NHS England Publications Gateway Reference 03001

Department of Health | Department for Communities and Local Government | Local Government Association | NHS England

Better Care Fund Task Force

Better Care Fund:

Guidance for the Operationalisation of the BCF in 2015-16

The Better Care Fund

Contents

PURPOSE

1. This document provides local partners to Better Care Fund plans – Clinical Commissioning Groups (CCGs), Local Authorities (LAs), and Health and Wellbeing Boards (HWBs) – with guidance on the operationalisation of these plans in 2015-16.

2. In particular it sets out:
    - the Care Act legislation underpinning the BCF;
    - the accountability arrangements and flows of funding;
    - the reporting and monitoring requirements for 15-16;
    - arrangements for the operation of the payment for performance framework;
    - how progress against plans will be managed and what the escalation process will look like; and
    - the role of the BCF Task Force / Better Care Support Team going forward.

3. There are a number of annexes that this document should be read alongside, as well as the policy framework[1] for the fund, published by the Department of Health (DH) and Department of Communities and Local Government (DCLG).

4. This guidance has been co-developed across the national organisations on the BCF Task Force with input from Local Authorities and Clinical Commissioning Groups.

LEGAL POWERS FROM THE CARE ACT (2014)

5. Under s.223G of the NHS Act 2006 (as amended most recently by the Care Act 2014), NHS England has the power to set conditions around the payment of funds to CCGs. In relation to the BCF allocation, section 223GA states that this must include a condition that funds are paid into a section 75 pooled fund, and may include (but is not limited to) conditions relating to:

    - the preparation and agreement of a spending plan by the CCG(s) and local authority party to the pooled fund;
    - the approval of the plan by NHS England;
    - the inclusion of performance objectives in a spending plan – i.e. the non-elective admissions reduction target; and
    - the meeting of any performance objectives included in a spending plan or specified by NHS England – i.e. payment proportional to performance as per the BCF Technical Guidance.

6. Where a condition is not met, s.223GA of the NHS Act 2006 (as amended most recently by the Care Act 2014) enables NHS England to:
    - ***withhold the payment*** (insofar as it has not been made);
    - ***recover the payment*** (insofar as it has been made);

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf

- ***direct the CCG(s) as to the use*** of the designated amount for purposes relating to service integration or for making payments under s.256 of the 2006 Act.

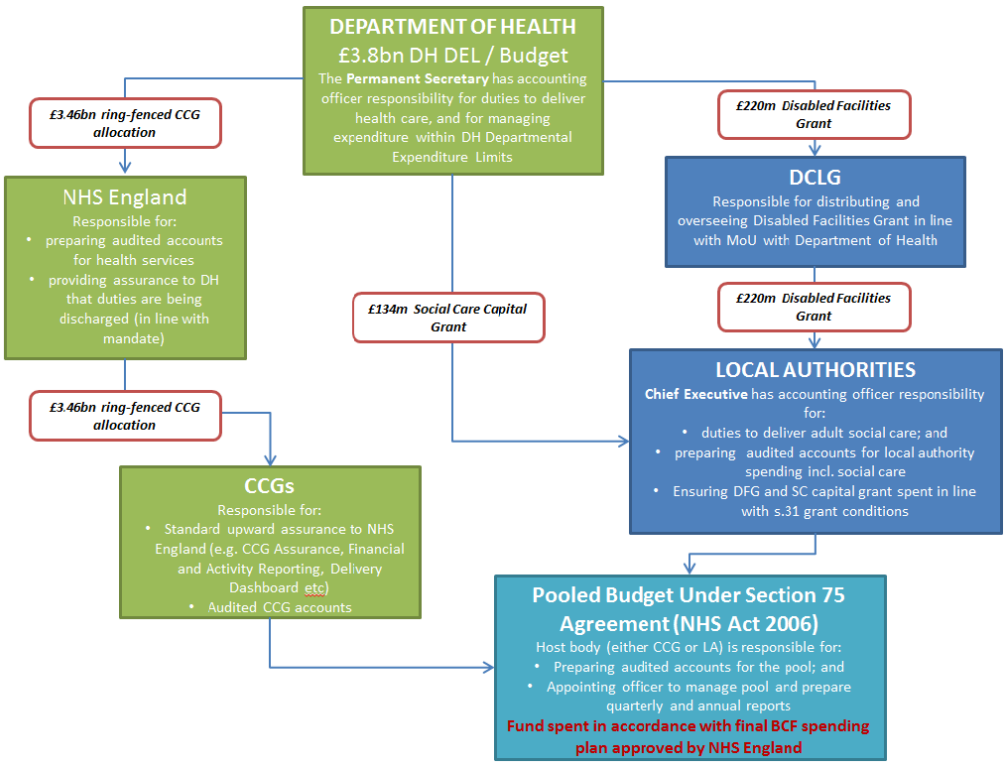
7. The three powers of intervention set out above where a condition is not met apply to the £3.46bn of the BCF that is being routed through CCGs. The powers do not apply to the remaining £354m (social care capital grant and disabled facilities grant) which will be paid by DH and DCLG directly to local authorities under s.31 of the Local Government Act 2003.

8. These powers are only triggered once the Secretary of State for Health uses his powers to include in the mandate a requirement for NHS England to ring-fence some of its funding to fund integration. The mandate for 15/16 was published on 11 December 2014 with the relevant requirements around the BCF.

9. The mandate requires that NHS England consult with the Department of Health and Department for Communities and Local Government before exercising its powers in relation to the failure to meet specified conditions.

ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 15-16

10. One of the recommendations of the 2014 NAO report[2] on the BCF was to develop clear accountability structures for the fund, including how accounting officers will gain assurance on how local areas spend the Fund. Below is a diagram setting out the accountability arrangements and flow of funding for the BCF.



[2] http://www.nao.org.uk/wp-content/uploads/2014/11/Planning-for-the-better-care-fund.pdf

11. In summary, at national level:
    - the full £3.8bn of funding will be part of DH's budget so overall accountability to Parliament will sit with the DH Permanent Secretary;
    - DCLG will retain policy responsibility for the Disabled Facilities Grant (DFG);
    - the NHS England Accounting Officer is accountable for the effective use of the £3.46bn of the fund which constitutes revenue grant;
    - the £3.46bn will pass from NHS England to CCGs through 15/16 allocations, and then from CCGs to pooled budgets (via section 75 agreements);
    - the capital grant monies will flow directly to LAs (from DH for the £134m Adult Social Care Capital Grant and from DH to DCLG and then to LAs for the £220m DFG), and then into the pooled budget via s.75; and
    - the monies will then be spent on services in line with their approved BCF plan.

12. At local level:
    - CCGs (Accountable Officers) will be the accountable body for their share of the £3.46bn of the BCF allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - local authorities (s.151 officers) will be the accountable body, under the terms of their grant agreements, for the £354m of funding that is paid directly to them by DH and DCLG (and any additional monies they plan to voluntarily add to the pooled fund).

13. At a local level, as legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the fund in accordance with the approved plan. At present these tasks cannot be delegated by them to the HWB. However, local authorities may be able to delegate such tasks to the HWB in the future as new regulations broadening the role of HWBs are being consulted upon[3]. LAs should check the DCLG website for progress.

14. HWBs are a valuable forum for stakeholders to come together to review performance of the BCF and consider future work. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners. Given they are a committee of the LA, HWBs are accountable to the LA and ultimately to the LA's electorate. HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with[4]. Particularly where members of a HWB include providers delivering care that is or could be commissioned under BCF, care will need to be taken to ensure that any conflicts of interest are appropriately dealt with.

[3] https://www.gov.uk/government/consultations/proposed-local-authorities-functions-and-responsibilities-england-regulations-2015

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

15. In terms of operational oversight of the BCF, the regulations[5] governing s.75 agreements require the agreement to set out (amongst other provisions):
    - the arrangements for monitoring the delivery of the services that it covers;
    - who the "host" organisation is that will be responsible for accounting and audit; and
    - who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

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

17. The BCF Task Force released guidance and support[6] for local areas in developing their local s.75 agreements in September which included a template s.75 agreement accompanied by an explanatory memorandum. The explanatory memorandum provides support for local areas considering their local governance and oversight arrangements. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that are signatories to the agreement. Each of those signatories should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

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

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

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

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

REPORTING AND MONITORING IN 15-16

20. The BCF will be embedded into business as usual processes in NHS England for planning, performance monitoring, assurance, and performance management[7] as far as possible. However, on the most part, this will be at CCG level rather than HWB level.

21. As previously agreed, and reflected in the assurance outcome letters, every CCG will have the following standard conditions on its BCF funding using powers under s.223G of the NHS Act 2006:
    - The fund being used in accordance with their final approved plan and through a section 75 pooled budget agreement; and
    - The full value of the element of the fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[8]. 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.

22. As part of the enforcement of the first condition, NHS England can require CCGs to:
    - explain the governance arrangements they have in place; and
    - report on spending and provide evidence that it has been spent in a particular way (in accordance with their approved plan).

23. As part of the enforcement of the payment for performance condition, NHS England can require CCGs to report on their non-elective admissions, how much money has been released into the pooled fund, and if any element has been held back (in accordance with the technical guidance) what that has been spent on. Contained in annex 1 is a summary of the guidance, including information on the baseline, data source, and dates of performance and related payment. ***This information should be included in the quarterly reports and annual reports, and the s. 75 agreement should require it.***

24. The size of the final Payment for Performance pot linked to the non-elective admissions reduction ambition is likely to change from the figures reported in October in the NCAR meta-analysis[9] for the following reasons:
    - Updated baseline data to reflect actual performance for Q1-3 in 14/15, and any changes to Q4 2013/14 figures resulting from 12 month routine data revisions in MAR (Monthly Activity Return);

[7] Such as: NHS England Board Performance Report, Regional Operations and Delivery Directors report, Delivery Dashboard, Finance and Activity Report, CCG Assurance Framework

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

[9] http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf

- areas who were 'approved with support', 'approved subject to conditions' or 'not approved' may have had an action on the back of their NCAR review requiring them to resubmit a revised plan with an amended non-elective admissions ambition; and
- any changes to targets agreed and approved in line with the further guidance on alignment of BCF targets with operational plan targets set out in the Payment for Performance section below.

25. An analytical tool has been published on the Better Care Fund webpage, which aims to support areas understand the impact of the revised baseline on their non-elective admissions plan, the resulting impact on the size of the payment for performance pot, and therefore the balancing minimum required amount to be invested in NHS commissioned out of hospital services. The tool will also help areas considering reviewing their BCF non-elective admissions target as part of the NHS operational planning process.

26. If there are any disputes locally between CCG(s) and LA(s) regarding the non-elective admission ambition and payment for performance, this should be managed locally and you should refer to your risk sharing agreement agreed as part of your BCF plan. If the dispute cannot be resolved locally, please then refer to your relevant NHS England sub-region, and Local Government regional peers for assistance. If there are any disagreements on data issues, this should be handled through the usual MAR revisions process.

27. The Better Care Fund Task Force has produced standard reports that will fulfil both local reporting obligations and the minimum national reporting obligations against the key requirements and conditions of the Fund. The standard reports aim to fulfil both the quarterly reporting and annual reporting requirements referred to earlier in this guidance document under the s.75 regulations. Using the standardised reports ensures there is a mechanism in place to monitor the totality of the fund at HWB level, i.e. the planning footprint of the BCF.

28. ***The joint BCF Task Force ask CCGs and LAs to use the quarterly reporting template (example contained in annex 2), as well as an annual reporting template which is currently in development and will be released in due course. The template covers reporting on: income and expenditure, payment for performance, the supporting metrics, and the national conditions. It is suggested that these reports are discussed and signed-off by HWBs given their lead role in the BCF as part of discharging their duty under s.195 of the Health and Social Care Act (2012) to encourage commissioners to provide health and social care services in an integrated manner***[10]. ***Furthermore, NHS England recommends to CCGs that this approach is built into their local s.75 agreements, and require CCGs to report back on this which should also include confirmation that the HWB has signed it off.***

[10] Section 95 of the Health & Social Care Act 2012

29. The draft Year-End reporting guidance and an annual report template is in development across NHS England and LGA, and will build on the quarterly reporting. There are some outstanding queries around accounting and audit being worked through before these can be finalised and issued. Once finalised the template and guidance will be available on the Better Care Fund webpage.

PAYMENT FOR PERFORMANCE

30. As detailed in the quarterly reporting template and guidance in annex 1, the reports are due for submission at 5 points in the year:

    - 29 May 2015 – for the period January to March 2015
    - 28 August 2015 – for the period April to June 2015
    - 27 November 2015 – for the period July to September 2015
    - 26 February 2016 – for the period October – December 2015
    - 27 May 2016 – for the period January – March 2016

31. The reason the reporting commences from January 2015, is due to the baseline for the quarterly Payment for Performance schedule, linked to the non-elective admissions ambition. This is detailed in the BCF planning guidance and technical guidance published in the summer of 2014, and summarised in annex 1.

32. We understand that Health and Wellbeing Boards may wish to consider the alignment of BCF targets with the planning assumptions included in final CCG operational plans. In some cases, differences might arise when a broad range of planning factors are taken into account, including:

    - actual performance in the year to date, particularly through the winter;
    - the actual outturn for 2014/15; or
    - progress with contract negotiations with providers.

33. BCF plans should continue to represent ambitious stretch targets that aim to accelerate progress on reducing non-elective admissions. It is therefore expected that the target included in the BCF plan may be higher than operational planning assumptions. A difference between these does not mean that the BCF target needs to be amended.

34. However, Health and Wellbeing Boards may feel that the emergence of large differences begins to affect the credibility of the BCF ambition. In these circumstances they may wish to amend the BCF target to more closely align with the CCG operational plan. If so we expect that:

    - there will be no change to the targets included in BCF plans where these are within 2 percentage points of assumptions in operational plans. For example, where the BCF target is for a 4% reduction in non-elective admissions, provided the operational plan target is for a 2% (or greater) reduction, the BCF target

should not change. In these HWB areas there will be no further central plan review and assurance; and

- where the target in BCF plans is greater than 2 percentage points away from assumptions in operational plans (for example a BCF target of 6% and an operational plan target of 1%), the HWB may, at its discretion, amend the BCF target where it believes this change is required to ensure it remains credible and realistic. Any changes will need to be agreed by the HWB and will be subject to approval by NHS England (in consultation with Ministers).

35. Any review or change to BCF targets around non-elective admissions should be undertaken within the partnership approach underpinning local BCF planning and agreed by the HWB.

36. If, through this process, the planned level of improvement is reduced the HWB must also approve a balancing increase in the amount to be invested in NHS commissioned out-of-hospital services, in line with the BCF planning guidance (unless that level of investment already exceeds the required minimum). Where any balancing increase is necessary, HWBs will need to ensure that this change does not impact on their ability to meet the national BCF conditions, in particular on the protection of social care. NHS England will be seeking assurance on this point as part of the approval process of any proposed changes to BCF targets.

37. The payment for performance element of the Fund will be linked to the performance of local areas in reducing non-elective admissions in line with the trajectory agreed in their BCF plan. This performance element of the Fund will be paid by CCGs into the pooled fund in four quarterly instalments, and payment will be proportionate to actual performance (as per annex 1). The first of these will be made in May 2015, based on performance in the fourth quarter of 2014/15. The first quarterly performance target will continue to be based on the trajectory for improvement set out in the BCF plan approved in October (or approved subsequently for plans initially not approved or approved subject to conditions). Any amendments which are approved to targets as a result of the process set out above will only affect the three remaining quarterly targets.

38. The nominal payment for performance sum will be equivalent to the number of reduced non-elective admissions in the BCF target paid at tariff, and an analytical tool has been published on the Better Care Fund website to help areas calculate the sum (and update the figure following final baseline data and any changes to targets agreed and approved by NHS England as set out above). The actual payment will be dependent on the actual level of reduction achieved.

39. Each CCG will be expected to have budgeted for a payment for performance sum consistent with the operating plan reduction in admissions. Where the BCF plan includes a greater level of reduction, and where this reduction is achieved, CCGs will need to ensure that their contracts are sufficiently sophisticated and granular to

ensure that where the stretch target is achieved, the money is available for payment for performance in line with the BCF plan.

40. Where contracts with acute providers are based on a marginal rate rather than full tariff the source of funding for the resulting payment will be as follows:

- a reduction in payment to acute provider at the agreed marginal rate; and
- the balance to full tariff which is currently withheld by the CCG and used for investment in services to relieve pressure on A&E services by the System Resilience Group (SRG). Any such money must not be committed beyond the date at which it would need to be released into the payment for performance pot unless there is express prior agreement of all parties through the Health and Wellbeing Board that this investment would be deemed a suitable use of the payment for performance pot and as such could continue to be invested in that scheme as part of the performance reward.

BETTER CARE SUPPORT TEAM IN 15-16

41. A joint Better Care Support Team with representation across NHS England, LGA, DH and DCLG will continue into 15-16 and will focus on the below, working through the NHS England and Local Government Regions:

- Supporting local areas with the implementation of their BCF plans;
- Monitoring progress with the delivery of plans through the quarterly and annual reporting processes set out in this document;
- supporting the performance management and escalation processes for the BCF, including the enactment of Care Act powers where relevant; and
- reporting progress to the national BCF Programme Board and Cross-Ministerial Board.

MANAGING PROGRESS AND WHAT THE ESCALATION PROCESS WILL LOOK LIKE

42. Performance management for the BCF will be led by NHS England and the local government regions, with the joint Better Care Support Team providing support and advice. Working with the Better Care Support Team, NHS England and the Local Government regions will monitor progress against plans from the quarterly monitoring process described above, and will determine whether areas are continuing to meet the standard conditions of the Fund as detailed in the BCF plan assurance letters:
    1. That the Fund is pooled under a s.75 agreement
    2. That the Fund is used in accordance with their final approved plan
    3. That they continue to meet the requirements around the payment for performance framework

43. In addition to the standard conditions of the Fund above, the NHS England and Local Government regions will work with the Better Care Support Team to monitor progress around the delivery of the national conditions. The national conditions were a key focus of the Nationally Consistent Assurance Review (NCAR) process. Areas will have been approved on the basis of having a satisfactory plan to achieve the national conditions – as access to the funds was conditional upon the plan satisfactorily meeting the national conditions.

44. If an area fails to meet any of the standard conditions of the Fund, including if the funds are not being spent in accordance with the plan with the result that delivery of the national conditions is jeopardised, the Better Care Support Team may make a recommendation to NHS England that they should initiate an escalation process. The key steps of the escalation process are detailed below – with the main principle being that intervention should be appropriate to the risk identified. The process ultimately leads to the ability for NHS England to use its powers of intervention provided by the Care Act legislation, in consultation with DH and DCLG as the last resort. Note that the quarterly reporting templates allow for any variation in spending from the plan to be explained.

45. The below table sets out the proposed escalation process which will normally be initiated if any of the conditions of the Fund are not met following the return of the quarterly reports. The Better Care Support Team will support this process, making recommendations to NHS England for decision where necessary. The process may be adapted to accommodate local circumstances. Local stakeholders will be notified if this is the case. It may also be updated to reflect learning from experience.

1 – Assurance meeting	The assurance meeting is the opportunity to use national and local insight to drive a discussion about areas of concern. It would be the first formal opportunity to raise concerns. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships via Regions, Area Teams and local government regional peers. The meeting would be an opportunity to discuss the concerns and agree actions and next steps, including whether support is required.
2 – Formal letter and clarification of agreed actions	The CCG(s) will be issued with a letter summarising the assurance meeting and clarifying the next steps agreed, timescales, and how this will be monitored and by whom. If support was requested by the CCG(s), an update on what support will be made available to them will be included. This may be support from regional or national teams.
3 – Regular monitoring of agreed actions	The agreed actions will be monitored by a named point of contact to track progress.
4 – Consideration of intervention options	If it is found that the concern is so deep set or serious (or the agreed actions do not take place satisfactorily) that intervention may be appropriate, then the

	implications of doing so will be considered carefully. The principle must be that the consequences of the intervention action for patients is at the very least no worse than the status quo of not intervening.
5 – Regional and national consistency	It will be important to ensure that peer review is sought through the assurance consistency process to ensure that the rationale for intervention is robust.
6 – Consultation with ministers	NHS England consults with DH and DCLG in accordance with the 2015/16 Mandate
7 – Summary report and directions drafted for committee approval	Finally, the relevant evidence and legal wording needs to be submitted to NHS England's Assurance and Development Committee for consideration. Once approved the documentation, including any directions, will be passed to the Chief Executive for signature.

ANNEXES

Annex 1 – Summary of Payment for Performance Guidance

Annex 2 – Example Quarterly Report Template and Guidance

ANNEX 1 – SUMMARY OF PAYMENT FOR PERFORMANCE GUIDANCE

1. 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 2015/16, 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.

2. Assessments of how suitable the locally set targets are will be made by HWBs and through the NCAR assurance process. Payments will be made in arrears as set out below:
   - May 2015 (based on Q4 2014/15 performance)
   - August 2015 (based on Q1 2015/16 performance)
   - November 2015 (based on Q2 2015/16 performance)
   - February 2016 (based on Q3 2015/16 performance)

3. 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 full-year reduction against the baseline). The relationship between payment and progress toward target will be directly linear (e.g. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target.

4. The steps to calculating the quarterly payment are:

   a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
   b. multiply that by the size of the performance pot available; and
   c. subtract any performance payments made for the year to date.

5. The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

6. Although we are asking areas to plan on the basis of the baseline being actual Q4 13/14 outturn, and planned Q1, Q2, Q3 14/15 outturn, for the purposes of assessing performance in 15/16, for quarters 1-3 in 14/15 areas will be assessed against their actual outturn. Through the technical guidance we asked areas to ensure any financial risk associated with this is managed appropriately and articulated in plans.

7. The data source for non-elective admissions data is Monthly Activity Returns (MAR) data. For the 15/16 planning round, both MAR and SUS (Secondary Uses Service) data will be collected with the aim that these data sources should begin to align.

ANNEX 2 – EXAMPLE HWB QUARTERLY REPORTING TEMPLATE

1. The example quarterly reporting template (attached as a spreadsheet) is to provide local areas with an early indication of what the report will cover.

2. The actual quarterly reporting templates will be accessible via the UNIFY system as soon as the MAR data has been released for each relevant quarter.

3. The template in UNIFY will pre-populate the baseline data and actual performance data at each quarter.