Department of Health

Department for Communities and Local Government

Better Care Fund

Policy Framework

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Prepared by the BCF Taskforce

Contents

The Better Care Fund 2015/2016

Policy Framework

1. Background

1.1. The Better Care Fund was announced in June 2013 to drive the transformation of local services to ensure that people receive better and more integrated care and support. The fund will consist of at least £3.8 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

1.2. This document sets out the detailed policy framework for the implementation of the fund, as agreed across the Department of Health, Department for Communities and Local Government, the Local Government Association and NHS England.

1.3. It is not intended to act as further guidance to local areas on implementation of the fund. NHS England, working with the partners above and the Local Government Association, developed and issued detailed guidance on developing Better Care Fund plans in July 2014. Local areas should continue to refer to and follow this guidance.

2. The Statutory and Financial Basis of the Fund

2.1. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

2.2. Under the NHS Mandate for 2015/16, NHS England is required to ring-fence £3.46 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.8 billion fund will be made up of the £134 million Social Care Capital Grant and the £220 million Disabled Facilities Grant, both of which are paid directly from the Government to local authorities.

2.3. NHS England and the Government will allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2015/16, the allocation will be based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund. Individual allocations of the Better Care Fund for 2015/16 to local areas were published in March 2014[1], and the detailed formulae used are set out in Chapter 4 of the *Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams*[2].

[1] http://www.england.nhs.uk/wp-content/uploads/2014/03/bcf-allocations-revised-w1415.xlsx

[2] http://www.england.nhs.uk/wp-content/uploads/2014/03/tech-guide-rev-allocs.pdf

3. Conditions of Access to the Better Care Fund

3.1. The amended NHS Act 2006 gives NHS England powers to attach conditions to the payment of the Better Care Fund. The 2015/16 Better care Fund will be subject to the following conditions set by NHS England:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with Ministers
- The fund is to be used in accordance with the agreed plan
- The element of the fund linked to non-elective admissions reduction target will be released into the pooled budget proportional to performance, as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

3.2. NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions agreed in the 2013 Spending Review:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- 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
- Better data sharing between health and social care, based on the NHS number
- 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
- Agreement on the consequential impact of changes in the acute sector

3.3. Detailed definitions of these national conditions are set out at **Annex A**.

3.4. Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of funding where conditions attached to the Better Care fund are not met. The Act makes provision at section 223GA(7) for the NHS Mandate to include a requirement that NHS England consult Ministers before exercising these powers. The 2015/16 Mandate confirms that NHS England will be required to consult Ministers before using these powers.

3.5. NHS England's power to set conditions on the Better Care Fund applies to the £3.46bn that is part of CCG allocations. For the £354m paid directly to local government, the Government will attach appropriate conditions to the funding to ensure it is included in the Better Care Fund at local level. For 2015/16, there is an additional requirement set out in the Better Care Fund planning guidance that, due to the statutory duty on local housing authorities to provide DFG to those who qualify each area will have to allocate DFG funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget. This will enable them to continue to meet their statutory duties in relation to the DFG.

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

4. The Assurance and Approval of Local Better Care Fund Plans

4.1. Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association[3].

4.2. The first stage of the overall assurance of plans will be local sign-off by the relevant Health and Wellbeing Board, local authority and Clinical Commissioning Group(s). Plans will then be subject to a robust national assessment process, carried out in accordance with a methodology agreed between NHS England, the Department of Health, the Department for Communities and Local Government and the Local Government Association. For 2015/16 the detailed methodology is set out in the published *Better Care Fund National Consistent Assurance Review Methodology*[4]. The national assurance process will involve three main steps:

- A detailed review of plan quality, led by a team of technical experts and building in interviews with each area and a 'triangulation' discussion across NHS area teams and local government regional peers.

- An assessment of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government.

- Bringing together judgements on 'plan quality' and 'risks to delivery' to place plans into four categories – 'Approved', 'Approved with support', 'Approved subject to conditions', 'Not approved'.

4.3. Local BCF plans will be approved by NHS England. NHS England will seek the agreement of DH and DCLG Ministers before approving (or not approving) plans. Final decisions on approval will be made by NHS England, in accordance with the legal framework set out in section 223 GA of the NHS Act 2006.

4.4. Where plans are not initially approved, or are approved with support or subject to conditions, NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2015.

4.5. As set out above, NHS England has the ability to direct use of the fund where an area fails to meet one of the Better Care Fund conditions. This includes the requirement to develop a plan approved by NHS England and Ministers. If a local plan cannot be agreed, any proposal to direct use of the fund and / or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DH and DCLG Ministers (as required under the 2015/16 NHS Mandate).

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

[4] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-nat-ass-methodology.pdf

5. Payment for Performance and National Performance Metrics

5.1. Of the £3.46 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.46 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan with no additional conditions. However, the remaining £1 billion of Clinical Commissioning Groups Better Care Fund allocation will be subject to a 'payment for performance' framework agreed by Ministers. The full detail of the framework is set out in the *Better Care Fund – Revised Planning Guidance* published on 25 July 2014. In summary:

- Each area will set a target for a reduction in total emergency admissions, with a quarterly profile. The baseline for the target will be actual performance from Quarter 4 2013/14 to Quarter 3 2014/15. The target will be performance for the period Quarter 4 2014/15 to Quarter 3 2015/16.

- The guideline national ambition will be for a reduction of at least 3.5%. However, local targets will be discussed and agreed locally, in line with the *Supplementary Guidance on the Expectation of a 3.5% Reduction in Emergency Admissions*[5] published on 20 August 2014.

- A proportion of each area's share of the £1 billion performance pot will be paid (on a quarterly basis) for achievement of this target. That proportion will be based on the savings which would result from the target reduction in admissions.

- Where a quarterly target is met, the relevant performance-linked money will be available to the local area to spend in accordance with the agreed BCF plan. If the target is not met, an amount of the funding (directly proportional to the extent to which the target has not been met) will be spent by the CCG(s), in consultation with the Health and Wellbeing Board.

- The 'balance' of an area's share of the £1 billion (i.e. the amount not linked to the achievement of the admissions target) will be available upfront to the pooled budget but must be spent on NHS-commissioned out-of-hospital services (including joint services), according to plans agreed locally by the Health and Wellbeing Board.

5.2. NHS England will oversee and implement the agreed payment for performance framework, using their powers in the NHS Act 2006 to direct the use of funding where specified conditions have not been met. As set out above, NHS England will consult Ministers in the use of these powers. This will include both:

- The release of funding where targets have been met
- Any direction to a Clinical Commissioning Group to spend the money in consultation with the Health and Wellbeing Board where targets have not been met

5.3. Local areas will also be asked to set targets against five other key metrics:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient / service user experience
- A locally-proposed metric

[5] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-supp-guidance-3-5.pdf

5.4. These metrics will not be linked to the payment for performance funding, but areas will be expected to set and deliver ambitious but realistic targets for improvement. The detailed definitions of these additional metrics are set out in the *Better Care Fund – Revised technical guidance (version 2 – August 2014)*[6].

[6] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

6. Implementation in 2015/16

6.1. The implementation of local Better Care Fund plans will formally begin from 1 April 2015. As part of its wider planning process, NHS England will develop and publish its 2015/16 Business Plan in the lead up to 2015/16. This will set out the actions and specific deliverables that NHS England will take forward to deliver the objectives set out in the NHS Mandate – including those relating to the integration of health and social care and implementation of the Better Care Fund.

6.2. In developing these detailed deliverables, NHS England will consult with the Department of Health, Department for Communities and Local Government, and the Local Government Association, to ensure these reflect shared ambitions for the Better Care Fund. While the detail will be developed as part of the NHS England Business Planning process, it is expected that it will include specific actions in relation to:

- Providing continuing support to local areas to ensure effective implementation of agreed plans
- Identifying and breaking down barriers to service integration
- Promoting and communicating the benefits of health and social care integration
- Monitoring the ongoing success of the Better Care Fund – including delivery against key metrics
- Implementing the agreed payment for performance framework
- Preparation as necessary for implementation from 2016/17

DEPARTMENT OF HEALTH
DEPARTMENT FOR COMMUNITIES AND LOCAL GOVERNMENT

ANNEX A
DETAILED DEFINITIONS OF NATIONAL CONDITIONS

CONDITION	DEFINITION
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.