The Better Care Fund Planning Requirements 2017-19: Frequently Asked Questions

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Contents

Overview

What are the other changes to the Better Care Fund (BCF) planning requirements for 2017-19?

The number of national conditions has been reduced from 2016-17; the current agreed conditions are:

1. A requirement for a jointly agreed plan, approved by the HWB.
2. Real terms maintenance of transfer of funding from health to support adult social care
3. Requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services
4. A requirement to implement the High Impact Change model (HIC) for managing transfers of care.

Plans will also need to set out the area's vision for integrating health and social care by 2020. The guidance and assurance process has been simplified as far as possible, but plans are expected to be an evolution of 2016-17 BCF plans.

The BCF also includes a specific grant to local government – the Improved Better Care Fund (iBCF). This funding is paid directly to local authorities (LAs) but spending plans should be included in the BCF plan.

Following the government's announcement of a package of measures to tackle delayed transfers of care (DToC), including expectations for both local government and the NHS to reduce delays; all areas must agree a metric for DToC that includes specific ambitions to reduce delays attributable to the NHS and to social.

How do the recent Government announcements on delayed transfers of care (DToC) and the BCF Planning Requirements change 2017-19 plan requirements and future allocations?

Better Care Fund plans need to include a target for reductions in DToCs across the Health and Wellbeing Board area that aligns to the expectation included in the DToC template issued to areas on the 13 July. These target reductions will comprise reductions in NHS attributed DTOCs (agreed between CCGs and NHS England on 30 June) and reductions in Social Care attributed DTOCs (issued by the Department of Health and Department for Communities and Local Government on 3 July).

Areas can agree variations in these splits, but should include a clear rationale in their plan. These targets will be scrutinised during the assurance process and variations will require sign-off by Regional Directors.

The Government will carry out a review of progress against these targets in November and will consider changes to allocations of the Improved Better Care Fund for 2018/19 for areas that are performing poorly. The final format of this review has not been agreed, but the overall IBCF allocation will remain within local government budgets and continue to be allocated for social care.

As indicated in the letter from Pauline Philip on 14th July, areas that have not made sufficient progress against the target to reduce DToCs will not be able to graduate from the BCF.

Frequently asked questions

General

1. **Where can I access the policy framework?**

   The Department of Health and the Department for Communities and Local Government published the policy framework for Integration and the Better Care Fund (BCF) in 2017-18 and 2018-19 on 31 March 2017. The document can be found on the gov.uk website.

2. **Where can I access the planning requirements?**

   NHS England, the Department of Health and Department for Communities and Local Government published the 2017-19 Integration and BCF planning requirements on 3 July 2017. The document can be found on the NHS England website and gov.uk website.

3. **Where can I access the planning template?**

   The Better Care Support team (BCST) circulated the 2017-19 BCF planning template to local systems on 13July. If you have not received the template, please contact your Better Care Manager (BCM) in the first instance. Their contact details can be found on the NHS England website.

4. What are the planned submission dates for BCF plans and the assurance process?

There will be one round of assurance for 2017-19 plans, with a narrative and planning template required for submission by 11 September 2017.

We have tried to allow sufficient time for areas to submit agreed plans first time, including arrangements for Health and Wellbeing Boards (HWBs) to clear plans. The timetable for submission dates and the assurance process was announced alongside the publication of the planning requirements on 3 July 2017.

5. Will there be an opportunity to amend plans during the two year period? What would the mechanism for this be?

As BCF plans are being drawn up for two years (2017-19), there will be an additional note on change control which will outline the process for reviewing plans during the two-year period. More detail on this will be provided in the BCF Operating Guidance which will be published later in the year.

6. Is it a two-year plan or a two-year rolling plan?

This will be a two-year BCF plan but there will be an opportunity to amend plans if there are significant changes, which are set out in the planning requirements, and will be described more fully, in the BCF Operating Guidance, which will be published later in the year.

7. Since 2017-19 plans will be a continuation of 2016-17 plans, would it be sufficient to provide last year's plan with an addendum that outlines changes - i.e. how new/amended Key Lines of Enquiry (KLOEs) are being met with new finance and performance templates - or are we expected to produce a whole new plan?

Plans can be an evolution of the 2016-17 plans but they should make sense as a standalone document. We would not recommend simply adding an addendum to the existing plan as it is likely to cause confusion. The KLOEs have been simplified for this year but they are different – not just reduced in number. Plans need to take on board these new KLOEs in a way that makes sense to assurers as well as other partners and, in the interests of transparency, the public.

Narrative plans need to include a joint vision for integrating health and social care and to comply with requirements on implementing the High Impact Change (HIC) model on Managing transfers of Care and setting of DTOC metrics, which differ from previous years. These will need to be developed or updated.

8. Is it acceptable to respond to the KLOE's in table rather than incorporating responses into a document with a chapter format?

We would not recommend this. As above, the document should be a coherent narrative that sets out the local context, vision for health and social care, plan for the BCF funding itself and risk/programme governance.

Setting this out purely as answers to the assurance KLOEs is likely to be fairly disjointed and difficult for partners and the public/community organisations to understand.

Planning requirements and national conditions

9. What is meant by jointly agreed plans across multiple HWBs?

There is already scope for two or more HWBs to agree a single BCF plan if all partners agree that this is more appropriate for the local health and social care economy. This will remain the case. The plan would need agreement of all the individual HWBs.

10. Will there be a requirement to consider a contingency fund against performance as part of the national conditions?

There is further guidance on setting contingencies in the planning requirements. Areas will need to consider putting in place additional targets for reductions in non-elective admissions (NEAs) over and above what is in the core CCG operating plans. Where a more stretching metric is set, areas are required to consider whether to hold some of this funding in contingency against any additional financial risk created for CCGs.

11. What does early escalation mean?

If it is clear that a local area has not submitted a plan by 11 September and it looks unlikely they are going to be able to reach agreement on a plan, we will commence escalation straight away to try to help reach an early resolution and panels will be held before the end of September. If it becomes clear that an area is not on track to agree a compliant plan, then the Better Care Support team will work with the relevant Better Care Manager to put appropriate support in place in an area to expedite production of a plan by the deadline and consideration will be given to arranging an earlier escalation panel meeting.

12. Will the changes between this BCF and previous BCF be mapped out?

A summary of the main changes from 2016-17 is set out in an annex to this FAQ. We also ran a teleconference to support planning to set out the changes as well as the guidance more broadly. This can be listened to on the Better Care Exchange, as well as a telephone briefing that was run with DCLG colleagues, on the iBCF.

13. Does the policy framework give guidance as to how the BCF fits with Sustainability and Transformation Plans (STPs), Urgent and Emergency Care Networks plans and A&E Delivery Board plans?

The planning requirements set out at a high level the alignment of these plans. The way in which the different local plans fit together is dependent on individual geographies and arrangements for integration and transformation. We recognise that this is a complex, challenging landscape. BCF plans will be agreed by HWBs and should take into account the priorities across the wider system.

14. Please clarify the required footprint for the 2017-19 plan and alignment with STPs.

The basic footprint is a HWB, but as in previous years, plans can be submitted across more than one complete HWB area. This could be to align with wider STP or devolution footprints.

Areas should set out their vision for health and social care integration in their narrative, including how the activities in the BCF align with STPs and other activity linked to integration.

15. Our BCF plan will be mostly informed by the local A&E delivery and STP plans. Is this the correct approach?

We would expect there to be an overlap in content of BCF plans with STP and A&E delivery plans, but the BCF plan must be a joint local government and health plan.

The plan will also need to demonstrate that it meets all of the requirements in the planning requirements, including the national conditions, metrics, approach to risk and a joint narrative for integrating health and social care – where this is already set out in the STP; then we would expect this to be consistent.

16. Given the continued focus on managing transfers of care and reducing delays, what should the role of A&E delivery boards be in agreeing plans and metrics for DToC?

The planning requirements set out that NHS and social care providers should be involved in the development of plans from the outset. Plans for managing transfers of care and implementing the HIC, as well as the DToC metric itself should be developed with trusts and A&E delivery boards. The Government has already set a clear deliverable in its Mandate for 2017-18 to NHS England, to reduce NHS-related delayed transfers of care in support of a total reduction in the delayed transfers of care rate (delayed days as a proportion of occupied consultant-led hospital bed days) to 3.5% by September 2017, equivalent to a rate of daily delays of 9.4 per 100,000 of the population) Government believes that health and social care should share the ambition to reduce delayed transfers of care equally and for BCF plans to contain metrics for reductions in both NHS and social care attributable DToCs.

BCF plans and metrics will continue to be agreed between LAs and CCGs, with local sign off and governance provided by the HWB. Although Trusts, social care providers and the Voluntary and Community Sector should be involved in the conversations; there is no formal role for A&E delivery boards in signing the plan off.

Funding contributions

17. What are the conditions for allocations for 2017-19?

- CCG minima will increase in line with CCG budgets – so increase by 1.79% and 1.9% respectively in the next two years.
- CCG minima continue to contain funding for carers breaks, reablement and Care Act implementation.
- The Disabled Facilities Grant (DFG) will continue to be included in the BCF and to be paid directly to upper tier authorities with social care responsibilities - see the DFG question below for more detail.
- Improved Better Care Fund – iBCF. This is a direct grant to local authorities. The conditions for this grant require authorities to pool the grant in their local BCF plan.

Final CCG minimum BCF allocations have been announced alongside BCF planning requirements on the NHS England website.

18. Will NHS England, the Association of Directors of Adult Social Services and the LGA agree rules of engagement to support areas where the LA and the CCG may be struggling to agree a minimum contribution to support adult social care?

Figures are set out in the planning template, with an opportunity for areas that do not recognise those minimum contributions, to question them by 31 July. If there are issues about agreeing the plans that sit behind those numbers, please talk to your BCM about whether a Better Care Advisor (BCA) or Multi-disciplinary (MDC) support would be appropriate support for agreeing any element of the plan including financial contributions.

19. Is there any additional money for BCF and, if so, how will it be administered, e.g. a new fund against which BCF areas bid to deliver specific projects?

A new funding element has been added to the BCF from 2017-18 – the Improved BCF (iBCF). This is new funding that will be paid to local government as a direct LA grant. The 2017 Spring Budget announced additional funding for social care from 2017-18 to 2019-20. This funding will be paid as part of the iBCF. England wide allocations for the iBCF will now be as follows:

	2017/18	2018/19	2019/20
BCF announced in SR2015 (£millions)	105	825	1,500
Additional funding announced in 2017 budget £(millions)	1,010	674	337
Total iBCF (£millions)	1,115	1,499	1,837

The Government has announced that it will review progress against the metrics set in each area for reducing DToCs. Following this review, reductions to allocations will be considered for poorly performing areas. See questions 24 -27.

There are three purposes for this money:

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

It is for local systems to decide how to allocate their share of the Budget money to best achieve these aims, depending on the needs of their populations.

In addition, local authorities are required to pool the iBCF into the BCF
The planning requirements set out that this funding does not replace, and should not be offset against the NHS minimum contribution to adult social care.

It was previously announced that the iBCF grant would be distributed using a methodology which ensures every authority gets its share of the total funding available through the iBCF and the Social Care Precept, as measured by the social care Relative Needs Formula. This means that there is sizable variation in the amounts that each authority receives in grant.

The additional funding announced in the Budget is calculated in the following way:

- 90% of the allocation is based on the IBCF formula (as above)
- 10% is based purely on Relative Needs Formula.

All authorities will receive some funding from the increased IBCF.

20. Will the new LA BCF allocations be included in the total allocations for BCF with planning requirements?

The funding announced in the Spring Budget (2017) is included in the allocations set out above. The grant conditions will apply to both original iBCF allocations announced in the Spending Review (2015) and the 2017 Spring Budget.

These allocations are pre-populated in the BCF planning template. To see the allocations by LA please see the gov.uk website.

21. What is the difference between the iBCF and the new grant for social care for 2017-18 announced in the Local Government Finance Settlement?

The Adult Social Care Support Grant is distinct to the iBCF. The Adult Social Care Grant is a one-off grant for 2017-18 worth £241 million nationally. This grant will be paid directly to LAs to support social care but, unlike the iBCF:

- Is paid for one year only.
- Authorities are not required to include the grant in a pooled BCF pot
- The grant is calculated on the Adult Social Care Relative Needs Formula, so the relative size of these grants will be different to iBCF

The Adult Social Care Support Grant is derived from money that was reprofiled through savings to the New Homes Bonus. It is inevitable that there will be some losers from changing the distribution of the £241 million; the authorities that built a large number of homes six years ago are not necessarily those with the greatest social care need today. However, those areas who deliver the most housing growth will continue to benefit most from the Bonus under the new scheme. The payments for the Bonus in 2017/18 are £1.2 billion and will still be worth £900 million in 2018/19.

Further information can be found on the gov.uk website here. Further information about allocations can be found on the gov,uk website here.

22. Are there any indications for uplifts in later years?

Figures beyond 2018-19 will not be confirmed at this stage

23. What form will the Government's Review of performance against DToC take?

The precise form and detail of the reviews has not yet been finalised.

24. What will the definition of 'poorly performing' be?

The precise details of the reviews have not yet been finalised.

25. How will re allocation of IBCF grant be determined and what is the scope for re allocating grant?

The Government has said that any reallocations of iBCF grant will remain within local government and be spent on social care. The precise details of the reviews have not yet been finalised.

26. Will there be any stipulation around the level of NHS Commissioned Out of Hospital service funding and what it is used for? CCGs may wish to hold back as a contingency against NEAs. What is difference between the two areas? How might a risk share arrangement work and how does it relate to NEAs?

CCGs will be required to ring-fence part of their minimum contribution to spend on NHS commissioned Out of Hospital Services.

Areas will need to consider putting in place additional targets for reductions in NEAs over and above what is in the core CCG operating plans. **This is not compulsory** and targets should be realistic and proportionate.

Where a more stretching metric is set, areas will be required to consider whether to hold some of this funding in contingency against any additional financial risk created for CCGs. The amount held back should be based on the value of the additional NEAs that you are seeking to avoid. More information is set out in the planning requirements.

27. What is the latest position on the conditions associated with social care usage of BCF - particularly whether there will be a requirement for the proportion of the fund spent on social care to increase?

The CCG contribution to social care will remain a national condition and the minimum expectations have been calculated by increasing the 2016-17 contributions in line with uplifts in overall CCG budgets. The minimum amounts have been prepopulated in the planning template.

As above, the new iBCF funding must be spent on social care.

28. What is the minimum percentage increase required in CCG contributions to support social care, and from what point is it measured?

The increases will be applied to the 2016-17 contribution to social care. The increase on this baseline will be 1.79% in 2017-18 and 1.9% in 2018-19. The minimum contributions are pre-populated in the planning template

29. Do uplifts get protected, i.e. will the amount to protect social care be explicit?

The planning template has been populated with the 2016-17 baseline and 2017-18 and 2018-19 contributions for each HWB.

30. Will the DFG funds continue to be ring-fenced, to enable district councils in two-tier areas to meet their statutory duty in this regard?

As in previous years, the DFG will be paid to upper tier authorities in two tier areas. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Hence, the conditions of grant require that the DFG funding is passed in full to relevant lower tier authorities, except where lower tier authorities have expressly agreed that some DFG money is to be used for other social care capital projects.

Housing authorities should be involved in the development of the BCF plan elements related to housing and DFG.

31. Will you be explicit about amounts for local allocations of Care Act, Carers Breaks and Reablement national monies (and basis used, i.e. RNF, CCG share of BCF, etc.) and will specific amounts be published for minimum transfers from CCGs for maintenance of social care?

Since 2015-16, money for the Care Act, alongside existing allocations that already went via CCGs (reablement and carers breaks) have been included within the BCF.

The amounts concerned were for agreement locally, taking into account local need and historical agreements and where desired the LGA's ready reckoner.

We understand that some areas included funding for these within the CCG minimum spend on social care, some did not. To start to centrally specify arrangements now, would cause confusion locally and may require local agreements to be unwound.

Local plans should agree how reablement, Care Act duties, etc. should be provided and the money needed locally to fund these. Contributions to social care from CCGs were agreed locally and the allocations that went into the overall pot were only partly based on RNF. Trying to retrospectively apply RNF to allocations now is not possible without undoing local agreements.

32. Areas may be entering into new Section 75 agreements (S75s) or contractual arrangements from 1 April. As BCF plans were not approved by that date, does NHS England guidance remain that the financial risk of such arrangements will sit with commissioners until their BCF is approved?

We recognise that the delay in publishing the BCF policy framework and planning requirements for 2017-18 creates a risk in cases where a service is currently in place and funded through a S75 agreement established to deliver the BCF in 2016-17. In order to prevent a break in continuity of service, areas intending to extend contracts that form part of their 2016-17 Better Care Plans may extend or renew contracts:

- For CCGs, as part of an NHS standard contract.
- For LAs, as a specific contract.'

Local commissioners should seek to reach agreement on renewal of schemes in the BCF in 2017-18. Where it will assist in ensuring continuity of care, commissioners may enter into negotiations on contract renewal, but do so at their own risk. Areas should consider inserting a break clause in the contract, stating that the contract is subject to amendment or cancellation in the event that the BCF plan is not approved.

Local government and CCG commissioners should agree their overall approach to the BCF and the services they intend to commission prior to letting or extending contracts in order to minimise the risk to them.

33. Will the BCF be a funding mechanism for STPs?

The BCF is not a funding mechanism for the STP, but some (or many) of the integration and community focussed elements of the STP could be BCF funded schemes

Graduation

34. Is the aim that all BCF areas will graduate over the next three years? If so, what does that look like in terms of additional pooling above minimum requirements?

It is the Government's policy intention that all areas move beyond minimum requirements for BCF and move towards fuller integration of health and social care by the end of this parliament. The timescales over which all areas will graduate are yet to be decided and will depend on when areas are ready, the time it takes for earlier waves to graduate and the levels of support needed for areas.

In terms of the details of how this will look and additional pooling, this has not been decided or agreed and would be an issue that will be tested in the first wave of graduation.

35. Where have the models for integration been published?

The 2015 Spending Review set out models around joint commissioning, accountable care organisations and devolution. Models for integration will also be included in any graduation material, when it is sent to local areas for expressions of interest (EoIs) to graduate from the BCF.

36. Will areas be able to graduate from BCF on their STP footprint?

We expect that some areas will want to graduate from BCF on their STP footprint, rather than on a single HWB footprint. We will consider this on a case-by-case basis dependent on the content of the evidence for graduation, its feasibility and the impact on all partners in that local area.

37. Will there be any guidance on how BCF and STPs relate?

Activity in BCF plans should align with other local plans, including relevant elements of the STP. The planning requirements set out at a high level how Better Care Fund plans and STPs should align; although we will not be specific, as this will be down to local areas. The degree of overlap between BCF plans and STPs will vary between different local areas.

38. What do you need to graduate? How is this measured?

The outline criteria are confirmed in the policy framework. They are likely to include consideration of the quality of joint planning, maturity of local integrations of health and social care, current trajectory against national metrics and the degree to which budgets are or will be pooled or aligned.

Following the government's recent announcement of NHS and Social Care specific targets for reducing DTOCs, achievement against these local targets will also now be one of the key criteria.

39. What are the benefits of graduating from the BCF?

Areas would be exempt from performance reporting on a quarterly basis. Areas which graduate in the first wave will not be obligated to submit an assured BCF plan for 2017-18 and 2018-19.

40. What is the envisaged long term plan for graduation? Is there a four year plan for tranches in place?

There is not a set plan beyond this first wave of 6-10 areas. Part of what it will need to do is to work out how and to what scale we look at graduation over remaining years of this parliament.

41. Will graduated areas need to agree DToC metrics and splits between CCG and LA locally?

Yes, areas will need to agree these locally and submit them even if they have graduated and NHSE will still hold CCGs to account for their performance and IBCF funding can still be reviewed by government if an area performs poorly on DToC.

Metrics and reporting

42. Will submission of BCF plans be at a different time to submission of quarterly reports?

Yes, we will take into consideration the submission timetable when planning for quarterly performance reporting.

43. How have the DToC metrics in the template been reached?

The Department for Health published indicative expectations for each HWB area, including expected levels for social care attributable delays, NHS attributable delays and jointly attributable delays.

CCGs had already been asked to agree targets for reducing delayed transfers of care by September 2017 and submitted these on 30 June.

The BCF DTOC template therefore takes account of both of these. Expected reductions have been set out by Government and NHS England that:

- Set out an indicative expectation for social care delays to be achieved by November for each local authority;
- Set an expectation for the number of jointly attributable delays to be maintained at the baseline level;
- Set an indicative expectation for NHS-attributable DToCs, calculated by subtracting the social care and joint expectations from the CCG's planned total. Where a CCG's level of DTOC would have risen as a result of this formula, the expectation has been kept at the baseline level (Q4, 2016/17) so that no area can see an increase in delays and still meet their target.

These figures are pre-populated in the template for submitting DTOC metrics by 21 July.

44. What are the parameters for adjusting DToC expectations in our BCF plans?

The area is expected to agree a plan that matches or exceeds the expectations set for the NHS, social care and joint attribution components of the delayed days metric.

Areas can, if there is agreement, amend the split between NHS/Joint/Social care DToCs. Where areas amend the split they will be expected to include evidence and a rationale for that change.

The final DToC target in the BCF plan will be subject to assurance and plans that do not set a sufficiently ambitious metric, or plans in which the proposed amendment to the split between NHS/joint/social care DToCs is not sufficiently evidenced and explained, may be approved with conditions around this aspect or will not be approved.

Overall if areas wish to propose a significant change these will be subject to additional scrutiny by the Integration Partnership Board and NHSE Executive Group.

There are specific approval requirements for CCGs to vary the expectations for reducing NHS DToCs. If a CCG wishes to propose such a change, the following conditions will apply:

- A variation of up to 5% in the Sept 17 target for either NHS-attributable or jointly-attributable DTOCs must be signed-off by the Regional Director for NHS England
- A variation greater than 5% must be signed-off by NHS England nationally

45. Will there be guidance around how effectiveness of reablement will be measured?

This will remain the same as the previous planning requirements; it will use the existing Adult Social Care Outcomes Framework (ASCOF). The metrics being used will help to ensure continuity by capturing the same metrics over a number of years.

46. Where will non elective admissions (NEA) data be sourced from?

The source of the non elective admissions will continue to be the Secondary Uses Services (SUS) repository, as has been the case in 2016/17.

47. Will the population being used remain resident vs registered?

The population used for BCF metrics is the same as HWB population i.e. resident.

If you have any further questions or would like any advice please contact the Better Care Support team at england.bettercaresupport@nhs.net