



Department for
Communities and
Local Government



Department
of Health

Integration and Better Care Fund planning requirements for 2017-19

The Better Care Fund



CONTENTS

| | |
|--|----|
| Introduction | 1 |
| Policy requirements..... | 2 |
| Further integration of health and social care | 3 |
| Planning requirements | 3 |
| Confirmation of funding contributions..... | 4 |
| National conditions..... | 9 |
| National metrics | 14 |
| Escalation and use of Direction Powers..... | 21 |
| Timetable | 23 |
| Graduation from the Better Care Fund..... | 24 |
| Appendix one - Specification of Better Care Fund metrics..... | 25 |
| Appendix two – Requirements for contingency in national condition three..... | 29 |
| Appendix three - Assurance diagram | 32 |
| Appendix four – Querying baseline for social care maintenance contributions | 34 |
| Appendix five - Quarterly reporting from local authorities to DCLG in relation to the Improved Better Care Fund..... | 35 |

Introduction

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework¹ for the implementation of the Better Care Fund (BCF) in 2017-18 and 2018-19. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The framework forms part of the NHS England Mandate for 2017-18. It requires NHS England to issue these further detailed requirements to local areas on developing BCF plans for 2017-18 and 2018-19.
2. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the IBCF grant to local authorities (LAs) and will be included in local BCF pooled funding and plans.
3. This BCF planning requirements document supports the core NHS Operational Planning and Contracting Guidance for 2017-19.² It is being published jointly with DH and DCLG in order to disseminate it directly to LAs.
4. The legal framework for the Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the Mandate) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.
5. The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.
6. The NHS Act 2006 also gives NHS England powers to attach additional conditions to the payment of the CCG minimum contribution to the Better Care Fund to ensure that the policy framework is delivered through local plans. These powers do not apply to the DFG and IBCF.

¹ <https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019>

² <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>

Policy requirements

7. Key changes to the policy framework since 2016-17 include:
 - A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
 - The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.
8. The four national conditions require:
 - i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
 - ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
 - iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
 - iv. All areas to implement the High Impact Change Model for Managing Transfer of Care³ to support system-wide improvements in transfers of care.
9. The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions. These remain key enablers of integration. Narrative plans should describe how partners will continue to build on improvements locally against these formal conditions to:
 - Develop delivery of seven day services across health and social care;
 - Improve data sharing between health and social care; and
 - Ensure a joint approach to assessments and care planning.
10. In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017. This was provided 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 local social care provider market is supported.
11. Annex B of the policy framework sets out the Government's ongoing policy requirements in relation to the former national conditions. Areas should note that the High Impact Change Model for Managing Transfers of Care includes seven day integrated working to support discharge.

³<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model>

Further integration of health and social care

12. The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans must set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans should set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View⁴, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan. This could also include alignment with work through Transforming Care Partnerships or other NHS programmes such as Integrated Personal Commissioning.

Planning requirements

13. Local partners will need to develop a joint spending plan that meets the national conditions. In developing BCF plans for 2017-19, local partners will be required to develop, and agree, through the relevant HWB(s):
 - i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions; and how their BCF plans will contribute to the local plan for integrating health and social care; and
 - ii. A completed planning template, demonstrating:
 - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
 - A scheme-level spending plan demonstrating how the fund will be spent; and
 - Quarterly plan figures for the national metrics.
14. Plans will be assured and moderated regionally. Recommendations for approval of BCF plans will be made following moderation at NHS regional level of assurance outcomes by NHS England and local government and cross regional calibration of outcomes to ensure consistent application of the requirements nationally.
15. Overall plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met. For the first time BCF plans will be agreed for a two year period. Arrangements for refreshing or updating plans for 2018-19, for instance to take account of progress against metrics, will be set out in separate operating guidance, which will be published later in the year.
16. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

⁴ <https://www.england.nhs.uk/five-year-forward-view/>

| Requirement | Collection method | Assurance approach |
|---------------------------------------|---|--|
| Narrative plans | Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format | Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level |
| Confirmation of funding contributions | BCF planning template (spreadsheet). CCGs should ensure consistency between the figures recorded in the BCF planning template and their core financial returns | Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally |
| National conditions | Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through the BCF planning template | Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level |
| Scheme level spending plan | Submitted to NHS England regional / DCO teams through the BCF planning template | Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally. |
| National Metrics | Submitted through UNIFY and through the BCF planning template | Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process |

Confirmation of funding contributions

17. Under the Mandate for 2017-18, NHS England is required to ring-fence £3.582 billion for 2017-18 rising to £3.65 billion in 2018-19 within its overall allocation to CCGs to establish the BCF. For 2017-18, the remainder of the £5.128 billion fund will be made up of the £431 million DFG, and a new £1.115 billion grant allocation to local authorities to fund adult social care, first announced in the 2015 Spending Review: the IBCF. The Spring Budget 2017 included a significant increase in IBCF allocations. For 2018-19, the remainder of the £5.617 billion fund will be made up of the £468 million DFG and £1.499 billion IBCF grant to local authorities.
18. NHS England has published allocations for CCG contributions to the BCF at individual HWB level for 2017-18 and (indicatively) for 2018-19, along with the

detailed formulae used, on its website.⁵ The IBCF and DFG monies are paid to local authorities directly under Section 31 of the Local Government Act 2003, with grant conditions requiring that the funding is pooled in the BCF.

19. The Government has attached conditions for the new IBCF grant to local authorities (see below). It is subject to the joint NHS England and local government assurance process.
20. As soon as plans for use of the IBCF funding have been locally agreed, IBCF funding can be spent through the pooled budget in line with the grant conditions.

| | 2017-18 (millions) | 2018-19 (millions; indicative) |
|---|-------------------------------|---|
| Minimum NHS ring-fenced from CCG allocation | £3,582 | £3,650 |
| Disabled Facilities Grant | £431 | £468 |
| Additional funding paid to local authorities for adult social care (IBCF) | £1,115 | £1,499 |
| Total | £5,128 | £5,617 |

21. All local partners will need to confirm mandatory and any additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework, relevant grant conditions and the guidance below. This confirmation will be collected nationally through the BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template.

Direct Grant to Local Government – the Improved Better Care Fund.

22. This funding, totalling £1.115 billion in 2017-18 and £1.499 billion in 2018-19, will be paid directly to LAs as a direct grant under Section 31 of the Local Government Act 2003 for adult social care⁶. The following grant conditions, detailed in the Grant Determination, apply to the entire IBCF allocation (i.e. the original grant announced in 2015 and the additional funding announced in the 2017 Spring Budget).

⁵ <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

⁶ The Liverpool City Region, consisting of six local authorities, Liverpool, Halton, Knowsley, Sefton, St Helens and Wirral, is participating in a pilot programme to test a new model for retention of business rates locally. As a result, the allocation of funding for the Improved Better Care Fund will not be paid as a grant to these authorities, but instead, the pilot areas will be required to pool their allocation from locally raised business rate income that has been retained.

23. The grant conditions for the IBCF require that:

Grant paid to a local authority under this determination may 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 local social care provider market is supported.

A recipient local authority must:

- a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption;
- b) work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
- c) provide quarterly reports as required by the Secretary of State.

The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with Clinical Commissioning Groups involved in agreeing the Better Care Fund plan.

24. The BCF planning template will be populated with the provisional grant allocation for each HWB area. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.
25. Areas must agree, within their BCF Plans, how this money will be spent, ensuring that the grant conditions are met. In May 2017, DCLG confirmed the department's requirements on quarterly reporting for the IBCF. Updates on progress in implementing the High Impact Change Model for Managing Transfers of Care will be included within the monitoring of national condition four.
26. DH and DCLG have made clear in their letter of 28 March to LA chief executives that there are three purposes of this funding, one of which is to reduce pressures on the NHS. When areas agree this local investment, it will therefore contribute to meeting the ambition in the 2017-18 NHS England Mandate for NHS organisations to reduce delayed transfers of care (DToC) to occupying no more than 3.5% of hospital bed days by September 2017. In order to meet this, daily delays need to fall to around 4,000 in September 2017. This would in turn meet the ambition to free up the 2,000-3,000 hospital beds across England set out in Next Steps on the NHS Five Year Forward View.
27. The funding can be allocated across any or all of the purposes outlined above as the LA and CCG(s) best determine to meet local pressures and reduce delayed transfers. No fixed proportion needs to be allocated across the purposes, nor should the funding be restricted to funding the changes in the High Impact Change Model.

28. DCLG has also required LAs to certify (via their Section 151 officer) that spending of the additional money provided at the 2017 Spring Budget will be additional to previous plans for adult social care spending. The IBCF is allocated over three years (until 2019-20) and is intended to support sustainable approaches to stabilising the social care market and relieving pressure on the NHS. The Government has committed to improve social care and bring forward proposals for consultation.
29. The Government has announced a package of measures to address DToC across the health and social care system. This package includes:
 - A dashboard showing how areas are performing against a range of metrics across the NHS-social care interface;
 - Targeted CQC reviews to examine performance in the areas with the worst outcomes across these metrics, with a view to supporting them to improve;
 - Considering a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care; and
 - Guidance on implementing a Trusted Assessor model.

Disabled Facilities Grant

30. Following the approach taken in previous years, the DFG continues to be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. In 2016-17, the housing element was strengthened through the national conditions, with local housing authority representatives required to be involved in developing and agreeing BCF plans. This has been retained for 2017-19.
31. As in previous years, DFG will be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.
32. In 2017-19, in two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county council to district councils (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- The funding is included in one of the pooled funds as part of the BCF;
 - The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
 - The relevant lower-tier authorities agree to the use of the funding in this way.
33. All areas are required to set out in their plans how the DFG funding will be used over the two years. Since 2008-09, the scope for how DFG funding can be used has been widened to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables authorities to use specific DFG funding for wider purposes.
34. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. For example, LAs could use an alternative means test, increase the maximum grant amount, or offer a service which rapidly deals with inaccessible housing and the need for quick discharge of people from hospital. The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

Care Act 2014 Monies

35. The BCF minimum allocation to CCGs includes funding to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal or family carers will be supported by LAs and the NHS. Further guidance and details of the exact breakdown has been set out in the Local Authority Social Services Letter, sent by DH to Directors of Adult Social Services.

Former Carers' Break Funding

36. The CCG minimum allocation to the BCF also includes, as in 2016-17, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes. In doing so, local areas may wish to make use of An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing, an NHS England resource that promotes and supports joint working between Adult Social Care services, NHS commissioners and providers, and third sector organisations.

Reablement Funding

37. The CCG minimum allocation to the BCF also includes, as in 2016-17, £300m of NHS funding to maintain current reablement capacity in LAs, community health services, and the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

National conditions

38. Local partners will be required to include a clearly articulated plan for meeting each national condition in their BCF narrative, as set out in the policy framework and operationalised by the guidance contained in this document, as well as in the scheme details entered in the planning template. This should include clear links to other relevant programmes or streams of work in place locally to deliver these priorities. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning template. More details on each condition are set out below

National condition one: A jointly agreed plan

Narrative plans

39. The BCF plan should build on approved plans for 2016-17 and demonstrate that local partners have reviewed progress in the first two years of the BCF as the basis for developing plans for 2017-19. Local providers must be involved in the development of plans. This includes NHS trusts, social care providers, voluntary and community service partners and local housing authorities.
40. The narrative plan will also need to demonstrate that local partners have collectively agreed the following:
 - i. The local vision and model for sustainable systems and better co-ordinated care through the integration of health and social care – showing how services will be transformed to meet the Government’s vision to move towards more fully integrated health and social care services by 2020, as set out in the policy framework and how the plans support a shift to a more community based, preventative approach to care and the role the BCF plan in 2017-19 plays in that context;
 - ii. A coordinated and integrated plan of action for delivering the vision, supported by evidence;
 - iii. A clear articulation of how they plan to meet each national condition, including the national commitment for each local area to free up its share of 2,000-3,000 hospital beds across England; and
 - iv. An agreed approach to performance and risk management, including financial risk management and, where relevant, risk sharing and contingency.
41. In all cases these elements can be demonstrated and referenced from existing plans or initiatives. Where a plan makes reference to other documents, the information being referenced should be made clear and contextualised and, in the interests of transparency, narrative plans should be coherent as standalone documents.
42. The policy framework describes the Government’s expectation that areas continue to make progress against the national conditions from the 2016-17 BCF that have now been removed. These are set out in Annex B of the policy framework. Narrative plans should briefly describe how areas will continue to make progress against these former conditions, referencing other plans where appropriate.

43. Local partners should consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012 and reduce inequalities between people from protected groups in line with the Equality Act 2010. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan should give an overview of any priorities and investment to address health inequalities or to address inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010.

Managing Risk

44. All plans must set out the approach to managing risk locally. This should include financial risks that impact on the delivery of the BCF plan as well as delivery risks. The assurance process will no longer involve separate assessments on plan quality and risk to delivery. Instead, all narrative plans must include an assessment of key risks to plan delivery, the approach to managing these risks and a risk log, setting out mitigations consistent with the level of risk in the plan. Assessment of risk should be consistent with wider assessments by partner organisations, provider market and strategic challenges set out in the plan's evidence base, such as market position statements, Joint Strategic Needs Assessment and other external assessments – for example from the Care Quality Commission.
45. Plans can include links to organisational risk logs as part of the plan-level risk mitigation. Further information can be found in the local plan development, sign-off and assurance section of this document.

National condition two: NHS contribution to social care is maintained in line with inflation

46. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition that the NHS contribution to adult social care is maintained in line with inflation. This condition gives effect to the commitment in the Spending Review to continue to maintain the NHS minimum mandated contribution to adult social care to 2020. This contribution to social care can be used to support existing adult social care services, as well as investment in new services. Maintaining existing services is essential in managing demand, maintaining eligibility and avoiding service cuts. Furthermore, in the light of the acute funding pressures on adult social care, HWBs need to be able to review the schemes funded through the BCF and reallocate resources in order for local authorities to continue to meet their adult care statutory duties.
47. In 2017-18 and 2018-19, the minimum contribution to adult social care will be calculated using the figure agreed through the 2016-17 plan assurance process as a baseline, uprated for each subsequent year in line with the CCG minimum contribution. This means that the minimum required contribution will rise by 1.79% in 2017-18 and 1.90% in 2018-19. Local areas will have the opportunity to query the baseline used for this calculation if they believe that it is not an accurate reflection of the CCG minimum allocation for social care in 2016-17. Grounds for this could include that:

- The baseline in the planning template includes non-recurrent payments. In this case, all partners must agree that the funding in question was not intended to be part of the baseline; and
 - The baseline is not correct due to mis-coded spend lines.
48. Areas need to query their baseline with the Better Care Support team by 31 July 2017. Agreement to any changes to the baseline, and resultant minimum required contributions, will be made by the Integration Partnership Board. Further details are at **Appendix 4**.
49. Areas can agree larger contributions if they wish. Any area proposing increases to social care funding from the CCG minimum contribution significantly above inflation should provide supporting evidence to set out the reasoning and benefits to the wider system of this increase. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution or a smaller increase in 2018-19, provided the contribution is greater than, or equal to the minimum requirement for 2018-19 published in the planning template.
50. The BCF planning template will be pre-populated with the required minimum contribution to social care from CCG minimum contributions in each year. In setting the level of contribution to social care, localities should ensure that any change does not destabilise the local health and social care system as a whole. This will be assessed compared to 2016-17 figures through the regional assurance process.

National condition three: Agreement to invest in NHS-commissioned out-of-hospital services

51. The policy framework establishes that a minimum of £1.018 billion of the CCG contribution to the BCF in 2017-18, and £1.037 billion in 2018-19, will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding will be set out in allocations and will need to be spent as set out in the national condition. This should be achieved in one of the following ways:
- Where areas do not plan for reductions in non-elective admissions (NEAs) beyond the CCG operational plans they may use the full allocation to fund NHS-commissioned out-of-hospital services. These services should have a clear evidence base and are expected to lead to reductions in acute activity and unplanned admissions. This could include a wide range of services including community nursing, therapeutic and adult social care, to be determined locally. Funding from the ring-fenced out-of-hospital spend can be used to pay for health related activity to meet national condition four (managing Transfers of Care), although funding from other parts of the CCG contribution can also be used. CCGs and local authorities should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan; or
 - If a local area is planning additional NEA reductions, it must consider putting part of its ring-fenced funding for NHS-commissioned services into a contingency fund equal to the value of the planned reductions in NEAs. In the event that NEA activity is higher than the metric in the BCF plan, an

appropriate amount can be withheld from the fund and used to cover the additional cost of unplanned admissions to the CCG, with the balance spent on NHS-commissioned out-of-hospital services.

52. Where local partners agree to use a contingency fund the default approach should be to base this on the 2015-16 payment-for-performance approach, as set out at **Appendix 2**. Any risk share agreement linked to National Condition 3 should relate solely to funding from the ring-fenced funding for out-of-hospital services from the CCG minimum contribution and should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.
53. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS-commissioned out-of-hospital services from the spending plan.

Risk shares and financial contingency not linked to national condition three.

54. Areas can agree local approaches to risk sharing or creating contingency reserves to cover costs incurred if preventative approaches are not successful. In designing these schemes, local systems must ensure that the financial position of CCG(s) or the LA(s) are not compromised. Any risk share agreement involving an LA should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.

National condition four Implementation of the High Impact Change Model for Managing Transfers of Care.

55. National condition four requires health and social care partners in all areas to work together to implement the High Impact Change Model for Managing Transfers of Care. BCF plans should set out how local areas are implementing the model, which was agreed by local government and health partners in December 2015 and republished in April 2017⁷. This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help reduce delayed transfers. It provides a framework to assess local services and offers practical options to support improvements. The changes cover:
 - Early discharge planning;
 - Monitoring patient flow;
 - Discharge to assess;
 - Trusted assessors;
 - Multi-disciplinary discharge support;
 - Seven day services;
 - Focus on choice (early engagement with patients and their families/carers); and;
 - Enhancing health in care homes.

⁷ <https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model>

56. Areas should agree a joint approach to funding and implementing these changes, building on existing successful local practice and tailored to local circumstance. If one or more of the changes are in the process of being implemented, plans should set out the target date for implementation. Where one or more of the changes is funded from budgets that are not included in the BCF, this should be set out in the narrative plan. Areas should set out a coherent and comprehensive set of measures to manage transfers of care. Where all parties in an area have agreed to a variation on the model or not to implement one of the changes (for example if an existing, successful, approach would be duplicated by elements of the eight change model); the plan should briefly explain the rationale for this and provide assurance that a comprehensive approach to managing transfers of care and meeting their obligations on DToC reductions is in place. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.
57. The Better Care Support Team will monitor progress against implementation of the model through the BCF reporting mechanisms.
58. The High Impact Change Model includes implementation of Enhanced Health in Care Homes. This approach is being demonstrated through the New Care Models Vanguard Programme. More details and guidance can be found in the Enhanced Health in Care Homes Framework⁸.
59. In addition to the High Impact Change Model, National Partners have produced a number of guides that areas can draw on in developing plans, including:
 - Quick guides on:
 - 'Improving hospital discharge into the care sector'⁹;
 - 'Discharge to Assess'¹⁰;
 - 'Better use of care at home'¹¹;
 - Supporting Patients' Choices to Avoid Long Hospital Stays¹².
 - 'a Simple Guide to the Care Act and Delayed Transfers of Care'¹³ published by ADASS, the LGA and NHS England; and
 - The BCF resource on Delayed Transfers of Care, available through the SCIE website¹⁴.

Scheme-level spending plan

60. A scheme-level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

⁸ <https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>

⁹ <http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf>

¹⁰ <http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf>

¹¹ <http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf>

¹² <http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf>

¹³ <http://londonadass.org.uk/wp-content/uploads/2015/11/DToC-Simple-Guide-Final.pdf>

¹⁴ <http://www.scie.org.uk/integrated-health-social-care/better-care/guides/delayed-transfers-of-care/>

- Area of spend;
- Scheme type;
- Commissioner type;
- Provider type;
- Funding source;
- Total 2016-17 investment (if existing scheme); and
- Total 2017-18 investment and indicative 2018-19 investment.

61. Detail on scheme-level spending plans will be collected nationally through a BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

National metrics

62. The BCF policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

- a. Non-elective admissions (General and Acute);
- b. Admissions to residential and care homes¹⁵;
- c. Effectiveness of reablement; and
- d. Delayed transfers of care;

63. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

| Metric | Collection method | Data required |
|---|--|---|
| Non-elective admissions (General and Acute) | <ul style="list-style-type: none"> • Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return | Quarterly HWB level activity plan figures for 2017-18, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 metrics |
| Admissions to residential and care homes | <ul style="list-style-type: none"> • Collected through nationally developed high level BCF Planning Return | Annual metric for 2017-18 and 2018-19 |
| Effectiveness of reablement | <ul style="list-style-type: none"> • Collected through nationally developed high level BCF Planning Return | Annual metric for 2017-18 |

¹⁵ The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.

| Metric | Collection method | Data required |
|---------------------------|--|--|
| Delayed transfers of care | <ul style="list-style-type: none"> Collected nationally through UNIFY at CCG level HWB level figures confirmed through BCF Planning Return | Quarterly metric for 2017-18. Each HWB area must submit their agreed DToC metrics by 21 July 2017 alongside their first quarterly return for IBCF spending |

Non Elective Admissions (NEAs)

64. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions¹⁶. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG-level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for meeting targets to reduce NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.
65. Areas that are planning additional reductions in non-elective activity beyond those in CCG operating plans should clearly identify these in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved. Where an additional reduction is planned, partners should consider placing an appropriate amount of the ring-fenced allocation intended for NHS-commissioned out of hospital services into a contingency reserve as per national condition three.

Delayed Transfers of Care

66. The NHS England Mandate for 2017-18 sets a target for reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017. This equates to the NHS and Local Government working together so that, at a national level, delayed transfers of care are no more than 9.4 in every 100,000 adults (i.e. equivalent to a DToC rate of 3.5%). This joint achievement would release around 2,500 hospital beds. This is a system wide obligation and responsibility for delivery is not limited to the BCF. Nevertheless, it is expected that activity in BCF plans will contribute to meeting it.
67. Each CCG and NHS Trust is already agreeing a trajectory to meet this requirement and maintain it for the remainder of 2017-18. This will reflect agreements between NHS Improvement and NHS England for each area.
68. Each Local Authority is now being required to agree a target for reducing social care attributed DToCs in 2017-18 as part of BCF planning.
69. In both cases, DToC levels will need to be reported in the quarterly BCF returns.

¹⁶ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>

70. Ministers are clear that the health and social care system should work together to achieve reductions in DToC and that the agreed trajectory for doing so should reflect ambitious targets for reducing delays attributed to both NHS organisations and social care.
71. In drafting BCF narrative plans, areas should set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the local, agreed ambition for DToC. In setting the DToC metric in the BCF planning template, areas should describe how the schemes and services commissioned will contribute to the system-wide DToC ambition agreed for each system. This will include activity in relation to national condition four to implement the High Impact Change Model for Managing Transfers of Care and use of the BCF where appropriate. Ministers have set out an expectation that the target reduction in delayed transfers should involve an equal reduction in DToCs from both social care and the NHS nationally. Metrics should be agreed locally and should reflect challenging but realistic ambitions to reduce NHS and social care attributable delays to free up 2,500 hospital beds based on the indicative reduction levels published by DH¹⁷. The locally agreed reduction in both NHS and social care attributable delays should be reported in the BCF plan.
72. Each area should therefore set a metric that reflects the target agreed by a) the CCG(s) in support of the reduction in DToC in the NHS mandate and b) the Local Authority in support of the reduction in social care attributed DToC set out by Ministers on 3 July 2017. Where the metrics or contribution to them from either social care or the NHS are not sufficiently ambitious, a more stretching metric may be set as part of the assurance process as a condition of approval for the plan.
73. Government will consider a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.
74. The BCF DToC metric in plans for 2017-18 and 2018-19 will continue to be calculated as total delayed days per 100,000 population. The BCF plan should link to the wider activity plans for reductions and ensure that ambitions set for the BCF plan are in line with the targets agreed locally for daily delays by relevant CCGs. Both metrics calculate the number of delayed days, so the BCF metric should reflect the CCG targets locally.
75. In order to verify that trajectories for reducing DToCs are consistent with the ambition in the NHS Mandate as soon as possible, areas must submit their provisionally agreed BCF DToC metrics for 2017-18 and 2018-19 to the Better Care Support Team on 21 July 2017, at the same time as their first quarterly reporting return for the IBCF.

¹⁷ <https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions>

Reporting of metrics

76. The detailed definitions of all metrics are set out at the end of this document. HWBs will be required to set challenging but realistic plans in relation to each metric. The national requirement to agree and report a local metric has been removed, but areas are still of course able to agree local metrics, where this will support improved performance. Areas will be able to review metrics for 2018-19 as part of any plan refresh at the end of 2017-18.

Local plan development, sign off and assurance

77. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice.
78. The assurance of plans will be streamlined into one stage, with an assessment of whether a plan should be approved, not approved, or approved with conditions. Plans should be submitted by 11 September 2017, having been approved or set to be approved by the relevant HWB(s). All plans will be subject to regional assurance and moderation. Judgements on potential support needs through the planning process, will be 'risk-based'. The IBCF funding can be spent as soon as the LA and CCG(s) agree.
79. BCF plans will be submitted and assured in the following way:-
80. The BCF submission will consist of a narrative plan, including a description of how the national conditions will be met, the alignment of the plan with the area's approach to integration of health and social care, assessment of risks in the local system and how the planned activity will help to address these. Areas should also complete and submit the BCF Planning Return, detailing the technical elements of the planning requirements. This will include funding contributions, a scheme-level spending plan, national metric plans, and any local risk-sharing agreement linked to NEAs under national condition three. At this point, local areas will also be asked to confirm that plans have been agreed between the LA and CCGs for spending IBCF grant to provide stability and capacity in local care markets. Plans should be agreed by the HWB.
81. CCGs should ensure that these returns mirror their operational planning returns for 2017-18 and 2018-19, submitted through central UNIFY and finance return templates. This will include some of the same data – including funding contributions and baseline NEA metrics agreed in the CCG operational plans and targets for reductions in DToCs should be consistent with the targets agreed by CCGs with NHS England. There will be a national reconciliation process to ensure the data provided matches in all cases. If any additional NEA metrics are planned as part of the BCF, these should be entered in the planning template.
82. Areas are asked to send copies of both the planning template and narrative plan to the relevant DCO team, copied to england.bettercaresupport@nhs.net. The Better Care Support Team will collate data from the planning template to assist regional assurance. Narrative plans will not be assured nationally, but will be used for identifying promising approaches to integration, wider trends to inform

our support offer (including development of benchmarking and support tools) and policy making.

83. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. NHS England assurance will take place within NHS England's Director of Commissioning Operations (DCO) teams and regional NHS England finance teams. NHS England will seek input from NHS Improvement regional teams at agreed points in the assurance process, to provide feedback on the quality and ambition of plans from a provider perspective. Local government has been funded to carry out assurance via regional local government leads. BCMs and the Better Care Support Team will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2017-19 and have capacity in place to participate in the process. A set of consistent key lines of enquiry (KLOE) have been produced to support the assurance process and will be available to local areas as a guide in developing plans. The assurance document sets out the main planning requirements for the BCF, and associated KLOEs. The document is intended to clarify the minimum requirements for a local Better Care Plan to be assured and the NHS funding elements approved.

Moderation, calibration and plan approval

84. Plan assurance will include moderation at NHS regional level, led by Better Care leads for each region, with appropriate representation from Regional NHS and local government.
85. Following moderation, the Better Care Support Team will co-ordinate a cross-regional calibration exercise to provide assurance to the Integration Partnership Board and NHS England that plans have been assured in a consistent way across England. The national team will provide data on assurance outcomes and facilitate the cross-regional discussion in order to agree a consistent approach nationally. Advice on approval will be provided to the Integration Partnership Board, which is jointly chaired by DH and DCLG, with representation from partners including the LGA, ADASS and NHS England.
86. The minimum elements of the funding have different legal bases:
- The CCG minimum contribution to the fund is governed by the amended NHS Act 2006 (s. 223GA). The Act gives NHS England powers to approve spending and set conditions on this money. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.
 - The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003. LAs are legally obliged to comply with grant conditions and the IPB will confirm, following assurance that it is content that the conditions are met in BCF plans.
87. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England under s.223GA (4) of the NHS Act 2006, following agreement with the Integration Partnership Board that all conditions, including the conditions of grant for the IBCF and DFG

are met. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved, the Better Care Support Team may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

88. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under section 75 of the NHS Act 2006. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies. Consideration will be given by the regional assurance panel, working with the Better Care Support Team, as to whether further support should be provided or whether the area should enter formal escalation.

Assurance categories

89. Assurers will check that plans meet all key lines of enquiry, including that they:
- Meet all national conditions;
 - Have agreed a spending plan for the IBCF grant;
 - Set out a vision and progress towards fuller integration of health and social care by 2020; and
 - Have in place a robust approach to managing risk to plan delivery, including adequate financial risk management arrangements, proportionate to the level of risk in the system.
90. Assessment of the overall risk in the plan will be based on:
- The overall quality of the plan, based on the compliance with the national conditions, degree to which key lines of enquiry have been met and quality of the narrative plans overall;
 - An assessment of whether the plan has adequately assessed and addressed risks to successful delivery; and
 - The current performance, capacity and financial position of the local health and social care system in relation to plan delivery, using information from NHS England, NHS Improvement and local government.
91. Based on this assessment, the plan will be classified as Approved, Approved with Conditions or Not Approved. Following assurance, a moderation exercise will be carried out to ensure that the planning requirements have been applied consistently across each NHS region. This exercise must include representatives from DCO teams, NHS finance and local government. Following assurance, and moderation, the Better Care Support Team will coordinate a cross-regional calibration exercise with assurers. This exercise will help areas to make sure that they are assuring plans in a way that is consistent with other parts of the country. This may result in some regions needing to re-visit judgements for particular areas.
92. If an agreed plan is not submitted by the deadline, the Better Care Support Team will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, escalation will be considered.

93. If, following moderation, a plan is not approved or is approved with conditions, more in-depth support will be agreed for the area in consultation with the BCM, the regional assurance panel and Better Care Support Team. In some instances, the conditions imposed may be the provision of further information or clarifications, but in instances where there are more substantial conditions to meet, areas will be expected to access the support on offer in order to meet the conditions specified. All areas will be expected to submit a compliant plan by the date set by the regional moderation panel.
94. The three assurance categorisations are as follows:

| Category | Description |
|--------------------------|---|
| Approved | <ul style="list-style-type: none"> Plan agreed by HWB Plan meets all requirements and KLOEs, including locally agreed targets for reducing NHS and social care attributed delays which achieve each area's share of the national commitment to free up 2,000-3,000 hospital beds. |
| Approved with conditions | <ul style="list-style-type: none"> National conditions one, two or three are met Most but not all remaining planning requirements met, – i.e. one or more KLOEs not satisfied; for example: <ul style="list-style-type: none"> Narrative plan (vision, approach to risk management) needs improvement; or National condition four not fully met Not all metrics agreed Progress is being made (including on national condition) and, provided feedback is incorporated, there is confidence that a compliant plan can be produced Assurance panel are confident that the area can agree a plan |
| Not approved | <ul style="list-style-type: none"> One or more of the following apply: <ul style="list-style-type: none"> Plan is not agreed One or more of national conditions 1-3 not met, No local agreement on use of the IBCF DToC ambition is not in line with the targets agreed with NHS England (for CCGs) and/or necessary to achieve expected reductions (for Local Authorities). |

Plans approved with conditions.

95. If a plan is approved with conditions following moderation and this categorisation is agreed by the IPB and NHS England, the area will receive authorisation to enter into a formal Section 75 agreement and the CCG authorised to release money from the BCF ring-fence. The notification will make clear:
- The planning requirements that were not met, the actions required to receive full approval, and the date by which this should be done; and
 - Escalation action and powers of direction/clawback will be used in the event that these conditions are not met by the date specified.

96. Areas that receive an Approved with Conditions classification should address all unmet requirements and resubmit their plan to their BCM by the date specified.
97. The overall assurance process is illustrated in the schematic at **Appendix 3**. More detailed guidance for those involved in assurance has been developed and published to aid local areas.

Escalation and use of Direction Powers

98. In the event that:
 - Signatories to a plan are not able to agree and submit a draft plan or:
 - The Health and Well-being Board do not approve the final plan; or
 - Regional assurers rate a plan as ‘not approved’.

The Better Care Support Team, in collaboration with the relevant Better Care Manager, will commence an escalation process to oversee the prompt agreement of a compliant plan.

99. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. Senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward.
100. The escalation process will involve the following steps.

| | |
|---|--|
| <p>1. Trigger - following failure to submit a plan, or a decision not to approve a plan during assurance</p> | <p>The Better Care Support Team in consultation with the BCM will consider whether a plan should be escalated. If escalation commences, a formal letter will be sent, setting out the reasons for escalation, consequences of not agreeing a plan and informing the parties of next steps, including date and time of the Escalation Panel</p> |
| <p>2. Escalation Panel</p> | <p>The Escalation Panel will be jointly chaired by DCLG and DH senior officials with representation from:</p> <ul style="list-style-type: none"> • NHS England • LGA/ADASS • Better Care Support Team <p>Representation from the local area needs to include the:</p> <ul style="list-style-type: none"> • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from LA <p>The Escalation Panel meeting is the opportunity to use national and local insight to consider the planned approach being put forward by the parties to the BCF plan to deliver a compliant plan and agree actions and next steps, including whether support is required. It is expected that in line with the principle of ‘no surprises’, issues will have been raised through ongoing relationships with Better Care Managers, NHS England regional offices and local government regional peers.</p> |

| | |
|--|---|
| <p>3. Formal letter and clarification of agreed actions</p> | <p>The local area representatives will be issued with a letter, summarising the Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Panel, an update on what support will be made available will be included.</p> |
| <p>4. Confirmation of agreed actions</p> | <p>The Better Care Manager will track progress against the actions agreed and ensure that a locally agreed plan is submitted within the agreed timescale for regional assurance. Any changes to the timescale must be formally agreed with the Better Care Support Team.</p> |
| <p>5. Consideration of intervention options</p> | <p>If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include:</p> <ul style="list-style-type: none"> • Agreement that the panel will work with the local parties to agree a compliant plan • Appointment of an independent expert to make recommendations on specific issues and support the development of an agreed plan – this might be used if the local parties cannot reach an agreement on certain issues. • Appointment of an advisor to develop a compliant plan, where the panel does not have confidence that the area can deliver a compliant plan <p>The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.</p> |

101. The Escalation Panel members will consider all relevant information, including financial and performance issues. This could include:

- Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
- Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers’ breaks;
- Whether the agreed transfer to social care from CCG minimum contributions represents a real terms maintenance of allocations. This will also include consideration of transfers prior to the establishment of the BCF

102. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DH and DCLG ministers, (as required under the 2017-18 NHS Mandate), with the final decision then taken by NHS England. In accordance with the legal framework set out in section 223GA of the NHS Act 2006 (as amended by the Care Act 2014), NHS England powers are only applicable to the minimum contribution from CCG budgets set out in the policy framework.

103. The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or IBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if the IBCF or DFG grant conditions are not met. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Timetable

104. The submission and assurance process will follow the timetable below

| Milestone | Date |
|--|------------------------|
| Publication of Government Policy Framework | 31 March 2017 |
| BCF Planning Requirements, BCF Allocations published | 4 July 2017 |
| Planning Return template circulated | w/e 7 July 2017 |
| First Quarterly monitoring returns on use of IBCF funding from Local Authorities. | 21 July 2017 |
| Areas to confirm draft DToC metrics to BCST | 21 July 2017 |
| BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net . | 11 September 2017 |
| Scrutiny of BCF plans by regional assurers | 12 – 25 September 2017 |
| Regional moderation | w/c 25 September 2017 |
| Cross regional calibration | 2 October 2017 |
| Approval letters issued giving formal permission to spend (CCG minimum) | From 6 October 2017 |
| Escalation panels for plans rated as not approved | w/c 10 October 2017 |
| Deadline for areas with plans rated approved with conditions to submit updated plans. | 31 October 2017 |
| All Section 75 agreements to be signed and in place | 30 November 2017 |
| Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care. | November 2017 |

Graduation from the Better Care Fund

105. The policy framework describes the approach that will be taken from 2017-18 to graduation from the BCF – the process for enabling areas that have integrated their health and social care commissioning or provision, to the extent that they exceed, and will continue to exceed, the requirements of the BCF.
106. Areas that graduate will no longer be required to submit BCF plans and quarterly returns, with the exception of evidencing ongoing compliance with funding contributions and national conditions, which can be demonstrated through annual self-certification. The footprint for graduates can be a single Health and Wellbeing Board area or more than one – for example a devolution deal area or STP geography if the relevant HWB(s) agree.
107. Areas (as defined above) will be able to put themselves forward for graduation over the next two years. Requests to graduate from the Fund will be considered through graduation panels that will take place at regular intervals over the period of the programme. The panels will include central government departments, NHS and local government stakeholders (LGA and ADASS). The sessions will focus on helping areas to both challenge their assumptions and readiness to move on from the BCF, and also to provide advice on where the proposal could develop further.
108. Panels will consider:
 - The key enablers to integration, common to all systems;
 - A self-assessment of local leadership, accountability and joint vision for integration;
 - How integration supports better outcomes for populations, including performance against key metrics (including DToC reductions) and assessing the use of own management data; and
 - Agreement of a clear, measurable and transparent objectives and milestones for fuller integration by 2020.
109. There were 17 first wave Expressions of Interest to graduate from the BCF. The short-list (who will go through graduation panels in the Autumn), is being finalised.

Appendix one - Specification of Better Care Fund metrics

Metric One: Total Non-elective spells (specific acute) per 100,000 population

| | |
|---|--|
| Outcome sought | A reduction in the number of unplanned acute admissions to hospital. |
| Rationale | Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings. |
| Definition | <p>Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.</p> <p>Numerator: Number of specific acute non-elective spells in the period.</p> <p>Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.</p> <p>Number of specific acute hospital provider spells for which:</p> <ul style="list-style-type: none"> • Der_Management_Type is 'EM' and 'NE' <p>Where 'EM' = Emergency and 'NE' = Non-Elective</p> <p>Please refer the Joint Technical definitions for Performance and Activity (2017/18-2018/19) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation.</p> <p>Denominator: ONS mid-year population estimate for all ages (mid-year projection for population)</p> |
| Source | <p>Secondary Uses Service tNR (SEM) - SUS tNR is derived from SUS (SEM) and not the SUS PbR Mart.</p> <p>For more details see Joint Technical definitions for Performance and Activity (2017/18-2018/19).</p> <p>Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)</p> |
| Reporting schedule for data source | <p>Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual.</p> <p>Timing of availability: data is available approximately 6 weeks after the period end.</p> |
| Historic | From 2017/18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric |

Metric Two: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

| | |
|---|---|
| Outcome sought | Reducing inappropriate admissions of older people (65+) in to residential care |
| Rationale | Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation. |
| Definition | <p>Description: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.</p> <p>Numerator: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital</p> <p>Denominator: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.</p> |
| Source | <p>Adult Social Care Outcomes Framework: NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016)</p> <p>Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)</p> |
| Reporting schedule for data source | <p>Collection frequency: Annual (collected Apr-March)</p> <p>Timing of availability: data typically available 6 months after year end.</p> |
| Historic | Data first collected 2014/15 following a change to the data source. The transition from Adult Social Care Combined Activity Return (ASC-CAR) to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was redefined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population." More details about the change can be found on page 18 of the 2014-15 data report . |

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

| | |
|---|---|
| Outcome sought | Increase in effectiveness of these services whilst ensuring that those offered service does not decrease |
| Rationale | Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal. |
| Definition | <p>The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.</p> <p>Numerator: Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.</p> <p>The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital.</p> <p>Denominator: Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).</p> <p>The collection of the denominator will be between 1 October and 31 December.</p> <p>This data is taken from SALT collected by NHS Digital</p> <p>Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.</p> |
| Source | Adult Social Care Outcomes Framework: (NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016) |
| Reporting schedule for data source | Collection frequency: Annual (although based on 2x3 months data – see definition above) Timing of availability: data typically available 6 months after year end. |
| Historic | Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013/14, 2014/15 and 2015/16) Resubmitted 2014/15 SALT data - as part of the extensive SALT validation process for the 2015/16 submission, councils have also had the opportunity to resubmit their 2014/15 return. The 2014/15 data in the current release is the resubmitted data. Due to the known data quality issues of the original data, Adult Social Care Outcomes Framework (ASCOF) scores previously published in the 2014/15 publication should no longer be used. |

Metric Four: Delayed transfers of care from hospital per 100,000 population

| | |
|------------------------------------|---|
| Outcome sought | Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. |
| Rationale | <p>This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care.</p> <p>The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.</p> |
| Definition | <p>Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)*</p> <p>A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.</p> <p>A patient is ready for transfer when:</p> <p>(a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.</p> <p>Numerator: The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period*</p> <p>Denominator: ONS mid-year population estimate (mid-year projection for 18+ population)</p> <p>*Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.</p> |
| Source | <p>DToCs (NHS England, http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/)</p> <p>Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)</p> |
| Reporting schedule for data source | <p>Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring).</p> <p>Denominator is annual.</p> <p>Timing: data is published approximately 6 weeks after the period end.</p> |
| Historic | Data first collected Aug 2010 |

The Baseline used for each metric is the latest period available prior to the collection period in the plan for each metric. For example for monthly/quarterly measures the baseline will be the corresponding period of the previous year where this is available. I.e. the baseline for NEA and DToC metrics in 2017/18 will be the corresponding quarter in 2016/17.

Appendix two – Requirements for contingency in national condition three

1. All CCGs must ring-fence a proportion of their overall BCF allocation to invest in NHS-commissioned out of hospital services. These allocations are set out in CCG financial planning templates for 2017-18 and 2018-19.
2. National condition three requires that all areas should consider holding back part of this ring-fenced funding in contingency, linked to performance against any **additional metrics to reduce Non elective admissions agreed in the BCF plan.**
3. The 'HWB metrics tab of the BCF Planning Template will be pre populated with the area's non elective admissions target, taken from CCG operating plans for 2017-18 and 2018-19, mapped to HWB areas. Each area should consider setting an additional NEA reduction metric linked to their BCF plan. Metrics should be stretching, but proportionate. The national condition only applies to risk share agreements linked to these additional metrics on NEAs. Areas are free to agree risk shares linked to other schemes within the BCF, but these do not form part of the national condition.
4. As in 2016-17, the default model for calculating the value of the contingency fund should be the Payment for Performance mechanism for 2015-16. Areas that did not meet their NEA activity reduction targets in 2016-17 should actively consider agreeing an additional reduction metric. Where a metric is set, a contingency fund should be considered. Arrangements made as part of this condition should:
 - Cover the full risk to the CCG of not achieving the reduction based on the tariff for NEAs. In other words the value of the risk share should be equivalent to the cost of the emergency admissions that the plan seeks to avoid.
 - Hold this amount, from the ring-fenced allocation for NHS-commissioned out of hospital services, in a contingency fund outside of funds pooled in the BCF.
 - Release money into BCF pooled funds based on performance against the additional NEA metric. Areas should agree, in advance, how this money will be spent.
 - Agree frequency of payment and baselines locally across the two years of the BCF plan.
5. Assurance of plans will include an assessment of whether CCGs are financially protected if investment in out of hospital services does not result in planned additional reductions in emergency admissions.
6. The value of the contingency fund should be calculated based on the number of additional reductions in non-elective admissions, multiplied by the value of these admissions, based on national reference costs for a non-elective admission. Again, areas can agree a local costing, but must set out their reasoning in their plan. As in 2015-16 areas can measure performance quarterly, releasing funding into the BCF based on performance in the previous quarter, commencing with quarter 4 (January to March) 2016-17.

Example

7. A Health and Wellbeing Board has a target, based on CCG core operational plans to reduce NEAs to 50,000 in 2017-18 and 49,000. As part of their Better Care fund plan, the LA and CCGs agree a further reduction metric of 1000 admissions avoided in both 2017-18 and 2018-19. The amount held back in each year is calculated based on the national tariff of £1490 per admission.

| Year | A: Target level of NEAs – operational plan | B: Agreed reduction through BCF plan | C: Target level of NEAs – BCF plan | Funds held in contingency (Column B x £1490) |
|---------|--|--------------------------------------|------------------------------------|--|
| 2017-18 | 50,000 | 1,000 | 49,000 | £1,491,000 |
| 2018-19 | 49,000 | 1,000 | 48,000 | £1,491,000 |

The quarterly reduction targets are therefore

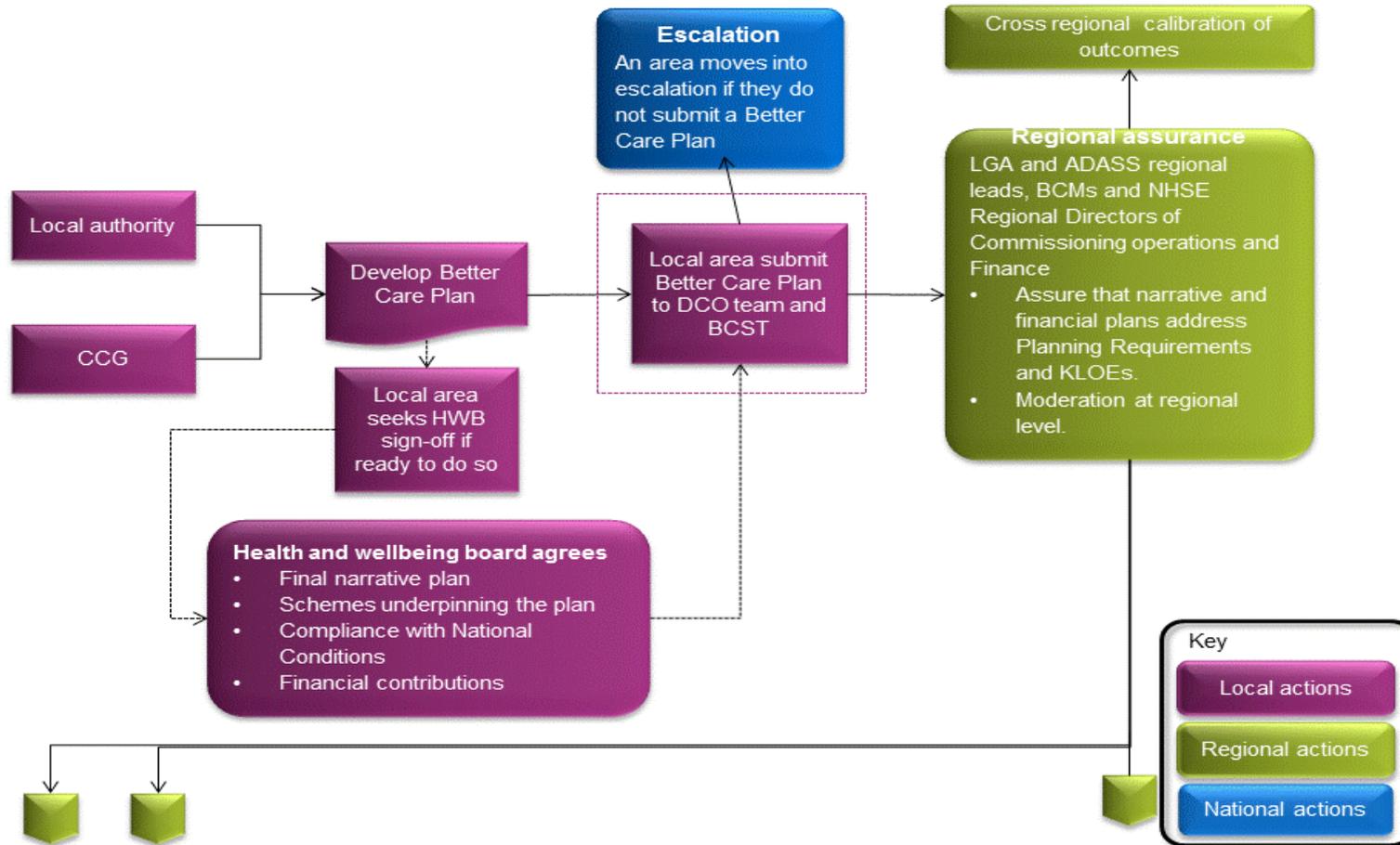
| | Q4 2016-17 | Q1 2017-18 | Q2 2017-18 | Q3 2017-18 |
|--|------------|------------|------------|------------|
| CCG baseline (quarterly) | 12,500 | 12,500 | 12,500 | 12,500 |
| CCG baseline (cumulative) | 12,500 | 25,000 | 37,500 | 50,000 |
| BCF stretch target (quarterly) | 12,250 | 12,250 | 12,250 | 12,250 |
| BCF stretch metric (cumulative) | 12,250 | 24,500 | 36,750 | 49,000 |
| Money held in contingency from CCG minimum (quarterly) | £372,750 | £372,750 | £372,750 | £372,750 |

8. If the target is wholly or partly met, funding should then be released from the fund, in this case on a quarterly basis; up to the total amount held in contingency. Payment released in each quarter should be calculated based on the cumulative performance against target. Examples are below.
9. Areas should agree how money released from the fund should be spent. The released funds should remain within the pooled fund but can be spent on any activities that are consistent with the aims of the local plan, including social care.

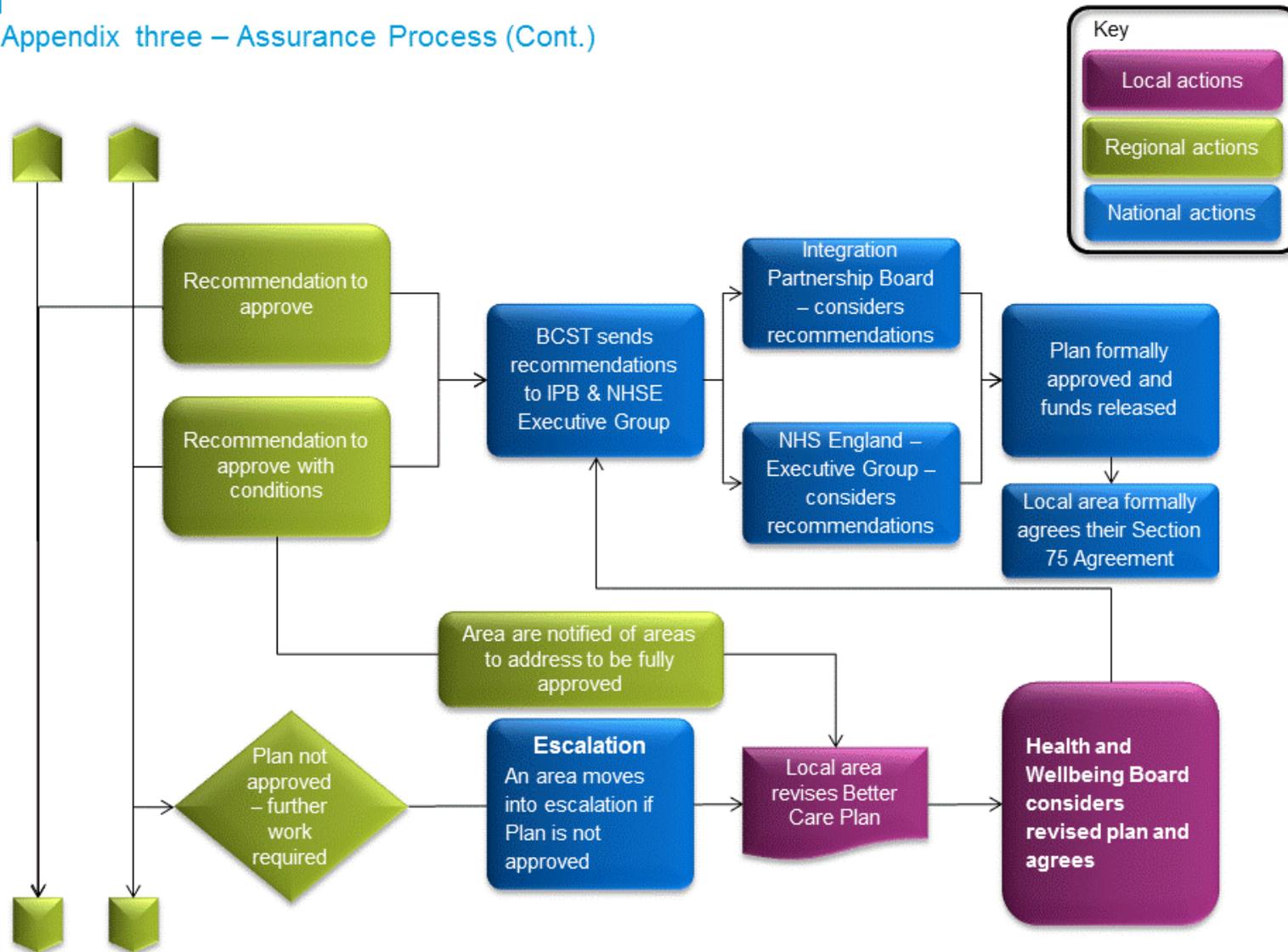
| | Q4 2016-17 | Q1 2017-18 | Q2 2017-18 | Q3 2017-18 |
|--|-------------------|-------------------|-------------------|-------------------|
| CCG baseline | 12,500 | 12,500 | 12,500 | 12,500 |
| BCF stretch target (quarterly) | 12,250 | 12,250 | 12,250 | 12,250 |
| BCF stretch target (cumulative) | 12,250 | 24,500 | 36,750 | 49,000 |
| Actual performance (quarterly) | 12300 | 12,200 | 12,500 | 12,250 |
| Actual performance (cumulative) | 12,300 | 24,500 | 37,000 | 49,250 |
| Money released from contingency reserve (quarterly) | £298,200 | £447,300 | £0 | £372,750 |
| Money released from contingency reserve (cumulative) | £298,200 | £745,500 | £745,500 | £1,118,250 |

Appendix three - Assurance diagram

Appendix three – Assurance Process



Appendix three – Assurance Process (Cont.)



Appendix four – Querying baseline for social care maintenance contributions

1. Required contributions to social care from CCG minimum contributions will be calculated for each Health and Well-being Board area based on inflation level increases to assured contributions in 2016-17 BCF plans. These figures will be pre-populated in the planning template for each HWB area.
2. The use of this baseline to calculate the minimum required contribution is agreed policy and we expect that the contribution in each HWB area will be equal to, or greater than, these figures for each area in 2017-18 and 2018-19. If local planners believe that this baseline is not correct, they will be able to query it. The grounds for doing so include:
 - The baseline in the planning template includes non-recurrent payments. In this case, all partners should agree that the funding in question was not intended to be part of the baseline.
 - The baseline is not correct due to mis-coded spend lines.

Process

3. Areas should inform their Better Care Manager (BCM) if they believe that the baseline for maintaining social care spend for 2016-17 is wrong by 31 July 2017, setting out their reasoning and any supporting documents. Areas must confirm that both the relevant CCG(s) and LA(s) agree that the baseline is not correct and certification should be provided from the chief executive in the relevant LA and the Accountable Officer(s) of relevant CCGs.
4. The query and supporting evidence will be reviewed by the Better Care Support Team with the Better Care Manager. Recommendations for amending a baseline will be made to the Integration Partnership Board (IPB). If the IPB agrees to amend a baseline, areas will be notified as soon as possible. All decisions will be made before 25 August 2017.
5. Where local planners believe that the baseline, as set out in the assured 2016-17 planning template, is wrong due to mis-coding; they should identify specific schemes that were coded wrongly and set out the reasons for changing the scheme classification or the value of the scheme.
6. Where a payment that has been included in the baseline for 2016-17 that was intended to be a non-recurrent payment, an area will need to provide details and demonstrate that there was mutual understanding that the payment was a one off. Government policy is that spending on social care services from CCG minimum contributions should be maintained in real terms through the period of the Spending Review. Areas must demonstrate therefore that
 - The payment was not part of the 2015-16 contribution to social care.
 - The payment was clearly intended to be to alleviate short term pressures or for specific, one-off purposes.
 - That both the CCG and the LA agreed at the time that this was the case.

Appendix five - Quarterly reporting from local authorities to DCLG in relation to the Improved Better Care Fund

This appendix replicates the reporting requirements issued by DCLG to local authorities confirming the reporting requirements attached the additional funding for the IBCF confirmed in the Spring Budget 2017.

Overall we are expecting to see a narrative report for the relevant quarter about how you are using the additional funding announced at Spring Budget 2017 to deliver the purposes of the grant, in meeting adult social care needs generally, reducing pressures on the NHS (including DToC) and stabilising the care provider market.

One of the grant conditions is to work with the relevant Clinical Commissioning Group 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. We expect the Better Care Fund will pick up reporting with regard to this however as the Planning Requirements are not yet published, we are asking for this information in your Q1 return. We will confirm whether this is necessary for additional quarters.

Quarter 1 (April – June 2017)

A. For Q1 you should provide a scene-setting narrative and then consider and address the following questions which will form the basis of further quarterly reports:

- *How has this money affected decisions on budget savings that may otherwise have been required?*
- *What initiatives / projects will this money be used to support? Please describe briefly their objectives / expected outcomes. You will be expected to comment on progress in later quarters.*
- *Have you engaged with your care providers in the light of this funding? If yes, what action have you taken? If no, outline your plans for engaging with your care providers.*
 - *What were your unit average costs for home care (per contact hour) and care home provision age 65+ (per client per week, excluding full cost payers, 3rd party top ups and NHS FNC) in 2016-17?*
 - *On the same basis, at what level are you setting costs for 2017-18?*

B. *What impact do you anticipate – in comparison with plans made before this additional funding was announced – on:*

- *Number of home care packages – provide figures*
- *Hours of home care provided – provide figures*
- *Number of care home placements – provide figures*

C. *Please provide any further information you wish us to be aware of, and use whatever further specific metrics you consider appropriate for your area; for example this might include on reablement, timeliness of assessments, carers, staff capacity etc. You will be expected to update these each quarter.*

D. *The grant determination requires you to work with the relevant CCG and providers to meet NC4 of the Integration and Better Care Fund. NC4 states that*

all areas should implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care. Please set out, from the local authority's perspective, what progress is being made to implement the High Impact Change Model with health partners and the intended impact on the performance metrics, including Delayed Transfers of Care.

Quarters 2 (July – Sept 2017) and 3 (Oct – Dec 2017)

- A. *A narrative report for the quarter which follows up the information you provided at Q1, including updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1.*
- B. *Report actual impact of additional funding on:*
- *Number of home care packages – provide figures*
 - *Hours of home care provided – provide figures*
 - *Number of care home placements – provide figures*
- C. *Update on additional metrics you identified at Section C in Q1.*
- D. *[To be confirmed.] Update on progress.*

Quarter 4 (January – March 2018)

- A. *A final report which provides a self-assessment against the information provided at Q1 including final updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1. This should include final comparative data on unit costs for home care and care home provision for end of year.*
- B. *report on actual impact of additional funding on:*
- *Number of home care packages – provide figures*
 - *Hours of home care provided – provide figures*
 - *Number of care home placements – provide figures*
- C. *Final report on additional metrics you identified at Section C in Q1.*

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the Better Care Support Team, Operations and Information Directorate.

If you have any queries about this document, please contact the Better Care Support Team at: england.bettercaresupport@nhs.net

For further information on the Better Care Fund, please go to:
<https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>