionment of activity between council areas by postcode needs consideration for template 2 on this basis – is there any further advice on this?**
   Submitted CCG plans are at registered population and we needed therefore to map to resident population LA level. We recognise that the approach used will not be perfect in all cases but there is no other national "mapping" and plans are not available at LA level.

7. **Most of the guidance seems to focus mainly on adults. What is the steer about the BCF's application to children?**
   The BCF is primarily focused on dealing with pressures in the system experienced and generated by adults; however, subject to meeting the national conditions in guidance, it is for local areas to decide if they want an increased focus on children.

8. **Will dementia be prioritised as part of the BCF?**
   Subject to meeting the various conditions, there is scope to prioritise various areas, for example, older people or dementia. However, it is up to local areas to use the flexibility to prioritise what is most important for their local population. The guidance makes clear that there should be no negative impact on the level of access and quality of mental health services.

9. **How will the BCF plan work where one HWB covers multiple CCGs?**
   You will be required to submit one plan for the Health and Wellbeing Board. This can cross reference the other 'footprint' plans and indeed any other local plans – that is entirely up to you and your local partners to agree and sign off, so long as you meet the national requirements. You would be required to hold the budget using a Section 75 agreement, but it is entirely up to you locally to agree how best to make this work. You could have one or a number of S75s, or you could use existing S75s. There may be a VAT

benefit if the local authority holds the budget, but we advise you to seek the advice of the relevant finance directors on this.

10. **Will there be changes in procurement rules to facilitate BCF implementation?**
    There are currently no plans to change procurement rules for the purposes of the NHS with regard to implementing the Better Care Fund. Monitor has recently published guidance on the Procurement, Patient Choice and Competition Regulations, including on improving the quality and efficiency of services through better integration, and has also published Integrated Care FAQs (both are available on its website).

    National partner organisations in the integrated care and support collaborative are committed to working to clarify the scope and extent of existing freedoms and flexibilities in the system. These will allow localities to innovate and develop their chosen models for integrated care and support. We will seek to address at local level any additional barriers that emerge as pioneers and other local areas push forward on integrated care and support. We will assess whether any rules should be changed at the national level, as experience grows.

11. **Do we know the extent to which the policy direction for integration may be expanded or extended in scope during 2014/15 and 2015/16 if the BCF deemed a successful approach to take and to be pushed further? If this is likely to be the case, this might put a different light on how we generate the right responses and look at more deeply rooted relationships with local authorities at a very early stage.**
    There will be no mandatory expansion of scope in 14/15 or 15/16 that we know of now. Local areas are actively encouraged to expand the scope of integration plans and pooled budgets beyond the minimum requirements of the BCF. All the political signals suggest the 15/16 BCF will be only the start of a longer term focus on integration. This may be reinforced in future spending rounds but we cannot predict that with any certainty.

12. **What happens if parties involved in writing the BCF plan cannot reach agreement?**
    Your plan will not be approved - all parties must try to reach agreement. Area teams can be used to guide teams towards a decision, but are unable to actually override a CCG to force them to go along with a majority view. If agreement is not possible, there will be set in train a process of regional peer assurance). A key part of the support that is being offered to areas over August and early September will focus on leadership and governance issues – you may wish to contact your relevant area team to discuss what support is available to help in developing a shared and agreed plan.

13. **Is a document available that maps CCGs to HWBs, and HWBs to Area Team and Local Government Region, and provides a list of email addresses that we need to send our plan to?**
    This is now available here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

14. **What is happening to support transformational change through tariff changes?**
    As part of the collective work on the Call for Action, NHS England is looking at how it can reform the pricing and contracting systems to support transformational change. Starting

from 1 April 2014 NHS England has agreed with Monitor that the rules around variation to the national tariff are changed so that localities with ideas that can transform services for patients are not held back from doing so because of tariff constraints. Further information is available at: https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents

15. **What does 7 day working for social care mean?**
    It is for local areas to determine arrangements for 7 day working to reflect local circumstances. However the imperative is to support timely hospital discharge at any points during the week.

16. **What does 'protect social care services (not spending)' mean?**
    This is a national condition that initially related to the NHS Transfer and has been extended into the BCF. It is for the local area though the Health and Wellbeing Board to determine how and the amount to which adult social care spend will be protected. This is in the context of maintaining the eligibility for 2015/16, set against rising demography pressures.

17. **How can we incentivise acute trusts to buy into these alternative delivery models?**
    Everyone believes that as the needs of the population have changed, our model of care must change too. They should be closely involved in developing and agreeing the plans. It will be necessary in many cases to decommission and close existing acute capacity. As part of the support package to help areas in developing BCF plans, teams are being deployed in each of the regions, and they should be able to help in engaging acute providers. We would also encourage you to talk to Monitor or the TDA who may be able to provide support and advice.

18. **I've heard that the BCF cannot be used to invest in primary care / general practice? Is this right?**
    No – the BCF can be used to pay for additional services commissioned from general practice or other primary care providers – i.e. those that do not duplicate services already being commissioned under the relevant primary care contract.

## PLAN ASSURANCE

**19. When will there be further information available about the assurance process for the plans?**

The BCF Taskforce are putting in place a National Consistent Assurance Review that will together be used to establish whether plans can be approved or not. The outcome of the review will mean that all BCF plans fall into one of four categories:

- Approved
- Approved with support
- Approved with conditions
- Not approved

This assessment will be determined by the National Consistent Assurance Review of the quality of the plans (carried out by externally commissioned providers all working to a common methodology) and the assurance checkpoints' assessment of the risk to delivery due to the local context facing each local health economy. A briefing will be published on the website outlining our overall approach to Assessment, Improvement and Assurance by the 18 August.

## UPDATED PAY FOR PERFORMANCE SCHEME

**20. What will constitute a sufficient level of ambition for area for reducing non-elective admissions, and will areas be able to agree a target below the 3.5% guideline?**
The national planning assumption for reduced total emergency admissions is 3.5% - this is the guideline minimum reduction that is set out in the revised BCF planning guidance that was issued on 25 July. We realise the scale of the challenge this poses for some areas. The guidance states that NHS England Area Teams will have a role in determining whether locally set targets are sufficiently challenging whilst being realistic, and we realise that for a small number of areas a 3.5% reduction as a planning assumption may be unsuitable. We intend to issue guidance on 18 August to clarify instances where planning for a reduction less than 3.5% may be deemed appropriate.

**21. Does the requirement for a minimum 3.5% reduction in unplanned admissions apply to the number of admissions or rate per 100,000 of population?**
The 3.5% reduction applies to the number of emergency admissions.

**22. Is the new pay for performance framework based on avoidable admissions, or total emergency admissions?**
P4P is based on total non-elective admissions (general and acute) as set out in the definition in the technical guidance

**23. What does the definition of the P4P metric, non-elective (general and acute), cover?**
Assuming that this is in reference to the baseline activity in the P4P tab, please see further advice in the technical guidance pages 20 and 21.

**24. Should underlying growth be factored into our unplanned admissions target?**
Targets should be set against the of Q4 2013/14 to Q3 2014/15 baseline non-elective admission count as this is the basis for the expected 3.5% reduction. However, areas may wish to take in to account factors such as their recent trend and population changes in setting realistic yet challenging levels of ambition.

**25. Is the expectation that areas should show a 3.5% reduction in each quarter, compared to the equivalent quarter in the previous year? What if the bulk of the reduction is achieved towards the end of the year?**
The target is a 3.5% reduction across the 12 month period, and can be variable across quarters. Annex One of the technical guidance provides worked examples and sets out how the P4P monies will be released over the four quarters.

**26. The technical guidance and template use an average unit cost per emergency admission of £1,490? Do areas need to use this figure or can we use a different figure to reflect local circumstances?**
The Technical Guidance and Part 2 planning template have been updated to enable areas to use a more localised unit cost. As set out in the guidance, a rationale for any change should be provided.

27. **If the 3.5% emergency admissions target is not achieved, is it for CCGs to decide how any funding 'held back' is spent, and how costs of any unplanned admissions are met?**
The council and CCGs will need an explicit risk share and contingency agreement on how the unplanned activity will be paid for if the planned reduction in admissions is not achieved. This might include holding a contingency reserve within the BCF pool or disinvesting funds from BCF schemes. It will be for local agreement.

28. **How will the 3.5% target/pay for performance operate in practice across multiple CCGs within a HWB area? Can we have a worked example?**
The target is across a HWB unit of planning, so there are likely to be multiple CCGs in a lot of cases. The part 2 template has built in a mapping methodology which is explained in the technical guidance. In terms of what happens if, for example, one CCG meets their target, but another does not, this will need to be discussed locally and should form part of local contingency planning/risk share arrangements.

29. **If one CCG achieves performance and another doesn't, which results in the overall HWB area not delivering its target, do all CCGs lose the ability to release money or just the underperforming?**
Performance will be assessed at the overall HWB level, so all of the partner CCGs would be covered by the same restrictions.

30. **Is the pay for performance fund the old section 256?**
No. The old s256 is replaced by the new larger BCF arrangements in 2015/16. The performance fund is simply the £1bn element of the Fund that ministers agreed should be linked to performance.

31. **Does the pay for performance framework apply to the £1bn as part of the £3.8bn only does it also apply to any additional funds pooled by choice by the CCG and Local Authority. An earlier template suggested 25% of the total funds pooled.**
The pay for performance framework only applies to the £1bn part of the £3.8bn fund. If local areas choose to pool additional funds, this will not be subject to the pay for performance arrangements.

32. **Is there a clear definition of precisely how much of each area's allocation will be affected by the performance related element or will a set national formula be used?**
Yes. We have uploaded a new version of the BCF allocations spreadsheet which breaks down how much of each CCG's funding is affected by the BCF payment for performance element: http://www.england.nhs.uk/wp-content/uploads/2014/03/bcf-allocations-revised-w1415.xlsx

33. **The 5-year plan required 3% reduction though BCF now requires 3.5%. How can we overcome this discrepancy between the plans?**

The planning guidance Putting Patients First used the example of a 15% decrease in emergency admissions to illustrate the scale of the funding which is moving into the Better Care Fund in 2015/16. This was not intended to be a five-year target. Based on a review of the BCF plans submitted in April, Ministers believe that more can be done to

reduce emergency admissions and so have set out a national expectation of a 3.5% decrease in non-elective admissions. Further guidance has been issued on the 3.5% target and what factors might contribute to a lower target being judged to be acceptable:
http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

**34. Is 3.5% over and above QIPP reductions?**

The planning assumption is that the total number of non-elective (general and acute) admissions between Q4 14/15 and Q3 15/16 will be 3.5% lower than the total number of non-elective (general and acute only) admissions between Q4 13/14 and Q3 14/15. This means that the target will be additional to any QIPP savings on non-electives planned up to Q3 of 2014/15, but that any QIPP savings on non-electives planned for Q4 2014/15 through Q3 2015/16 will contribute towards the 3.5% target.

**35. How does the update for actuals work?**

Please see the updated BCF Technical Guidance published on 19 August 2014 – Annex 1 provides further specific details: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

**36. What if there is a specific error in the data for your area?**

CCGs are unlikely to have the opportunity to submit new CCG activity or plan figures before setting their BCF plans, although this should be possible at a later stage. If areas think that the UNIFY data is incorrect then they should ensure that they set targets which will give the correct percentage change in non-elective admissions. They can then seek to have the data revised through UNIFY when the opportunity arises. P4P performance will be measured against the actual baseline figures using the percentage targets set in the plan, so if there was an error in the planning figures this should not affect the PfP arrangements provided the correct percentage targets are set.

**37. Is benchmarking info available on all local CCG baselines on admissions – this would be helpful in setting local aspirations?**

The new template is pre-populated with the HWB (and CCG) baseline data. The 'Metric Trends' tab also provides historic data for the 4 national metrics as well as projected activity to aid with setting aspirations. The recently published supplementary guidance on setting admissions targets also includes detailed benchmark data to help local areas in setting targets.

**38. The updated technical guidance sets out how the baseline will be updated from Q1-Q3 2014/15 plans to actuals in-year. What does this mean for the size of the performance fund as the activity reduction will change as the baseline changes and therefore the size of the savings will change?**

The size of the performance fund will remain as determined by the plans savings as set out in 19 September submission (i.e. before baselines are updated with actuals). This is because we'd expect planned savings to be committed to contract, and in reality we would not anticipate the differences between plan and actual baselines to have much of an impact on the size of the performance fund.

## FINANCIAL AND GOVERNANCE ARRANGEMENTS

**39. Does the 'social care capital grant' element of the BCF allocation include the Care Act implementation capital allocation for IT?**

£50m of the capital element of the Better Care Fund has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016. This money is not ring-fenced, but local plans should show how the new duties are being met. As this funding is not ring-fenced, you can if you wish use the funding provided for the Care Act IT for another purpose, provided that your LA still meets the Care Act requirements in some other way.

**40. Can you clarify what the respective requirements are for 2014/15 and 2015/16 funding in terms of pooling budgets?**

In 2015/16, the whole of the local share of the Better Care Fund must be held in a s.75 pooled budget, even if it is then dispersed to individual organisations to carry out their parts in the plan. In 2014/15, the local share of the £200m BCF funding will be paid to the council as part of the s.256 transfer, and need not be held in a pooled budget.

**41. Is there any guidance to how the national amounts relating to Care Act implementation, carers break and CCG reablement funding should be allocated amongst firstly HWBs and then at CCG level?**

The total £3.8bn fund includes

- £130m Carers' Break funding
- £300m CCG reablement funding
- £135m Care Act implementation

These are not ringfenced, but you can work out what your notional share is based on your BCF allocation as a proportion of the overall fund. The actual amounts are for you to agree locally, though. The technical guidance to CCG allocations published by NHS England (link below) goes into some detail on how the £3.8bn was divided between HWBs/CCGs. The £1.1bn which came from the s.256 transfer and the social care capital grants are distributed between HWBs following the social care formula, the DFG is distributed following its own formula and the remainder of the revenue funding is distributed according to the latest CCG allocations formula:
http://www.england.nhs.uk/2014/03/27/allocations-tech-guide/

As all of the revenue funding is distributed through CCGs, the elements of the fund which are distributed between HWBs have then been broken down into the relevant CCG allocations. Again, the technical guidance goes into some detail on this.

**42. Will a separate s256 agreement be required for the BCF revenue funding that is routed through NHS England, or is the whole transfer covered through the s75?**

The whole transfer is due to be covered through Section 75 agreements for 15/16. In 2014/15, the BCF element of the s256 funding will be included in the existing agreement. In 2015/16, there won't be a Section 256 transfer, as all the funding will go into the Section 75 pooled budget.

**43. What happens if the HWB and the relevant governing bodies not meet / sit within the proposed timeframe of submitting signed-off plans for 19 September?**
Arrangements should be made to secure HWB sign off by 19 September. If a meeting is not scheduled, it may be necessary to call an extraordinary one or to agree delegated authority.

**44. Are Health and Wellbeing Board (HWB) Chairs personally required to sign off local plans or can it be a representative of the Health and Wellbeing Board**
Yes, HWB Chairs are personally required to sign off the BCF Plan

**45. 'Who is the Accountable Body' for the BCF?**
The accountable body will be the organisation from where the money originated, but the existing statutory Section 75 arrangements will still apply for the delivery of services.

**46. Will the CCG and Local Authority be expected to have a section 75 agreement joint finance agreement in place to receive the pooled BCF fund in 15/16?**
Yes

**47. Where does the Section 75 pooled budget have to sit – with the CCG or the Local Authority?**
The BCF funds will come through the CCG allocations and then transfer into a pooled budget. Whether the pooled fund sits within the CCG or the Local Authority is up to local agreement. However, there may be some VAT benefits and some additional flexibility if the pooled fund sits within the Local Authority. You should seek advice from your finance department to explore the options available to you locally.

**48. How much of the £1.1bn 14/15 fund is subject to the pooled budget arrangements?**
In 2014/15, LAs will receive their share of a section 256 transfer from NHS England totalling £1.1bn. Of this total, £900m will be under the old governance (social care spending with health benefit) and £200m will be part of the BCF and should be included in your HWB's BCF plan. In 2014/15, each HWB's share of this £200m does not have to be held in a s.75 pooled budget. The requirement for a pooled budget will take effect in 2015/16.

**49. Can organisations agree to add further budgets to the pool?**
Yes, many areas are exploring whether further resources could be included within the Fund.

**50. Can money within a Section 75 be carried over from one year to the next?**
It depends on what arrangements are set out in the written s.75 agreement and on who holds the budget: e.g. a CCG cannot hold a cash surplus from one year to the next. You should consult your local finance team in developing the s.75 agreement to understand the options and implications, and ensure that your proposed arrangement satisfies all parties' external auditors.

**51. The North West London tri-borough example BCF plan used ranges for their plan's finances, rather than specific figures. Will this be acceptable in the final version of the plan?**

Using a range of finance will not be acceptable for what the fund will be spent on, but it is possible in some cases for only a range to be produced for the projected benefits. Benefits can be reinvested in the pool – what it is used for needs to be agreed locally. Risk sharing arrangements should be drawn up locally and over a period of time to ensure sustainability, whilst also considering the impact on the acute sector.

**52. It is unclear how we quantify the savings/benefits. In some cases this will be a 'finger in the air', particularly schemes that are further from hospital care and are more preventative in nature.**

The requirement for financial benefits recognises that £1.9bn of the BCF funding for 2015/16 was previously part of CCG's core allocations. To maintain service quality, the BCF's investment needs to reduce demand for other CCG funded services, for example by improving community care so that local hospitals see fewer emergency admissions. There is no national standard for how you quantify these benefits. You should seek to agree the best way to do this between your HWB and local health and care providers: it's in everyone's interest to ensure the plan is ambitious but realistic.

**53. What types of risk share arrangements are available for use with partners including local authorities? i.e. as each pound allocated to the BCF requires an associated admission avoidance strategy to avoid duplicated spend. Should this prove not be effective, the commissioners will overspend to the amount allocated to the LAs.**

The risk described is correct. The parties to the plan can agree a risk sharing arrangement if they choose to do so. They must set out clear contingency plans to address the risk of NHS activity not reducing in line with the plan.

**54. If there are existing plans to put money in a S.75 pooled budget in 2015/16, can these be used towards the BCF target?**

Existing plans for a S.75 pooled budget in 2015/16 can count towards the targets for the Better Care Fund provided that the pooled budget meets the governance requirements and delivers the national conditions set out for the Better Care Fund.

**55. Can local authorities disinvest local contributions or "top-ups" to mandatory current DFG grants prior to April 2015?**

The Better Care Fund allocations will set out how the DFG grant from DCLG will be distributed to upper-tier local authorities to go into the BCF, and how this money will be paid out from the BCF to lower-tier authorities to deliver their DFG responsibilities. Upper-tier local authorities are still free to make additional payments for disability facilities to lower-tier authorities, either directly or through the BCF.

**56. Will the Disabled Facilities Grant (DFG) and Adult Social Care capital grants continue to be capital?**

Yes.

**57. Can a Health and Wellbeing Board establish multiple S.75 pooled budgets for the purposes of the BCF?**

A Health and Wellbeing Board can use as many S.75 pooled budgets as it wishes to in order to deliver the BCF, provided that each of the pooled budgets so established meets the governance requirements (e.g. joint CCG/LA sign off of plans) set out in the BCF guidance and each of the pooled budgets helps to deliver the national conditions on the BCF funding.

**58. Is the Better Care Fund additional allocation to CCGs in 2015/16 recurring or non-recurring?**

The £3.4bn of revenue funding for the BCF is part of CCGs' allocation for 2015/16, not additional to it. It is recurrent funding, but we do not know (and will not know until after the 2015 General Election) whether the Better Care Fund will continue in its current form in 2016/17, nor whether it will be larger or smaller than in 2015/16.

**59. Can you confirm if the additional funding of £200m, or 0.3% of CCGs budgets in 2014/15, for BCF will be funded through the allocations to CCGs?**

The £200m of Better Care Fund money for 2014/15 will be distributed through Section 256 grants to local authorities, not through CCG allocations.

**60. Is the £130m identified for Care Bill Implementation within part of the £335m?**

No, it is in addition. The total funding for the Care Bill is £465m.

**61. Is there any detailed information available to clarify what amount of the BCF for each area is allocated for Care Bill implementation?**

This has not been split out within the allocations, however you should be able to estimate your allocation by calculating the proportion using the relative needs formula on the proportion allocated from local authorities.

**62. Will the "host" organisation for the pooled budget have delegated authority for the exercise of the NHS or Social Care functions? Within the pooled fund, would specific allocations be ring-fenced for respective organisations (e.g. £x to social care for DFG, £x to CCG for District Nursing etc) for payments?**

Each organisation will remain accountable for their contribution to the Fund, which must be spent in accordance with the jointly agreed plan, and must continue to deliver statutory services and meet all of the national conditions.

**63. What is the approach regarding the terms 'recurrent' and 'non recurrent'? Some people have interpreted this that the spending is NR, whereas in health we interpret that as the funding streams?**

In general, we have used the terms as described: the funding is part of CCGs' recurrent allocation, but that does not mean that it must be spent on a recurrent commitment. Until the General Election in 2015, we won't know what will happen with the BCF in 2016/17. However, in the planning template we use the term to relate to both costs and benefits, e.g. to distinguish between the one-off costs or benefits of BCF schemes (e.g. equipping a new consultation room in a day care centre, selling a capital asset) and the continuing costs of providing a service. We would expect that 'recurrent benefits' would

continue indefinitely, not just be a one-off saving to something which is funded recurrently.

**64. Is all funding other than the £1.1b transfer from NHS to LA and capital coming from CCG baseline, including Care Act implementation?**

Yes. The bullets below show a breakdown of where the funding has come from:

- £1.9bn of additional NHS revenue funding
- £1.5bn of revenue funding based on existing funds in 2014/15. This will comprise:
    - £130m Carers' Break funding (in CCG budgets)
    - £300m CCG reablement funding
    - £1.1bn existing transfer from health to adult social care.
- £354m capital funding (including £220m Disabled Facilities Grant)

**65. Of the £1.9bn additional NHS contribution, £1bn goes on payment by performance and NHS out-of-hospital services. How is the other £0.9bn to be spent?**

The remaining £0.9bn is to be used for the broader aims of the BCF plan: this might include NHS out-of-hospital services, protecting social care services, preparing to implement the Care Act, etc. As the revised planning guidance says, the additional £0.9bn will also fund the £135m for Care Act implementation.

## PLANNING TEMPLATES

**66. Do we need to fill out Annex 1 (detailed scheme description) only for schemes directly related to our target for reduced admissions, or also for other uses of the BCF funding (e.g. Care Act implementation, etc.)?**

The detailed description of the scheme (Annex 1) is intended to set out the reason why that scheme achieves the aim of the Better Care Fund, so it is important to fill out this template for both new and existing schemes. We do recognize that the Disabled Facilities Grant comes with its own legal conditions, so there is no need to fill out Annex 1 for your DFG funding.

**67. For completing Annex 1 of Template 1, should smaller schemes be aggregated together and is there any further guidance on this – for example is there a fixed threshold in terms of the value of each scheme, below which they should be aggregated?**

There isn't a threshold for the aggregation of benefits, but you may wish to use a 5% principle. It is essential that there is differentiation of schemes that derive benefits from different areas though (i.e. Reduction in delayed transfers of care, Reduction in permanent residential admissions, Increased effectiveness of reablement, Reduction in non-elective admissions, etc.).

**68. Is there a specific process local areas are expected to adhere to in engaging providers in the BCF planning?**

Ensuring that the potential impacts of proposed schemes on providers are understood, and that providers are fully engaged, is a key requirement for plans under the revised templates. The updated planning and technical guidance sets out in detail how areas are expected to engage with providers and what evidence they should include in their plans – including a new requirement to obtain commentary from acute providers around admissions targets. Providers do not have to sign-off the plans, however there does need to be robust evidence that they have been meaningfully engaged.

**69. Do the 2 year operational and 5 year strategic plans also need to be signed off by Health and Wellbeing Boards?**

No, but the BCF is an integral part of the 2 year and 5 year plans and this part requires sign off by Health and Wellbeing Boards.

## OTHER METRICS

**70. On the Patient Experience Metric, is there any expectation that, if an area decides to use the menu of existing survey questions, that multiple questions are needed, taken from a number of surveys? Or is the intention that just one survey question be selected for the metric?**

A recognised shortcoming of the existing measures is their ability to reflect experience across entire journeys of care. We would therefore advise considering using more than one question to facilitate a broader measure of integration. However, the main priority is that the question(s) selected meet your BCF objectives and is focused around your target population.

**71. Can you clarify if there is an expectation to provide baseline data for our patient experience metric by 19th September if the approach taken is to introduce a new survey?**

No – we recognise that it would be unrealistic to expect baseline information in this situation. You should set out in the narrative template how the survey is being introduced, with key milestones for establishing a baseline and measuring improvement.

**72. For delayed transfers of care should we use the 'Patient snapshot' or the 'total delayed days', both of which are published by NHS England**

Total delayed days' should be used. Note, though, that this is different to the ASCOF delayed transfers of care publication which uses a patient snapshot collected for one day each month".

**73. For all metrics in the BCF the rates used are crude rates rather than standardised rates. Why is that?**

For most metrics there is not sufficient data available (e.g. age and sex split) to enable standardisation to be performed. However, where it is possible we do not believe it is required, and would only add complexity to the scheme. Standardisation is important for comparing geographical areas or different time periods where there are marked differences/changes in e.g. age-sex structure of the populations involved. In the case of the BCF, the only comparison being made is change across a relatively short time period for each local authority. It is expected that in such a short time period that there will be only small changes to e.g. the age-sex structure of the relevant populations and therefore standardisation will have little impact on the rates.

**74. For delayed transfers of care why was it decided to use the 'total delayed days', rather than the 'Patient snapshot'?**

The total delayed days includes all recorded days of delay during the month, which is the key measure that should decrease as a result of better integration between health and social care. The patient snapshot only records a count of patients delayed regardless of the number of days each are delayed. Additionally, this measure only collects data for one day of the month which may or may not be representative of the rest of the month.

**75. Delayed transfers of care data include breakdowns by the organisation responsible and also the reason for the delay. Why was it decided to simply use the total number of delayed days?**

The intention is that improved integration will reduce all delayed transfers of care, not just those attributable to both health and social care or for a particular reason.

**76. Patients can be treated in hospitals within local authorities where they are not resident. For delayed transfers of care is it not therefore possible that a local authority could be penalised because of a delayed transfer attributable to a hospital in a different local authority?**

Yes this is possible. However, it is anticipated that this will only occur in a small proportion of cases and because this can occur in each direction will likely 'balance out' to some extent. However if there is evidence that in some areas this is an issue then this should be considered and made clear during the HWB planning and assurance process.

**77. For delayed transfers of care and avoidable emergency admissions exactly what figures should be inserted in to the metrics table in the planning template?**

In both cases, the numerator should be the total 'count' for the metric across the time period in question e.g. for the 1st payment of delayed transfers of care this should be the total number of delayed days for the 9 month period. The denominator should be the relevant mid-year ONS population estimate or projection. The rate however should be the average per month, such that the rates for baseline, 1st payment and 2nd payment period are comparable. For avoidable emergency admissions if the baseline, 1st payment and 2nd payment period are the same length (i.e. 6 months) then the rates for whole periods can be used since these are comparable.

**78. The residential care admissions metric concerns admissions for those aged 65 and over. However, in the Adult Social Care Outcomes Framework there are also 18-64 admissions relating to disability and mental health problems, which seem relevant to health and social care. Why are these not included?**

The 18-64 admission rate is typically much lower than the over 65 admission rate, and given the extra complexity involved in using both (separate denominators for each) the decision was made to only include the 65+ admissions for this metric

**79. The residential care admissions metric only includes council-supported admissions, but this will not include all admissions in to residential care?**

This is the only national routine data collection available for counting admissions in to residential care. Although HES data can identify discharges from hospital to residential care, this would only represent admissions directly from hospital. In some areas other factors may have an impact on this metric, such as high rates of non-council supported admissions or providers entering/ leaving the market. This should be considered and made clear by HWBs during the planning and assurance process.

**80. Why is the effectiveness of reablement after 91 days being used in the scheme rather than the rate of those offered the service?**

The effectiveness of reablement is the key measure that should improve as a consequence of better health and social care integration, rather than the number of

people offered the service. However, it is important that the effectiveness metric doesn't improve as a result of a decrease in the rate in which this service if offered, and therefore the rate at which the service is offered must at least be maintained.