Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS England

The Integration and Better Care Fund

Operating Guidance For 2017-19

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Integration and Better Care Fund

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CONTENTS

1. PURPOSE OF THIS DOCUMENT

1. This document is for local partners that agree and administer Better Care Fund 2017-19 plans – Clinical Commissioning Groups (CCGs), local authorities (LAs) and Health and Wellbeing Boards (HWBs).

2. This document sets out refreshed operating guidance for approved Better Care Fund (BCF) plans for 2017-19.

3. This document sets out:

    - accountability structures and funding flows for 2017-19 plans
    - refreshed metric plans for 2018-19
    - guidance on amending BCF plans
    - guidance on reporting on and continued compliance with BCF 2017-19 conditions
    - the support, intervention and escalation process
    - the legislation that underpins the BCF

4. This document should be read alongside the 2017-19 Integration and Better Care Fund Policy Framework (the Policy Framework)[1], published by Department of Health (now the Department of Health and Social Care or DHSC) and the Department for Communities and Local Government (now the Ministry of Housing, Communities and Local Government or MHCLG) and the Integration and Better Care Fund Planning Requirements for 2017-19 (the Planning Requirements), published by NHS England, the Department of Health and the Department for Communities and Local Government.[2] If there is any disparity between the Planning Requirements and this operating guidance then this operating guidance will take precedence. This includes changes to Delayed Transfer of Care metrics, legal powers and the process for escalation.

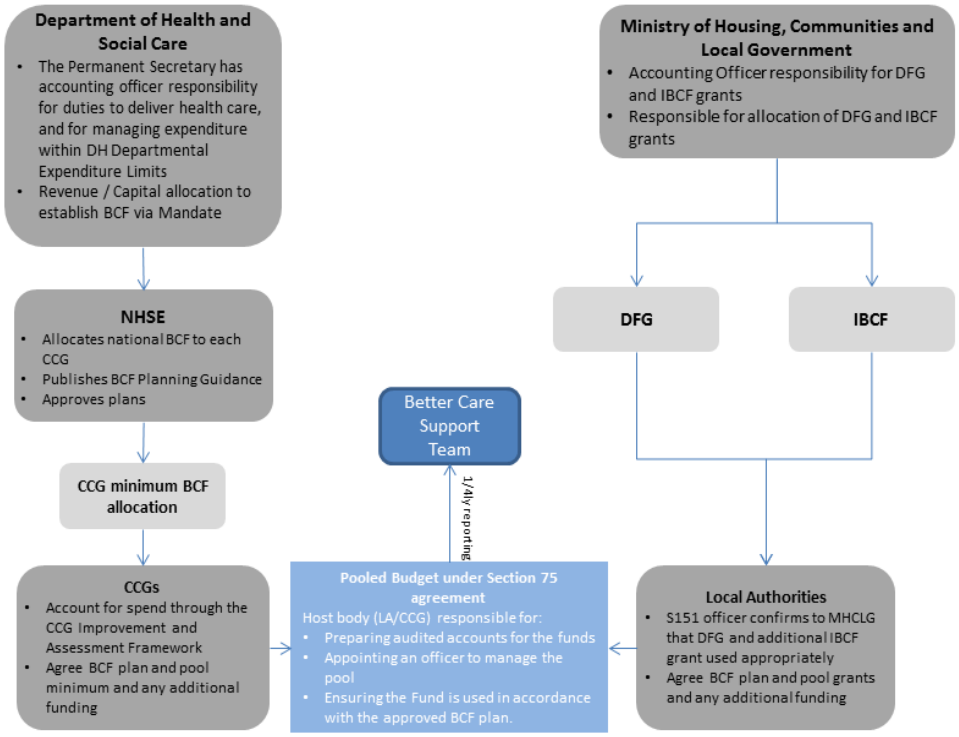
5. This document replaces the BCF Operating Guidance for 2016-17 and has been co-produced in consultation with BCF national partners.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

2. ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 2017-19

6. The below diagram sets out the accountability arrangements and flow of funding for the BCF.



7. In summary, at a national level:

- The BCF funding for CCGs is part of NHS England's budget allocation.
- From 2017-18, the Improved Better Care Fund (iBCF) is paid to Upper Tier Local Authorities by the MHCLG and is part of the MHCLG's Departmental Expenditure Limit.
- MHCLG provides funding for the Disability Funding Grant (DFG), and MHCLG is accountable for the allocation of funds to local authorities, as well as for the policy framework. A Memorandum of Understanding, signed by both DHSC and MHCLG, governs this arrangement. A Grant Determination issued under section 31 of the Local Government Act 2003 requires that the DFG is spent in accordance with a BCF spending plan jointly agreed between the local authority and relevant CCGs.
- The BCF minimum funding allocation must be transferred into one or more pooled funds as established under section 75 of the NHS Act 2006 (s.75).
- The NHS England Accounting Officer (the Chief Executive) is accountable for the effective use of the BCF funding allocation to CCGs made by NHS England

via the reporting requirements set out in NHS England's mandate from Government.

- Section 151 Officers (Chief Finance Officers) in local authorities are required to certify that the additional iBCF (the 2017 Spring Budget money) is being used exclusively on adult social care in 2018-19.The BCF funding allocations from the CCGs to the BCF will pass from NHS England to CCGs through 2017-19 allocations, and then from CCGs to pooled budgets (via s.75 agreements).
- The iBCF and DFG funding will flow from MHCLG to LAs, and then into the pooled budget via s.75 agreements. In two tier areas, DFG funding will flow from the county to the districts (in full, unless jointly agreed to do otherwise).
- The monies will then be spent on services in line with the approved BCF spending plan for 2017-19.

8. At a local level:

    - As legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the funding in accordance with the approved plan and their general duties.
    - CCGs (Accountable Officers) will be the accountable body for the BCF funding allocation allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - LAs (section 151 officers) will be the accountable body, under the terms of their grant agreements, for the DFG and iBCF grant funding that comes from MHCLG (and any additional monies they plan to voluntarily add to the pooled fund).

9. HWBs are expected to continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[3]. Given they are a committee of the LA, HWBs are accountable to elected members and ultimately to the electorate. Where members of a HWB include providers delivering care that is or could be commissioned under BCF, particular care should be taken to ensure that any conflicts of interest are dealt with appropriately.

10. The regulations[4] governing s.75 agreements require the agreement to set out (amongst other provisions):

[3] Section 195 of the Health and Social Care Act 2012

[4] NHS Bodies and Local Authorities Partnership Agreements Regulations 2000

- the arrangements for monitoring the delivery of the services that it covers;
- who the "host" organisation is that will be responsible for accounting and audit; and
- who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

11. Therefore, arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement, in addition to the separate reporting and accountability arrangements each partner organisation will have for their share of the funding being pooled.

12. Guidance and support[5] is available from the Better Care Support Team (BCST) for local areas in developing their local s.75 agreements where required. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that have signed up to the agreement. Each individual who has signed the agreement should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

13. Where a risk sharing arrangement linked to the Non-Elective Admissions (NEA) activity is put in place by the HWB through the planning process for 2017-19, local areas should ensure that arrangements for this are clear and there is a process in place for monitoring this locally. This should be detailed within s.75 agreements. If the local area chooses to use the model for a risk sharing arrangement set out by NHS England in the Planning Requirements (and summarised here at annex 1), then CCGs should ensure that they have withheld the funding related to NEA activity from the pooled fund at the beginning of the year as set out.

14. In order for the HWB to review performance of the BCF and consider future work, it would need to have the appropriate information reported to it from a partnership board. HWBs can require CCGs that are represented on the HWB, and the LA that established the HWB, to provide it with relevant information, for example the quarterly reports and annual report. This can be done under section 199 of the Health & Social Care Act 2012. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s) – many localities will already have a partnership board in place and where this is the case there is no need to set up one specifically for the BCF.

15. In setting up, and overseeing, the s.75 agreement, it is strongly recommended to CCGs and LAs:

[5] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

- that a partnership board is in place to govern the s.75 agreement;
- that the s.75 agreement includes a clause that sets out what information should be included in the host partner's quarterly reports and annual reports. This is to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to BCF national partners as to the appropriate use of the fund (this is explained in more detail in the next section); and
- that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.

Conditions of the Better Care Fund

16. As in previous years every CCG has a set of standard conditions placed on its BCF funding in 2017-19. These conditions are set in the BCF Planning Requirements for 2017-19. The legal basis for imposing these conditions is set out below. It is a requirement that in each area the BCF funding is transferred into one or more pooled budgets, established under s. 75, and that plans are approved by NHS England in consultation with DHSC and MHCLG.

17. Grant Conditions for the iBCF and DFG require that the grants are transferred into one or more pooled budgets and their use agreed, in line with the grant conditions, through the BCF Plan.

18. The Planning Requirements apply the four national conditions from the Policy Framework to ensure plan approval, as set out in the BCF Planning Requirements. In summary these four 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 Care to support system-wide improvements in transfers of care.

19. The Planning Requirements also sets the four national metrics for which each area must agree ambitions in their BCF plans. Some of these are discussed further below. The BCST collect quarterly monitoring data for each of these metrics as well as progress against and compliance with the national conditions of the fund.

3. REFRESHING METRIC PLANS FOR 2018-19

20. The BCF Policy Framework 2017-19 applies for a two year period and BCF plans have already been submitted and assured for this period. This section updates some of the national expectations for metrics for 2018-19.

Non Elective Admissions (NEAs)

21. The baseline for the NEA metric in the BCF for 2018-19 is the target set for NEAs in CCG Operating Plans for 2017-19. Local BCF plans could set additional reductions over and above the NEA CCG Operating Plans where there was local agreement. For 2018-19, areas can consider and submit revisions to these additional reductions or apply additional reductions where none are in place currently. Areas that set additional NEA reduction targets as part of their BCF plan for 2018-19 should confirm any changes, by resubmitting a planning template with details of any retained or amended additional reduction targets.

22. Revisions to the baseline NEA CCG Operating Plans are not required to be submitted, via the BCF planning template unless they impact on any additional reductions agreed in the original 2017-19 BCF plan, as this is sourced nationally from Unify.

23. For the 'Residential admissions' and 'Reablement' metrics, local areas can submit revisions to the planned metrics for 2018-19 on their planning templates with an accompanying note summarising the rationale for this revision.

Delayed Transfers of Care (DToCs)

24. As part of the BCF 2017-19 planning round, all areas were required to set a metric for reducing DToCs to meet nationally set expectations and to submit a separate monthly trajectory to the end of March 2018. This plan was used as the basis for assurance of DToC metrics in 2017-19 BCF plans, rather than the quarterly plans submitted via the BCF main planning template.

25. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. Based on this national ambition, Departments and NHS England have agreed updated expectations for each local BCF plan for 2018-19, in consultation with local government partners and regions. These expectations have been sent to individual HWBs and will be published shortly on the GOV.UK website along with a more detailed explanation of the methodology. The guidance to

CCGs and NHS Trusts[6] for refreshing 2018-19 plans has also set an expectation that local health and social care commissioners will work together to reduce delays to the equivalent of around 4,000 daily delays.

26. The expectations for each HWB for 2018-19 include centrally set expectations for reducing DToCs attributable the NHS and social care, based on the principle that both health and social care contribute equally to reducing delays. Joint delays are expected to remain at their current level. These expectations have applied an updated baseline (Q3 2017-18) and the scale of the expected reduction has been set according to the distance each area is from the national target rate – with areas further away from this rate expected to contribute a larger reduction.

27. Areas will be expected to agree a DToC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. Areas should plan based on the assumption that the expectation will be met by the end of September 2018 and that this level will be maintained or exceeded thereafter. Further detail can be found in Annex 3. Where more than one CCG is signatory to a BCF plan, the CCGs can agree the level of the reduction of delays that they will each be responsible for.

28. If there is a change in expectation to that set in 2017-18, CCGs, local authorities and NHS acute, community and mental health trusts, should revisit local plans for reducing delays to ensure that they are still fit for purpose and agree amendments where necessary. This could include:

    - Consideration of implementation plans for the High Impact Change Model (HICM) (national condition four of the BCF in 2018-19).
    - Other BCF schemes that contribute towards reducing delays and managing transfers.

29. Overall performance in reducing DToC has been encouraging, with the national rate of delays reducing from a peak of over 6,500 daily delays in February 2017, to under 4,500 in May 2018. We are grateful for the considerable effort and collaboration that has delivered this and to those areas that have met challenging expectations in 2017/18. In 2018/19 it is important that all local partnerships continue to focus on minimising DToCs and for areas that remain furthest from their expected levels address this. National partners will continue to offer support to areas to reduce DToCs and your local Better Care Manager (BCM) will be able to discuss available support with you as well as share information on schemes and good practice from other areas.

[6] https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

30. For all BCF metrics, areas should agree any changes at their HWB, or seek delegated approval from all local partners. Any revised metrics, besides adoption of revised DToC ambitions, should be submitted to the BCST, copied to BCMs.

4. AMENDING BCF PLANS

31. Better Care Fund plans were agreed for two years (2017-18 and 2018-19). Places are not, therefore, required to revise their plans for 2018-19 other than in relation to metrics for DToC as set out above. Places can, if they wish, amend plans to:

    - Modify or decommission schemes.
    - Increase investment, including new schemes.

32. Any changes to plans that impact on schemes or spending in the assured BCF planning template must be jointly agreed between the LA and the CCGs that are signatory to the plan and be accompanied with an updated Planning Template and brief rationale.

33. Amended plans must continue to meet all planning requirements and conditions. Please speak to your BCM if you are planning to refresh your BCF plan. Amended plans should be submitted to the BCST, copied to BCMs by 24 August 2018**.** These plans will be scrutinised by your BCM to ensure that they continue to meet the requirements of the Fund.

34. Similarly, if a change is made in-year that impacts on schemes or spending in assured BCF planning template, this change should be jointly agreed between the LA and CCGs that are signatory to the plan and a revised template and rationale should be sent to the BCST and your BCM.

5. REDUCING THE NUMBER OF PATIENTS WITH LONG STAYS OF 21 DAYS OR MORE IN HOSPITAL

35. NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy. NHS England and NHS Improvement have asked trusts and CCGs to work with local government partners to agree local sectoral ambitions to achieve this reduction. Figures have been shared with local systems that show the baseline (average number of beds occupied by patients in hospital for 21 days or more) and the expected reduction.by December 2018. These ambitions are intended to reduce the number of long stay patients by 4,000 nationally. The percentage reduction required from each system is based on their baseline rate of long stay patients. The level of improvement expected from each system is based on the proportion of beds occupied

by long stay patients, with the most challenged systems expected to make the greatest levels of improvement.

36. Achieving this will require concerted effort across the health and care leadership system: at least half the opportunity rests within the direct control of hospitals, and the remainder in joint working with GPs, local authorities, community health, social care providers and others.

37. BCF plans will support delivery of this reduction through the continuing focus on delivery of the local DToC expectations (paras 24-30) and through the implementation of national condition four – the High Impact Change model. Particular focus in relation to length of stay should be given to the implementation of the HICM in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven). National partners will give consideration to applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19. Any revisions to existing plans for implementing the High Impact Change model should be reflected in Better Care Fund quarterly reporting.

6. REPORTING ON AND CONTINUED COMPLIANCE WITH THE BCF NATIONAL CONDITIONS OVER 2017-19

Monitoring continued compliance with the conditions of the fund

39. Better Care Managers (BCMs) and the wider BCST will monitor continued compliance against the national conditions through the BCF quarterly reporting process described below and their wider interactions with local areas.

40. If an area is not compliant with any of the standard conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, the BCST, in consultation with national partners, may make a recommendation to NHS England to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

41. The intervention and escalation process (outlined in subsequent sections) ultimately leads to NHS England exercising its powers of intervention provided by NHS Act 2006, in consultation with DHSC and MHCLG, as the last resort. These powers and interventions are summarised in subsequent sections.

Quarterly Reporting in 2017-19

42. The primary purpose of the Better Care Fund quarterly reporting is to provide national partners with a clear and accurate account of compliance with the key requirements

and conditions of the fund as set out in the Policy and the Planning Requirements. The secondary purpose is to inform policy making and the national support offer by providing a fuller insight, based on narrative feedback from systems, on local progress, issues and highlights on implementation of the BCF plans.

43. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2017-19.

44. It is expected that these reports are discussed and signed-off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into s.75 agreements. Quarterly monitoring will include confirmation that s.75 agreement is in place.

45. The quarterly reporting template will be made available to the local systems with associated guidance and timetables via the Better Care Exchange, an online platform that all Better Care leads are able to access. For the first time this also includes the reporting template for the additional improved Better Care Fund, as collected by MHCLG, responding to calls to align and integrate reporting.

7. SUPPORT, INTERVENTION AND ESCALATION PROCESS

Support

46. The Better Care Support Programme leads and facilitates the delivery of the Better Care Fund policy. This includes bespoke support for areas, performance management, formal guidance and, where needed, intervention. This section describes these functions and advises areas of the support available. Areas should speak to their BCM if they have concerns over the delivery of their BCF plan or performance against metrics.

47. The support programme constitutes:

    a. the national Better Care Support Team (BCST)
    b. the regional Better Care Managers (BCM)
    c. the national and regional Better Care Support Offer
    d. the Better Care Exchange

48. The BCST and BCMs are responsible for ensuring that local systems continue to comply with the conditions of the BCF and for improving performance against the national metrics, as well as supporting the wider ambition in relation to the overall integration of health and social care. This includes:

    - Support and advice through the national BCST

- Formal support to address high levels of DToC
- Intervention where there are performance or compliance concerns, including:
    - Performance discussions with regional leads;
    - Formal escalation to national partners;
    - Use of NHS England intervention powers, including the power to direct CCGs regarding expenditure

49. The Better Care support offer for 2017-19 is delivered through two streams: the centrally-led national support programme and the regionally-led support offer. The scope of this support focuses on plan, delivery and improvement.

50. The centrally-led national support consists of a number of elements:

- **Better Care Advisers**: a pool of advisers that local areas can draw upon to provide senior level support where requested or required. This hands on support will be available to areas who wish to drive their integration agenda forward, whether that be through facilitated discussions and workshops, or peer-led interviews, it will enable areas to challenge themselves and share learning from other areas.

  This strand continues to provide independent facilitation for local areas that are facing difficulties or disagreements, as well as support any assurance requirements.

- **Intensive support for better managing transfers of care**: the BCST and national partners will offer a range of support to assist local areas in working together to ensure people benefit from speedy and safe transfers of care from hospital to their community. This will include:

    - Workshops on the High Impact Change Model
    - DToC counting workshops
    - National CQC learning events
    - Local area peer reviews
    - Bespoke peer support

- **National workshops**: a programme of workshops focussing on the key challenges associated with integrated care. The thematic workshops are intended to look at and share different approaches and experiences around a theme of interest at national level. They are expected to bring together the most up to date information, insight and solutions on priority themes associated with integrated care.

- **Regional workshops**: regionally-led events focussed on sharing experiences and dealing with challenges locally. This aspect of the support programme is concerned with creating the links and relationships between peers from

different health and social care systems within a region, to encourage peer-to-peer support, learning and challenge. Workshops can cover a theme of specific importance/interest to the region.

- **Programme of guidance and insight**:
    - Case studies
    - Webinars
    - Guide to the Better Care Fund

- **Integrated Care Learning Programme**: Access to two learning programmes developed in conjunction with the Social Care Institute for Excellence (SCIE). One tailored to BCMs and the other for local area BCF leads, which will count towards Continuous Professional Development (CPD).

51. The programme of support for 2018-19 is intended to build on the 2017-18 offer. Support will continue to be developed utilising ongoing feedback from local areas through the quarterly reporting, discussions with BCMs, key partners, the 2018-19 needs assessment and in response to national policy.

52. The regionally-led support offer consists of funding that has been allocated to each region, in order to enhance and support regions' capacity and capability to achieve the overall aims and vision for the Better Care Fund. BCMs are in place across each region to gather learning and co-ordinate support to local areas. Regions can commission bespoke packages of support to respond to regionally identified needs, generate shared solutions at a regional level and tailor national resources and products to regional needs.

53. The Better Care Exchange is the collaboration platform operated by the BCST. The purpose of the exchange is to provide a shared collaboration space for individuals from both health and social systems who work on delivering the BCF plans or work closely with the BCF with the shared agenda of health and social integration. The platform the forum for operational communication, providing quarterly reporting and other BCF related templates and to share information and insight.

54. If further information is of interest on the components of the Better Care Fund Support Programme, please contact ENGLAND.bettercaresupport@nhs.net which is the primary point of contact for the BCST.

Intervention and escalation

55. Where an area remains non-compliant, or performance remains poor, further intervention will be considered.

56. If it becomes apparent that local implementation is not in line with the approved BCF plan, and that this resulted in one or more requirements of the BCF not being met in an area – for instance through the quarterly monitoring process or through information given to the BCM or BCST– the BCST will consider commencing an escalation process.

57. Prior to escalation, for a plan that has previously been approved, the BCST will work with national partners, the BCF Programme Board and BCF Senior Responsible Officer (SRO), the BCM for the area and local partners to consider options to resolve the issues, including use of Better Care Advisor support. Senior staff from the LA and the CCG(s) will need to attend a formal discussion with regional NHS England and local government representatives and their BCM to attempt to agree a resolution or recovery plan.

58. Escalation will be considered if there is evidence that:

- One or more of national conditions 1-4 are no longer being met.
- There have been changes to spending made without agreement, particularly those that would impact on continued compliance with the national conditions.
- There are significant concerns over performance against any of the BCF metrics.
- The area does not locally agree a compliant metric for reducing DToCs in 2018-19.

59. As outlined in the Planning Requirements, the purpose of escalation in the event of a non-compliant plan is to:

"… assist areas to reach agreement on ***a compliant plan and is not an arbitration process.*** *Senior representatives from all parties required to agree a plan will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward."*

60. Escalation is not arbitration, mediation or legal advice. The single aim of the escalation process is to ensure that an area has and maintains a compliant Better Care Fund plan. More details on escalation as part of the assurance process is set out in the Integration and Better Care Fund Policy Framework 2017-19; Integration and Better Care Fund Planning Requirements 2017-19; and the Better Care Fund 2017-19: A guide to assurance of plans.

61. If an area that is performing poorly against BCF metrics is unable, following support and local intervention, to make improvements, then escalation will be considered. The purpose of escalation will be to consider the actions that the area is taking to address underperformance and whether further intervention or use of powers of direction is warranted. National Partners will review progress against 2018-19 DToC expectations

once data for September 2018 are available. Progress on reducing DToC will continue to be monitored by national partners and will be taken into account in setting expectations for 2019-20.

62. Appendix 2 describes the steps involved in escalation as applicable to the ongoing BCF compliance. The escalation process which will be initiated if any of the conditions of the BCF are not met following the return of the quarterly reports and wider information collected by BCMs.

63. The BCST will support the escalation process, which will involve DHSC, MHCLG, NHS England and the LGA.

64. The Escalation Panel members will take into account 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 (see paragraphs 35, 36 and 37 of the Planning Requirements);
- Whether agreed spending on social care services funded by CCG minimum contributions has been maintained in real terms i.e. taking into account inflation. This will also include consideration of transfers prior to the establishment of the BCF;
- Previous and current diagnostic reports that have been prepared by Better Care Advisers or those appointed to work with the area, such as on enhanced support for DToC.

65. NHS England has the ability to direct use of the CCG minimum contribution to a local BCF fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that has been locally agreed and 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 DHSC and MHCLG, with the final decision then taken by NHS England.

66. 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. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

67. A summary of the approach to support, escalation and intervention is at Annex 2.

8. GRADUATION

68. We hope that a first wave of shortlisted areas eligible for graduation from the Better Care Fund will be confirmed in 2018-19. National partners would then work with shortlisted areas to test readiness for full graduation and co-produce what a meaningful graduation model would look like. . NHS England, MHCLG, DHSC and the LGA will agree a memorandum of understanding with graduate areas, setting out the BCF requirements that will be removed or relaxed and any expectations of graduate areas, including:

    - Participation in learning events
    - Commitment to work with BCF national partners to develop models of integration, informing development of Integrated Care Systems and the health and care integration agenda.
    - Areas for improvement – for instance on specific metrics
    - Expectations for light touch self-certification process.

69. Through 2018-19, DHSC, MHCLG, NHS England, the LGA and the BCST, will work with these areas to develop the model for graduation further.

BCF 2018-19

70. The mandate to NHS England for 2018-19[7] has been published and contains deliverables around the BCF.

71. NHS England will be using section 223G(4) to impose conditions on the allotment of BCF funding to CCGs that is identified in the mandate to NHS England for 2018-19.

72. The conditions that NHS England is imposing are again those set out in the 2017-19 BCF Policy Framework (page 16) and the BCF Planning Requirements for 2017-19 (pages 9-14) i.e. the four national conditions plus establishing a pooled fund under section 75 of the NHS Act 2006 and agreeing plans locally with sign off by the relevant local authority and CCG(s).

73. The funding awarded by NHS England under section 223G is also conditional on the fact that if the national conditions are not met, future payments of minimum BCF funding can be withheld and minimum BCF payments already made can be clawed back by NHS England at NHS England's discretion. Under section 223G(6), NHS England may direct CCGs as to the expenditure of the allotment of BCF funding. In

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

practice this means that the interventions available to NHS England if conditions are not met are the same from 2018-19 as for 2017-18.

ANNEXES

ANNEX 1 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. National condition three of the 2017-19 Better Care Fund required areas that had agreed additional target to reduce Non Elective Admissions over and above the metrics in CCG operating plans to consider holding a portion of the CCG minimum contribution in contingency against the additional costs of these targets not being met. The Planning Requirements set out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2017-19. Where this is the case the arrangements are described within narrative plans.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. The Planning Requirements set out the mechanism for calculating the maximum value of the contingency.

3. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

ANNEX 2 – SUPPORT AND INTERVENTION 'LADDER'

Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCST and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger** - identification of BCF non-compliance or significant concerns about performance on BCF metrics	The BCM and regional partners in consultation with the BCST and the Programme's Director will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or Local Government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal Support	The BCM will work with the BCST to agree provision of a Better Care Advisor, multi-disciplinary consultancy or other support, including provision of specific support to address compliance and/or high levels of DToC.
4. Formal regional meeting	Areas will be invited to a formal meeting with NHS England regional and regional local government representatives to discuss the compliance or performance concerns, the area's plans to address these and a timescale for addressing the issues identified.
5. Pre-escalation meeting	Discussion with BCST, BCM and regional representatives from NHS England and local government. This meeting will seek to agree a set of actions to address issues without the need to escalate further. A timescale for completion of these actions will be agreed at the meeting.
6. **Commencing Escalation** as part of non-compliance	If, following the pre escalation meeting, a solution is not found or performance issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, the members of the Integration Partnership Board will be consulted on next steps.

	To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the Escalation Panel.
7. The **Escalation Panel**	The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials with representation from: • NHS England • LGA/Association of Directors of Adult Social Services (ADASS) Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from local authority
8. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter, summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan or addressing performance issues. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included.
9. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCST.
10. Consideration of **intervention options**	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: • Agreement that the Escalation Panel will work with the local parties to agree a plan • Appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan. • Appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant

	plan • Appointment of an advisor or support to address performance issues, including progress towards agreed DToC metrics. • Clawback of BCF funding already paid • Withholding BCF payments that are due to be made • Directing the CCG as to how the minimum BCF allocation should be spent 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.

ANNEX 3 – REVISION OF DTOC METRICS – METHODOLOGY

1. In order to ensure that the expected contributions to continued reduction in DToC are proportionate and achievable in each area of England, national partners have agreed to revise the existing HWB-level expectations.

2. In approaching this year's ambition setting, we have determined key guiding principles to steer this work: providing a clearer, easier to explain methodology with a consistent rationale, and balancing fairness and stretch across local systems.

3. The expectations have been set as follows:

    - A common baseline for (i) NHS and (ii) adult social care delays (October to December 2017).
    - Expectations set to deliver an equal reduction in the number of daily delays attributable to each of the NHS and social care.
    - Expected progress from this baseline calculated for NHS and adult social care delays is based on the distance from a target rate. The target rates are 5.5 daily delays per 100,000 population for NHS delays and 2.6 daily delays per 100,000 of the population for adult social care.
    - The level of improvement expected depends on the distance from the target rate – this is set out in more detail below.
    - The maximum target reduction is capped at 30% for NHS delays and 40% for Adult Social Care. The target date for achieving these reductions is the end of September 2018. As in 2017-18, joint delays are expected to remain the same and no stretch target has been set.

4. The bandings are shown below:

Baseline	Expectation
Adult Social Care	
DToC rate below 2.6 daily delays per 100,000 18+ population	Maintain that rate
DToC rate between 2.6 and 4.3 daily delays per 100,000 18+ population	Reduce to 2.6 daily delays per 100,000 18+ population
DToC rate over 4.3 daily delays per 100,000 18+ population	Reduce delays by 40%

NHS	
DToC rate below 5.5 daily delays per 100,000 18+ population	Maintain that rate
DToC rate between 5.5 and 7.9 daily delays per 100,000 18+ population	Reduce to 5.5 daily delays per 100,000 18+ population
DToC rate over 7.9 daily delays per 100,000 18+ population	Reduce delays by 30%
Joint	
Average number of jointly attributed daily delays October to December 2017 per 100,000 18+ population	Remain at or below this rate