Technical Guidance Annex 4:

Better Care Fund Planning Requirements for 2016-17

February 2016

NHS England Publications Gateway Reference 04437

CONTENTS

INTRODUCTION

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund in 2016-17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England. This forms part of the NHS Mandate for 2016-17 to 2017-18. It requires NHS England to issue further detailed guidance to local areas on developing Better Care Fund (BCF) plans for 2016-17.

2. For 2016-17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process. This guidance, which has been developed in conjunction with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), is therefore included here as an annex to the core NHS planning guidance for 2016-17. This does not diminish the requirement for plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards. This guidance is also being disseminated directly to local authorities via the Local Government Association.

3. The policy framework signals the need for stability in 2016-17, and a reduction in the overall planning and assurance requirements on local areas. This includes a shorter narrative plan requirement, reduced detailed requirements on the scheme level data, and for plan assurance to be owned by NHS England and local government regional teams, rather than through the national assurance and resubmission process that existed for 2015-16.

4. Whilst the policy framework remains broadly stable in 2016-17, local areas should be mindful in developing their plans about the linkages with NHS sustainability and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

POLICY REQUIREMENTS

5. The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2016-17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

    i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

[1] https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

iv. Better data sharing between health and social care, based on the NHS number;

v. 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;

vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

vii. That a 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

viii. Agreement on a local action plan to reduce delayed transfers of care.

6. Conditions i - vi, above are based on policy set out in the 2013 Spending Review and were included in the 2015-16 BCF framework. They have been updated to reflect further policy developments and the 2015 Spending Review.

7. New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. We expect a similar local performance element will be deployed other than in those local areas that delivered their emergency admission reductions in 2015-16 and are confident that this can be repeated in 2016-17.Condition viii is also a new national condition for 2016-17. The details of each of the conditions are set out in the new policy framework.

PLANNING REQUIREMENTS

8. Local partners will need to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The process for developing plans will be simplified from the approach used for 2015-16 plans and will be aligned to the timetable for developing CCG operational plans. All national partners have agreed to minimise the amount of information that is collected and assured nationally as part of this process. In developing BCF plans for 2016-17 local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board (HWB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;

ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

iii. A scheme level spending plan demonstrating how the fund will be spent;

iv. Quarterly plan figures for the national metrics.

9. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Metrics	Submitted through UNIFY and through a nationally developed high level BCF template return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process

These will be the only planning requirements for the Better Care Fund in 2016-17.

NARRATIVE PLANS

10. There will not be a 'Nationally Consistent Assurance Review' of BCF plans for 2016-17 and therefore no national assessment of narrative plans. Local partners are still required to have in place a shared HWB level plan for integrating health and social care services through the BCF. This should build on approved plans for 2015-16 and demonstrate that local partners have reviewed progress in the first year of the BCF as the basis for developing plans for 2016-17. High level narrative plans produced for 2016-17 will therefore be expected to demonstrate incremental changes to 2015-16 plans reflecting this review of progress. As part of its assurance of CCG plans, NHS England will review BCF plans to ensure the appropriate use of risk management arrangements in the context of the BCF Condition 7.

11. In building on current BCF plans, the high level narrative plans that will need to be produced will also need to demonstrate that local partners have collectively agreed the following:

i. The local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016-17 plays in that context;

ii. An evidence base supporting the case for change;

iii. A coordinated and integrated plan of action for delivering that change;

iv. A clear articulation of how they plan to meet each national condition; and

v. An agreed approach to financial risk sharing and contingency.

12. In all cases these elements can be demonstrated and referenced from existing plans or initiatives, including refreshed 2015-16 BCF plans. There will not be a need to restate information that is already satisfactorily provided in existing plans. This does not diminish the need for local areas to develop plans together and publish them in line with the requirements of their respective organisations.

13. In addition to the national condition relating to improving data sharing (see below), narrative plans are expected to demonstrate how digital or information technology is being established as an instrumental enabler to the delivery of integration, with reference to the Five Year Forward View and Personalised Health and Care 2020[2]. 90 communities have so far come together to create local digital roadmaps, with CCGs and local authorities included in each one. Where these are in place they should be referenced within BCF plans; where they are not it is expected that BCF plans will include a reference to their development. This recognises that integrated planning and delivery of the enabling information technology (including access to integrated digital records) is a vital part of the infrastructure to support improved operational performance on a number of areas that are a core focus of the BCF. These include reducing unnecessary non-elective admissions, seven day-a-week out-of-hospital services, and timely discharge.

CONFIRMATION OF FUNDING CONTRIBUTION

14. NHS England has published individual HWB level allocations of the BCF for 2016-17, and the detailed formulae used, on its website.[3] This builds upon confirmation of each CCG's contributions to the BCF in 2016-17 which is included in the core CCG allocations, also published on the NHS England website.[4]

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

[2] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/ and https://www.gov.uk/government/publications/personalised-health-and-care-2020
[3] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[4] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

Disabled Facilities Grant

16. Following the approach taken in 2015-16, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. In 2016-17, the housing element has been strengthened through the National Conditions, which require local housing authority representatives to be involved in developing and agreeing BCF plans. Again, following the approach taken in 2015-16, the DFG will be paid to upper-tier authorities in 2016-17. 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 its 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.

Care Act 2014 Monies

17. As described in the Policy Framework, the BCF allocation to CCGs includes £138m to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal family carers will be supported by local authorities and the NHS. This funding is not new but has been uplifted from the £135m made available through the BCF in 2015-16 for a broader set of duties around the Care Act – this has been simplified to focus mainly on carer support. Further guidance and details of the exact breakdown will be set out in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

Former Carers' Break Funding

18. The BCF also includes, as in 2015-16, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care).

Reablement Funding

19. The Better Care Fund also includes, as in 2015-16, £300m of NHS funding to maintain current reablement capacity in councils, community health services, the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

NATIONAL CONDITIONS

20. Local partners will be required to articulate a plan for meeting each national condition, as set out in the BCF policy framework and operationalised by the guidance contained in this document, through their BCF narrative plan. This

should include clear links to other relevant programmes or streams of work in place locally to deliver on these priorities. It is expected that local areas will want to provide more detailed plans for the new conditions in 2016-17. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning return.

21. The two new national conditions and the conditions on 'Better data sharing between health and social care, based on the NHS number' and 'Maintain provision of social care services' should be read in conjunction with the additional guidance as set out in paragraphs 23 –34 below.

22. Confirmation that BCF plans meet the eight national conditions will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

FURTHER GUIDANCE ON NATIONAL CONDITIONS

Maintain provision of social care services

23. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition to maintain provision of social care services.

24. In setting the level of protection for social care localities should ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through NHS England's regional assurance process.

25. It should also 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"

Better data sharing between health and social care, based on the NHS number

26. At the present time the HSCIC is not extending the NHS Number batch service to additional local authorities. We understand that for some local authorities this will be causing difficulties in meeting the condition set out in the BCF to use the NHS Number as an identifier across the health and care system. We are working closely together to resolve the issue at a national level. If a locality is currently unable to obtain the NHS Number from the HSCIC then this should be noted in the BCF plan and it will be taken into account when assessing the plan.

Agreement to invest in NHS commissioned out-of-hospital services

27. The BCF Policy Framework establishes that £1 billion of the CCG contribution to the Fund required to deliver investment to the NHS and previously linked to the performance framework will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, whilst supporting local integration aims. Each

CCG's share of this funding will be set out in allocations and will need to be spent as set out in the new national condition.

28. Local areas should agree how they will use their share of the £1 billion that had previously been used to create the national payment for performance element of the fund. This should be achieved in one of the following ways:

    - To fund NHS commissioned out-of-hospital services, that demonstrably lead to off-setting reductions in other NHS costs against the 2014-15 baseline; or

    - Local areas that did not meet their 2015-16 emergency admission reduction goals are expected to consider putting an appropriate proportion of their share of the ring-fenced £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2015-16).

29. Specifically, where local areas successfully delivered their agreed 2015-16 emergency admission reductions and all partners are confident that the 2016-17 BCF plan can meet its objectives then they can choose to invest the full element of the £1bn linked to NHS-commissioned out-of-hospital services upfront. This could include a wide range of services, to be determined locally. CCGs and Councils should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan.

30. However, where the local partners recognise a significant degree of risk associated with the delivery of their 2016-17 BCF plan, for example where emergency admission reductions targets were consistently not met in 2015-16, we expect them to consider using a local risk sharing agreement, given that 'the same pound cannot be spent twice' – on emergency admissions *and* on NHS-commissioned out-of-hospital activity at the same time.

31. Where local partners agree to use a risk share agreement the default approach should be to base this on the 2015-16 approach, as set out at **Appendix 2**. However, we are open to other local approaches that demonstrably achieve the same objective. The key point is that BCF investment does not cause a CCG to over extend itself in financial terms and hence put the financial balance of the health economy at risk.

32. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced £1 billion fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS Commissioned out-of-hospital services from the spending plan. There is also an opportunity to confirm the value of additional funds that are part of appropriate risk sharing arrangements. Further details on this are set out in the guidance section of the return template.

Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

33. In planning to meet this condition all areas should consider their performance in relation to DTOC (and patient flow) and work together to develop a proportionate plan to improve their position. The key elements that local areas should include in their action plan are set out below. These are drawn from existing best practice approaches and available mechanisms for managing effective transfers and delays, rather than introducing new ones.

- **Situation Analysis**
  In order to ensure that the plan developed is proportionate to address the local situation partners should review their current performance and assess the level of opportunity within the system for reducing delays and improving transfers. This should include:
    - Detailed analysis of current performance levels (including trend analysis) and the causes of delays;
    - An assessment of current schemes in place to reduce delays and improve transfers of care and how effective these are;
    - A gap analysis comparing local measures to the best practice interventions (see below);
    - A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate.

- **Target and Action Plan**
  In developing their plan, local partners are expected to agree a target for reducing DTOC that is realistic but ambitious. There should be a clear articulation of how the target has been set, with reference to the situation analysis. The DTOC target and CCG planning assumption should be in alignment and include a trajectory for reducing the number of delays. The target should be underpinned by a set of clear actions to deliver improvement that builds both on successful local initiatives and on the nationally agreed best practice interventions. In addition, areas may also want to consider other metrics which monitor patient flow (such as average length of stay) at a local level. There are a number of metrics being used locally by the Emergency Care Improvement Programme (ECIP) which can be shared.

  Information about the best practice interventions can be found on the Local Government Association's website at http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/5516287/ARTICLE#impact-change or on the Better Care Exchange at https://bettercare.tibbr.com/tibbr/

- **Accountability Arrangements**
  All actions need to be clearly owned, so the plan should set out lines of responsibility and accountability for delivering each element of the plan, as well as an agreed process for local assurance and escalation where any issue cannot readily be resolved.

- **Using Local Capacity**
  Local partners are encouraged to include an analysis of their local capacity and requirements in their plans and to set out how that capacity can best be used across health and social care to minimise delays and meet evolving

need. A joint commissioning approach between health and care is encouraged. In capacity mapping and planning, local areas will need to consider the long-term sustainability of the market for both health and social care.

Many areas already recognise the role that the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital. Local plans can consider explicitly how this sector can contribute to reductions in DTOC. Areas should consider whether other local stakeholders, such as housing providers, have a role to play in efforts to reduce delays.

- **Additional measures**
  As set out above, areas should consider as part of the situation analysis and the development of an action plan, what measures are proportionate to address local levels of performance. Where DTOC are high and rising, or there are significant issues with patient flow across the health and care system, local areas should demonstrate how they have considered all options for addressing this, including the potential use of risk sharing arrangements and broader incentives within the system.

  A local CQUIN has also been included in the NHS contract for 2016-17 which provides a mechanism for local areas to reward improvement in the proportion of patients discharged to their usual place of residence within 7 days of admission.

  If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care. These arrangements are explained in the Care and Support Statutory Guidance and reiterated in NHS England's Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance[5].

  Local areas may decide that they want to use wider mechanisms as part of a risk sharing mechanism and have the flexibility to do so. In doing so, local areas should ensure that their approach takes into account the legal framework on payments set out in the Care Act and that they are content that they are not acting in any way which goes against current legislation.[6]

  In considering the use of reimbursement under the Care Act and wider risk sharing mechanisms, local areas should agree collectively on the approach and assure themselves that it will lead to resources being spent in the best interest of the local population and with a positive impact on the performance of the local health and care system.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf and https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

[6] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm and http://www.legislation.gov.uk/allTheCareandSupportDischargeofHospitalPatientsRegulations2014

SCHEME LEVEL SPENDING PLAN

34. A scheme level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:
    - Area of spend
    - Scheme type
    - Commissioner type
    - Provider type
    - Funding source
    - Total 15-16 investment (if existing scheme)
    - Total 16-17 investment.

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

NATIONAL METRICS

36. The BCF Policy Framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2015-16, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and care homes[7];
    c. Effectiveness of reablement;
    d. Delayed transfers of care.

37. The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions[8]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in first draft CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

38. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, should be clearly identified in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved, and, in any case, the emergency admissions baseline for 2016-17 must not be set any higher than the BCF stretch ambitions used in 2015-16. This is because 'the same pound cannot be spent twice', so if emergency admissions were not prevented in 2015-16 then the funding will have had to be used to reimburse

[7] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.
[8] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

hospitals for their emergency admissions.

39. The detailed definitions of the other three metrics are set out at the end of this document. HWBs will be required to set ambitious plans in relation to each metric. The national condition on DToC sets out further requirements in relation to setting targets for that metric.

40. Information on all four metrics will continue to be collected nationally. The below table sets out a summary of the information required and where this will be collected:

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2016-17, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 targets.
Admissions to residential and care homes;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Effectiveness of reablement;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Delayed transfers of care;	• Collected through nationally developed high level BCF Planning Return	Quarterly target for 2016-17

Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

41. In addition the requirement for BCF plans to include a locally determined metric and a locally determined patient experience metric is again included within the requirements of the BCF planning return. It is expected that local areas will continue to use measures that allow them to effectively track the implementation of integrated care locally.

42. Work to establish a set of new integration metrics continues to be led by the Department of Health. Information collected on a number of potential new measures through the BCF quarter 2 reporting return will help inform that process. The new measures will not be used as part of the BCF framework for 2016-17. Work will continue through 2016-17 to develop them further.

LOCAL PLAN DEVELOPMENT, SIGN OFF AND ASSURANCE

43. Local partners are expected to continue working together to develop a joint, HWB level plan for integrating health and social care services. These should continue to build on plans delivered in 2015-16, and also look forward to longer

term strategic plans. There may be flexibility for devolution sites to submit plans over a larger footprint if appropriate.

44. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Information on planning support requirements collected through the BCF Q2 quarterly returns will also be used to develop further planning specific support. A self-assessment process is also being conducted as part of the main NHS planning approach to identify areas which feel they need more targeted support.

45. The first stage of the overall assurance of plans will be local sign-off by the relevant local authority and CCG(s). In line with the NHS operational planning assurance process, plans will then be subject to regional assurance and moderation. Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an areas plan being proportionate to the perceived level of risk in a system.

46. BCF plans will be submitted and assured through the following steps:-

- The first submission will be of the high level BCF Planning Return only, detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.
- Then brief narrative plans will be submitted to regional teams from HWBs, setting out how the plan will meet the national conditions and the other planning requirements.
- At the same point HWB partners will be required to submit a second version of the completed BCF Planning Return.
- CCGs will also be submitting further versions of their operational planning returns during this period, using central UNIFY and Finance return templates. This will include some of the same data – including funding contributions and NEA figures. There will be a national reconciliation process to ensure the data provided matches in all cases.
- The assurance process, including reconciling any data issues, will happen within NHS England's Directors of Commissioning Operations' (DCO) teams, in alignment with the process for reviewing CCG operating plans. Better Care Managers will work with these teams to ensure they have the knowledge and capacity required to review and assure BCF plans. A set of consistent 'Key Lines Of Enquiry (KLOE) will be produced to support the assurance process and will be available to local areas as a guide in developing plans.
- The assurance process will check specifically that the requirements of Condition 7 have been satisfied, i.e. that planned investment in the Better Care Fund is affordable to CCGs, and contains adequate performance/risk management schemes in respect of emergency hospital admissions.

- To support this, local government regional leads for the BCF (LGA lead CEOs and ADASS chairs) will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation) and will be consulted by DCO teams when making recommendations about plan approval;
- As part of that regional moderation process an assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Authority, Monitor and local government;
- These judgements on 'plan development' and 'risks to delivery' will help inform the placing of plans by NHS England into three categories – 'Approved', 'Approved with support', 'Not approved'. The next steps for a HWB whose plan is placed within each category are set out below:
    - Approved – proceed with implementation in line with plans;
    - Approved with support – proceed with implementation with some ongoing support from regional teams to address specific issues relating to 'plan development' and / or 'risks to delivery';
    - Not Approved – do not proceed with implementation. Work with the NHS England DCO team, Better Care Manager and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

47. The overall assurance process is illustrated in the schematic at **Appendix 3**.

NATIONAL ASSURANCE AND PLAN APPROVAL

48. There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

49. In accordance with the legal framework set out in section 223GA of the NHS Act 2006, final decisions on approval will be made by NHS England in consultation with DH and DCLG. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

50. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and / or impose a spending plan on a local area, and the content of any imposed plan, will be

subject to consultation with DH and DCLG (as required under the 2016-17 NHS Mandate), with the decision then taken by NHS England.

HIGH LEVEL TIMETABLE

51. The submission and assurance process will follow the following timetable:

NHS Planning Guidance for 2016-17 issued	22 December 2015
Technical Annexes to the planning guidance issued,	19 January 2016
BCF Planning Requirements; Planning Return template, BCF Allocations published	February 2016
First BCF submission (following CCG Operating Plan submission on 8 Feb), agreed by CCGs and local authorities, to consist of: • BCF planning return only All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	2 March 2016
Assurance of CCG Operating Plans and BCF plans	March 2016
Second submission following assurance and feedback, to consist of: • Revised BCF planning return • High level narrative plan All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

52. This timetable should be read alongside the timetable of page 16 of the NHS shared planning guidance.[9]

STATUTORY FRAMEWORK AND ALLOCATIONS[10]

53. 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.

54. Under the NHS Mandate for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to CCGs to establish the BCF. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

[9] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
[10] As set out in the policy framework for the BCF in 2016-17: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

55. Of the £3.519 billion BCF allocation to CCGs, £2.519 billion will be available upfront to HWBs to be spent in accordance with the local BCF plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to the requirement of the new national condition vii set out in paras 27 to 32 above.

56. Within the BCF allocation to CCGs is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in paragraphs 14-19 above.

57. For 2016-17, the allocations have been based on a mixture of the CCG allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund. Full HWB level allocations have been published on the NHS England website.[11]

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

APPENDIX 1- SPECIFICATION OF BETTER CARE FUND METRICS

Metric 1: Non-Elective Admissions (General and Acute)

The baseline for measurement continues to be 2014-15, as incorporated into the local 2015-16 targets.

The definition of this metric is published as part of the technical definitions for NHS planning in 2016-17, which can be found here:

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

Metric 2: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Annual (collected Apr-March) Timing: Final data for 2014-15 was published in October 2015 Baseline: This will be 2014-15 data as published by the HSCIC (note that for the published data the 2014, not the 2015 ONS population estimate has been used for the population denominator)

Historic	Data first collected 2014-15 following a change to the data source. The transition from ASC-CAR to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was re-defined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population."

Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016)

Reporting schedule for data source	Frequency: Annual (although based on 2x3 months data – see definition above) Timing: Final data for 2014-15 was published in October 2015 Baseline: This should be 2014-15 data as published by the HSCIC.
Historic	Data first collected 2011-12 (currently four years data final available (2011-12, 2012-13, 2013-14 and 2014-15)

Metric 4: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.
Definition	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Numerator collected monthly (aggregated to quarters for monitoring). (Denominator annual) Timing: 2 month lag. Baseline: 2014/15 quarterly rates
Historic	Data first collected Aug 2010

APPENDIX 2 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. Paragraph 30 sets 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 2016-17. Where this is the case the arrangements should be described within narrative plans in line with the requirements set out in paragraph 31 to include an agreed approach to financial risk sharing and contingency.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. Further guidance on how to complete this is included within the guidance tab of the template itself.

3. As a minimum, a risk sharing arrangement that is put in place in this way should:

    a) Create a maximum risk share fund which is equal to the value of non-elective admissions that original BCF plans aimed to avoid.

    The reference point below which reductions can be credited to the BCF is the LOWER of the 14/15 outturn used as the baseline for 15-16 BCF plans, or the activity levels included in CCG Operating Plans for 16-17 after accounting for efficiency measures to reduce non-elective admissions (but before adjusting for the impact of actions taken in the context of 16-17 BCF plans). This is how the BCF risk fund meets the principle that "the money follows the patient" and "the same pound can't be spent twice" – on the emergency admission not avoided, and on other services.

    b) Ensure the value of this fund is withheld by CCGs from their BCF allocation which is paid into the pooled budget at the beginning of the year (recognising that CCG allocations have been set to take account of a number of efficiency measures to reduce non elective admissions which will need to be taken account of when setting the baseline against which the impact of BCF initiatives will be measured);

    c) Make payments into the pooled fund on a quarterly basis equivalent to the value of admissions avoided, up to the maximum risk share fund;

    d) Ensure that unreleased funds are retained by the CCG to cover the cost of additional non-elective activity.

4. 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.

5. In addition to this specific guidance, the assurance of overall risk sharing arrangements and contingency plans will look at the management of risk in each plan, with reference to key metrics. This will be consistent with the approach set out in guidance for 2015-16, focusing on whether each plan includes:

a) A quantified pooled funding amount that is ‘at risk’;

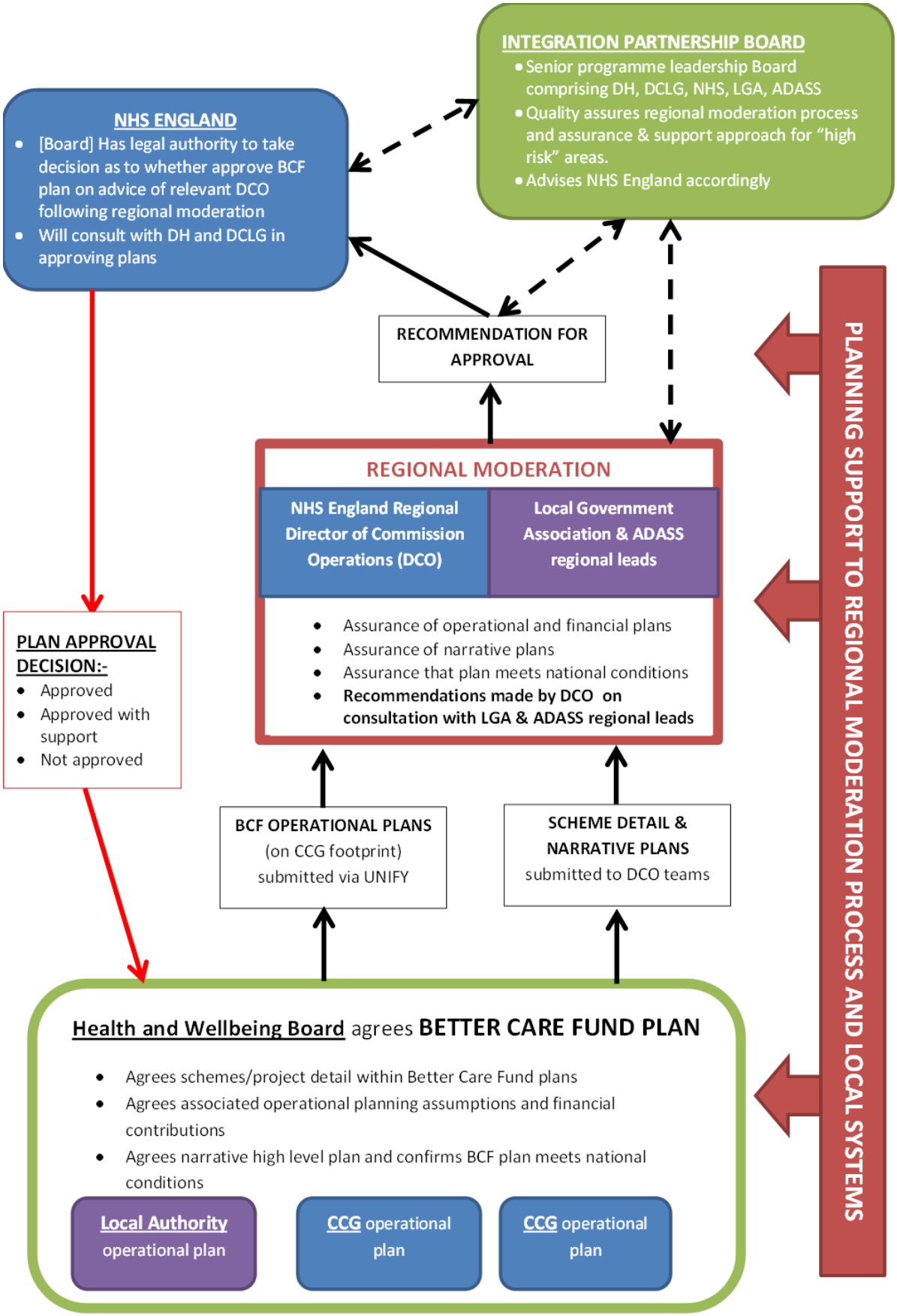
b) Demonstration that this has been calculated using clear analytics and modelling;

c) An articulation of any other risks associated with not meeting BCF targets Non-Elective Admissions and Delayed Transfers Of Care in 2016-17;

d) An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements;

e) An articulation of the proportion of the financial risk will be borne by each party, and how these are reflected in contracting and payment arrangements.

APPENDIX 3 - ASSURANCE DIAGRAM



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