Better Care Fund – Revised Planning Guidance

INTRODUCTION

1. The Better Care Fund (BCF) was announced in June 2013. It provides an opportunity to transform local services so that people are provided with better integrated care and support. Every local area submitted a plan in April and these plans clearly demonstrated a commitment to ensuring more people received joined-up, personalised care closer to home.

2. The BCF is ambitious, and the majority of local plans submitted in April showed that same ambition. The April plans showed that significant progress has been made in bringing together organisations and moving to a new and more collective way of working, addressing key conditions such as a commitment to seven day working, better sharing of information and protection of social care services, for example.

3. Unplanned admissions are the biggest driver of cost in the health service that the BCF can affect. As such, Ministers are clear that plans will need to be revisited to demonstrate clearly how they will reduce total emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community. Protection of social care also remains a top priority and a vital requirement on the BCF, both in securing better outcomes for local populations as well as reducing the demand on hospital services.

4. On 11 July, Jon Rouse and Helen Edwards wrote to each Health and Wellbeing Board to ask all areas to submit revised plans. This guidance sets out the additional requirements and sets out the timetable that will mean we can move as quickly as possible from improving and assuring the plans to letting local areas get on with delivery.

5. This planning guidance updates and supersedes the previous planning guidance '*Better Care Fund Annex of Planning Guidance*' from December 2013. It should be read alongside:

    - Letter from Andrew Ridley (25/07/14) – which outlines the high level changes
    - Technical guidance – detailed guidance on completing the planning templates
    - Part 1 template – the 'narrative' of the plan
    - Part 2 template – the finance and metrics underpinning the plan

POLICY CHANGES IN SUMMARY

6. The substantive change in policy is that, of the £1.9bn additional NHS contribution to the BCF, £1bn will remain within the BCF but will now be either

commissioned by the NHS on out-of-hospital services or be linked to a reduction in total emergency admissions. The intention of this policy change is to ensure that the risk of failure for the NHS in reducing emergency admissions is mitigated, and CCGs are effectively compensated for unplanned non elective activity. The following bullet points summarise the changes to policy agreed by Ministers.

- The £1bn proportion of the BCF will replace what was originally the 'pay for performance' fund linked to the production of a plan and delivery against national and local metrics. No payment will now be linked to these metrics, although Health and Wellbeing Boards will be expected to continue to set levels of ambition for these within their plans. Further detail on requirements for these metrics is included in the technical guidance. Total emergency admissions replaces the original metric of avoidable emergency admissions.
- Health and Wellbeing Boards are invited to agree a target reduction in total emergency admissions. The funding corresponding to any reduction forms one element of the pay for performance fund. The outstanding balance will be spent by CCGs on 'NHS commissioned out-of-hospital services' as part of the BCF plan.
- For the proportion of the £1bn funds linked to a reduction in total emergency admissions, money will be released from the CCG into the pooled budget on a quarterly basis, depending on performance. These payments start in May 2015 based on Quarter 4 performance in 2013/14. The remaining proportion of the £1bn will be released to the CCG upfront in Quarter 1 in 2015/16.
- If the locally set target is achieved then all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. If the target is not achieved, then the CCG will retain the money proportional to performance, to be spent by the CCG in consultation with the Health and Wellbeing Board
- The expected minimum target reduction in total emergency admissions will be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. All areas can set more ambitious targets should they wish, and the amount of funding linked to performance will increase accordingly.
- The local target and resulting funding linked to total emergency admissions will be based on the total figure for the whole Health and Wellbeing Board area, not just to the portion resulting from BCF schemes.
- All plans will be expected to clarify the level of protection of social care from the £1.9bn NHS additional contribution to the BCF, including that at least £135m has been identified for implementation of the Care Act
- Every Health and Wellbeing Board is asked to sign off and resubmit their Better Care Fund Plan by 19 September. Up to and after this date there will be a support and assurance process so that the Chief Executive of NHS England (as the accounting officer of the BCF) and Ministers can be confident that the plans are affordable and deliverable in 2015/16.
- A separate note will be sent to areas outlining the expectations of the support and assurance process through to 19 September and beyond

REQUIRED ACTIONS

7. All areas must now revise their BCF plans in light of the updated policy framework

8. Using the new templates that sit alongside this guidance, local BCF plans must set out the local **vision for health and care services**, and describe the schemes that will deliver this vision but the plans must also go beyond this, specifically to clearly set out:

   - **The case for change**: a clear analytically driven and risk stratified understanding of where care can be improved by integration

   - **A plan of action**: A coherent and credible evidence-based articulation of the delivery chain that underpins the shift of activity away from emergency admissions developed with all local stakeholders and aligned with other initiatives and wider planning

   - **Strong governance**: clear local management and accountability arrangements, and a credible way of tracking the impact of interventions and taking remedial action as necessary, as well as robust contingency plans and risk sharing arrangements across providers and commissioners locally

   - **Protection of social care**: How and to what level social care is being protected, including confirmation that the local share of the £135m of revenue funding resulting from new duties within the Care Act is protected, and the level of resource dedicated for carers is spelled out.

   - **Alignment with acute sector and wider planning**: including NHS two-year operational plans, five-year strategic plans, and plans for primary care as well as local government plans

THE REVISED TEMPLATES

9. Both part 1 and part 2 of the planning templates have been revised. The purpose of the revisions is to ensure that the questions are as clear as possible and provide added emphasis on the following:

   - A clearer articulation of the analysis and evidence that underpins the BCF plans (particularly Part 1 template, section 3)

   - A clearer articulation of the delivery chain that will underpin the shift of activity away from acute activity (particularly Part 1 template, section 4)

   - A tighter description of the schemes underpinning the plan schemes and the underlying success factors (particularly Part 1 template, section 4c and annex 1)

   - A much clearer focus on the risks, the risk sharing arrangements and the contingency plan in case the target reduction in admissions are not met (particularly Part 1 template, section 5)

- A clearer articulation of the alignment between the BCF and other plans and initiatives within a locality across NHS and social care (particularly Part 1 template, section 6)

- Ensuring that the potential impact of proposed schemes on providers are understood, and providers are fully engaged (particularly Part 1 template, sections 8b and c and Annex 2)

10. In addition further detail is required on the protection of social care services (Part 1 template, section 7a), including the new duties resulting from the Care Act. The changes reflect the fact that social care services and the changes within the Care Act not only impact on local authorities but more broadly on the NHS and other local partners. Local plans should consider how the BCF may be used to support common areas of focus which deliver the Care Act but also underpin shared local priorities. In addition to previous questions the template now asks for the following:

    - the total amount from the BCF that has been allocated for the protection of social care services

    - the total level of resource that will be dedicated to carer-specific support, and the nature of that support

    - Confirmation that at least the local proportion of the £135m has been identified from the NHS £1.9bn funding for implementation of new Care Act duties on councils (including new entitlements for carers, national minimum eligibility threshold, advocacy, safeguarding and other measures in the Care Act)

    - The financial impact on local authority's budgets resulting from changes to the BCF policy since April 2014

11. There are some new questions, some revised questions and some questions which have not changed. The table below summarises the changes – please note the numbers below refer to the numbering in the new template. The detailed requirements for the changes can be found within the templates themselves and within the technical guidance.

New questions	3) The case for change 4) a) b) c) d) Plan of action 5) Risks and contingency 6) a) b) c) Alignment 8) c) Implications for acute providers Annex 1: Detailed scheme description Annex 2: Provider commentary

Slightly revised questions	2) a) b) c) Vision for health and social care services 5) a) b) Risks and contingency 7) a) Protection of social care services 8) a), b) Engagement
Questions which have not changed	1 a) b) c) Summary details 7) b), c), d) National conditions

12. In addition, to meet the core requirements of the BCF, all plans must articulate:-
    - How the plan will meet the remaining national conditions of the BCF (detail included in Annex 1 of this document, the technical guidance and the Part 1 template)
    - Detail of agreements made on the local target for total emergency admissions (detail within the technical guidance and the Part 2 template)
    - The specific financial investment and benefits resulting from the schemes or groups of schemes included within the BCF (detail within the technical guidance and Part 2 template)

PAYMENT FOR PERFORMANCE

13. Payment of the £1bn pay for performance fund will now only be linked to total emergency admissions and not the range of other metrics that are included within the plans. However, CCGs and councils, through Health and Wellbeing Boards, will still need to identify their ambitions for improvement against the wider performance metrics already identified:

    - admissions to residential and care homes;
    - effectiveness of reablement;
    - delayed transfers of care;
    - patient / service user experience; and
    - a locally defined metric

14. Setting and achieving appropriate ambitions against these metrics remains important in achieving the system change required to transform care for people. As such this will continue to form a part of the assurance and sign off process for BCF plans, but will no longer form the basis of payment for performance on the BCF. The Better Care Dashboard tool, to be published later this year, will enable comparisons and benchmarking against these and a broader range of metrics associated with integration. Further detail on requirements for these metrics is included in the technical guidance.

Total emergency admissions

15. The measure to be used for performance payments will also change from avoidable to total emergency admissions. There are a number of reasons for this: it is consistent with the measures used by CCGs in wider operational plans, with

data readily collected and analysed already; it provides better statistical significance over the time/population in question, and it maximises the opportunity for payment for performance. It also captures a range of activity that is relevant to the Better Care Fund that would otherwise not have been included within avoidable admissions only.

16. CCGs and Councils are invited to agree the target for reducing total emergency admissions. There is a national expectation that areas will set a target to reduce their total emergency hospital admissions by at least 3.5%. NHS England's Area Teams will discuss with CCGs, along with local government, what an appropriate level of improvement might be in the context of this overall expectation, should this target be unrealistic locally. All areas can set more ambitious targets should they wish. The baseline for the level of ambition will be based on quarter 4 2013/14, and quarters 1 to 3 2014/15.

17. The value of the performance related payment for each area will be determined by the ambition agreed for reducing emergency admissions. The higher the target, the larger the performance related payment will be on success. The performance related payment will be a proportion of the local share of the £1 billion performance budget, and the remaining proportion will be available upfront in 2015/16 for CCGs to spend on NHS-Commissioned out of hospital services.

NHS-commissioned out of hospital services

18. The remainder of the local share of the £1 billion performance budget will be within the BCF for investment in NHS-commissioned out-of-hospital services. These could include a wide range of services, to be determined locally, including existing out of hospital services. This ring-fenced money will be available up front as part of the core BCF allocation in April 2015. CCGs and Councils should include a breakdown of spend, including the amount they identify as NHS-commissioned spend from the £1bn in the revised templates.

19. Further detail on how this will work is set out in the technical guidance. The part two planning template also contains a sheet to help determine the proportion of the £1bn for payment for performance, and the proportion that is for investment in NHS commissioned services.

Summary of different elements of revised P4P scheme

20. Of the £1.9bn NHS contribution to the BCF, £1bn will be made up of the following parts:

Part 1: Payment for performance on total emergency admissions		**Part 2: NHS commissioned spend**
Target met	**Target not met**	
Full amount included within the BCF To be released at quarterly intervals for local HWBs to invest in locally agreed priorities, as set out in BCF plans	Payment is proportional to performance so some funding remains within CCG budgets proportional to the level by which the target was missed. CCGs will decide how to spend this portion of the funding, in	Included within the BCF to be spent by CCGs on NHS-commissioned out of hospital services. This money will be allocated to the pooled budget up front as part of the core BCF allocation in April 2015.

	consultation with HWBs. It is expected that this money will be used to compensate CCGs for unplanned emergency admissions costs	

How will performance payments work?

21. The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 15/16, against the trajectory as set out in the plans. HWBs are therefore required to set an annual target (from Q4 2014/15 until end of Q3 2015/16), with quarterly milestones in the finance and activity plan template. Payments will be made in arrears as set out below:

    1. May 2015 (based on Q4 2014/15 performance)
    2. August 2015 (based on Q1 2015/16 performance)
    3. November 2015 (based on Q2 2015/16 performance)
    4. February 2016 (based on Q3 2015/16 performance)

22. At each 'payment point', CCGs will release money into the BCF pooled fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned reduction against the baseline). The relationship between payment and progress toward target will be directly linear (i.e. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target. If targets are met then funds will be released for local HWBs to invest in locally agreed priorities, as set out in BCF plans. Full details are included in the technical guidance.

What if agreed targets are not hit?

23. If a Health and Wellbeing Board area fails to deliver the agreed ambition to reduce total emergency admissions only a portion of the locally agreed performance money will be automatically released to be spent on the planned activities. The amount released will be linked to the level of performance achieved e.g. achieving 70% of the target reduction will secure 70% of the performance payment.

24. The remaining performance money will not leave the local area, and it will remain within the CCG, intended for use to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board. In the example given above 30% of the performance money will remain within the CCG for this use.

25. This system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. Strong risk sharing agreements and contingency plans will be crucial in case targets are not met on total emergency admissions. Local areas may also wish to explore the payment and contract levers available locally to ensure that incentives are aligned with the overall policy objective.

Links to wider NHS planning

26. Some of the changes to the BCF described above, will have an impact on wider two-year NHS operational plans. Providers and CCGs have recently submitted their final planned projections for non-elective activity for 2014/15 and 2015/16 on UNIFY., The change to the metric attached to the payment for performance element of the fund to total emergency admissions may therefore have an impact on the already submitted operational plans. Although UNIFY will not be reopened, CCGs should ensure their revised figures are reflected when the next planning round commences.

27. It is also recognised that the assumptions councils have made in their operational plans may be affected by the policy changes. Continued local dialogue will be required to ensure that revised plans adhere to the original ambitions of Health and Wellbeing Boards to deliver better care for the benefit of local people and the health and care system.

PLAN DEVELOPMENT, ASSURANCE AND SIGN OFF

Timetable

Date	Process
25 July	• Guidance and templates issued
28 July – 19 September	• Support to local areas to strengthen plans • Checkpoints for regional support and assurance on 8 August, 29 August, 12 September
19 September	• Revised BCF plans submitted to bettercarefund@dh.gsi.gov.uk and copied to Area Teams and local government regional peers by 12pm
22 September – 3 October	• Desktop review of plans
10 October	• Moderation exercise complete
17 October	• Final presentation and recommendations to Sir Bob Kerslake, Simon Stevens and Ministers

Improvement support

28. Local areas are being asked to revise their BCF plans and supply additional information to ensure that they are in the best possible position to deliver their ambitions for more integrated health and social care. Substantial progress has already been made, but there are areas where extra support is needed to bring about the transformation at scale and pace.

29. Support will be commissioned nationally but deployed locally through agreement of support needs with NHS England Area Teams and Local Government regions at the checkpoints outlined in the timetable above. The central BCF programme

team led by Andrew Ridley will have national oversight to ensure the right support is being put in place. Further details on the support will follow separately.

Assurance and moderation

30. The crucial element of assurance of plans is for local areas to make arrangements for sign off by the Health and Wellbeing Board. Following this, plans should be submitted to bettercarefund@dh.gsi.gov.uk by 19 September 2014.

31. Area Teams and Local Government regional leads will be working closely with HWBs during the summer to ensure areas get the support they need to deliver plans by 19 September. They will provide regular updates to the central team (at the checkpoints detailed in the above timetable) on progress locally during this period so that we can offer support if needed.

32. Once plans have been submitted, there will be an intensive two-week desktop review of plans, focused on:
    1. Overall review of narrative of plan
    2. Analytical review of data, trends and targets
    3. Financial review of calculations and financial projections

33. The combination of the feedback from Area Team and Local Government regional peers, and the outcome of the desktop review, will form the basis of the assurance process ahead of plans being recommended to Ministers for sign-off.

34. Further details will follow separately on the support, assurance and moderation process

ANNEX 1: Key elements of the BCF

1. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers.

2. The June 2014 Spending Round set out the following:-

2014/15: A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned
2015/16: £3.8bn to be deployed locally on health and social care through pooled budget arrangements

3. In 2015/16 the Fund will be created from:

£1.9bn of additional NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

4. The £3.8bn Fund therefore includes £130m of NHS funding for carers' breaks. 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 (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement.

5. The Disabled Facilities Grant has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. 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 this funding to their respective housing authorities (district councils in two-tier areas) 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.

6. DH Adult Social Care capital grants (£134m) will also reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund.

7. In addition, it was announced as part of the Spending Round that the Better Care Fund would include £135m of revenue funding for costs to councils resulting from the Care Act in 2015/16. This revenue funding will be identified from the £1.9bn of NHS funding, and will cover a range of new duties on councils relating to the

Care Act, (including new entitlements for carers, national minimum eligibility threshold, advocacy, safeguarding and other measures in the Care Act)

The statutory framework

8. The Care Act sets out that the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[1] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

9. BCF revenue funding will be routed through NHS England to ensure a process that works coherently with wider NHS funding arrangements.

10. BCF capital funding, including funding for the Disabled Facilities Grant (DFG) will be routed through direct grant allocations from the Department for Communities and Local Government and the Department of Health.

11. Government will use the NHS Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

Local BCF Allocations

12. BCF allocations for each local area were confirmed in March 2014, and are available at:

    http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

[1] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

National conditions

The Spending Round established six national conditions for access to the Fund:

Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should:

- confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.

The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in.

Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.