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Better Care Fund planning requirements 2022-23

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Introduction

1. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2022-23. The framework forms part of the NHS mandate for 2022-23.

2. The use of BCF mandatory funding streams (NHS minimum contribution, Improved Better Care Fund grant (iBCF) and Disabled Facilities Grant (DFG) must be jointly agreed by integrated care boards (ICBs) and local authorities to reflect local health and care priorities, with plans signed off by health and wellbeing boards (HWBs). BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund. No new metrics have been introduced for 2022-23.

3. One of the findings from the 2018 BCF review was to provide clearer and more focused objectives for the BCF that address wider system and prevention outcomes through co-ordination of services. The two objectives for 2022-23 BCF are:

   i. Enable people to stay well, safe and independent at home for longer.

   ii. Provide the right care in the right place at the right time.

4. National condition four of the BCF has been amended to reflect these two objectives and now requires HWB areas (referred to as areas in this document) to agree an approach within their BCF plan to make progress against these objectives in 2022-23.

5. BCF plans must be submitted by 26 September 2022. Draft plans can be submitted to Better Care Managers (BCMs) by 19 August for feedback, and areas are strongly encouraged to do this. Assurance will be carried out on final plans.

6. As in previous years, this guidance forms part of the core NHS Operational Planning and Contracting Guidance. ICBs are required to have regard to this guidance, which is issued using NHS England's powers under the NHS Act 2006.

   These planning requirements are being published jointly with the Local Government Association and will be disseminated directly to local government.

7. The iBCF and DFG continue to be paid to local authorities with a condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.

8. For 2022-23, BCF plans will consist of:

   - a completed narrative template
   - a completed BCF planning template, including:
     - planned expenditure from BCF sources
     - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
     - ambitions and plans for performance against BCF national metrics
     - any additional contributions to BCF section 75 agreements.
   - A completed intermediate care capacity and demand plan submitted alongside the BCF plan. (These will not be subject to assurance.)

Legal framework

9. The government's mandate to the NHS for 2022-23, issued under section 13A of the NHS Act 2006, sets an objective for NHS England to ringfence funding to form the NHS contribution to the BCF. The Policy Framework confirms that this ringfence is £4.504 billion in 2022-23.

10. These planning requirements set allocations (published on the NHS website) from this ringfence to ICBs, and in turn from ICBs to their HWB areas, and apply conditions and requirements to their use.

11. BCF plans and their delivery should comply with these conditions as part of the delivery of ICB duties relating to the promotion of integration, acting effectively and efficiently, the improvement of the quality of services and the reduction of health inequalities under the NHS Act 2006.

Mandatory funding sources

12. The following minimum funding must be pooled into the BCF in 2022-23.

Source	2021/22 (£m)	2022-23 (£m)	Percentage change
NHS contribution	4,263	4,504	5.66%
Improved Better Care Fund	2,077	2,140	3%
Disabled Facilities Grant	573	573	0

National conditions

13. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

    1. **A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.**
    2. **NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.**
    3. **Invest in NHS commissioned out-of-hospital services.**
    4. **Implementing the BCF policy objectives.**

14. Compliance with the national conditions will be confirmed through the planning template and narrative plans. Spend applicable to these national conditions will be calculated in the planning template based on scheme-level expenditure data.

National condition 1: Plans to be jointly agreed

15. National condition 1 requires that a plan for spending all funding elements is jointly agreed by the relevant local authority and ICB(s) and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006. Plans will need

to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these planning requirements.

16. Plans must be agreed by the ICB (in accordance with ICB governance rules) and the local authority chief executive, prior to being signed off by the HWB.

17. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

18. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2021-22 plans and update these, where appropriate. Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF funded services are being delivered to address these, including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

19. Data on avoidable admissions and on discharge to be used in the BCF for 2022-23 will be made available on the Better Care Exchange. This will include ethnicity and age information to support analysis as well as links to guidance and documents on equality. ICBs will need to have regard to the NHS Operational Planning and Contracting Guidance regarding the reduction of health inequalities. This guidance emphasises the importance of partnership working for effective use of the available resources to ensure that reducing inequalities in access is embedded in the NHS's approach. While local authorities will have their own priorities under the Equality Act, BCF plans will need to reflect what NHS bodies are doing to address inequalities under Core20PLUS5, which focuses on the most deprived 20% of a population, the ICS-identified groups in each area that experience poorer than average access and five additional areas of focus.

Mandatory components of the Better Care Fund

NHS minimum contribution to the Better Care Fund

20. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2022-23 on its website. The minimum

NHS contribution to each HWB area is the 'NHS minimum contribution' or the 'NHS minimum'. The allocations for all mandatory funding sources are pre-populated in the BCF planning template at HWB level.

21. For 2022-23, the allocations of the NHS contribution to the BCF have been increased by 5.66% for each HWB area. The contribution for each HWB area continues to include funding to support local authority delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£161.62 million). Local allocations of these elements of the NHS minimum contribution are not set for each area, and it is for local government and ICBs to agree the funding to allocate to these services as part of their local BCF plans. BCF plans should reflect clearly how this funding has been identified.

22. With particular reference to funding to support carers' breaks and carer support under the Care Act 2014, the narrative section of BCF plans should also include a brief overview of how BCF funding available in their locality is being used to support unpaid carers. This supports the government's recent commitments on empowering unpaid carers, as set out in the adult social care reform white paper: People at the Heart of Care.

23. When agreeing plans for use of BCF funding to support reablement, areas should consider how this expenditure and the approach to commissioning these services aligns to wider plans. Plans should set out how reablement (and rehabilitation) services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care, and how BCF funding is supporting capacity for these services, along with NHS and local authority funding (see national condition 4). For the BCF in 2022-23, systems are required to agree high level capacity and demand plans for intermediate care services, covering both BCF and non-BCF funded services (see paragraphs 45–52 and Appendix 4).

24. National conditions 2 and 3 apply only to spend from the NHS minimum contribution and are set out below.

National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution

25. National condition 2 requires that, in each HWB area, the contribution to social care spending from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF in that HWB area.

The NHS minimum contribution for each HWB area has been uplifted by 5.66%, and this uplift must be applied to the minimum expectation for social care spend in 2021-22 plans for the HWB.

26. The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the NHS minimum contribution to the BCF.

27. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. Any schemes where the spend type is 'social care' and the funding source is the NHS minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

Revisions to baselines for social care maintenance

28. Baselines for social care contributions are based on local agreements for maintaining the financial contribution from the NHS to social care (baselined from 2016-17).

29. Areas were able to query the baselines in 2017 to 2019. However, if since then, an area has identified that the baseline used for calculating the minimum contribution is wrong, they can request that the figure is reviewed. This can only be done, by exception, in cases where activity has been miscoded and the request must be made by the HWB. Further details are set out in Appendix 2.

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services

30. A minimum of £1.28 billion of the NHS contribution to the BCF in 2022-23 is ringfenced to deliver investment in out-of-hospital services commissioned by ICBs, while supporting local integration aims. Each HWB area's share of this funding is set out in the BCF planning template and will need to be spent as set out in national condition 3. This condition will be assured through the planning template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by ICBs from the NHS minimum contribution.

Grant funding to local government

Improved Better Care Fund (iBCF)

31. The grant determination for the iBCF was issued on 22 April 2022. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant but is not ringfenced for use in winter.

32. The grant conditions remain broadly the same as in 2021-22.

33. The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

34. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with ICB(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes.

35. The grant conditions for the iBCF also require that the local authority pools the grant funding into the local BCF and reports as required through BCF reporting. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (national condition 2).

Disabled Facilities Grant

36. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

37. In two-tier areas, decisions around the use of DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to

enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

38. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care, and strategic use of the DFG can support this.

39. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- the funding is included in one of the pooled funds as part of the BCF
- as DFG funding is capital funding, the funding can only be used for capital purposes
- the funding supports a strategic approach to housing and adaptations that supports the aims of the BCF
- the use of the funding in this way has been developed and agreed with relevant housing authorities.

40. The scope for how DFG funding can be used includes to support any local authority expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding more flexibly. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[1] and Foundations websites.

41. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. The Care Act 2014 also requires local authorities to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

[1] An account is needed to access the Better Care Exchange, if you do not have one and would like to set one up, please email england.bettercarefundteam@nhs.net

42. The Government published updated guidance for local authorities on 28 March 2022 that sets out how they can effectively and efficiently deliver DFG funded adaptations to best serve the needs of local older and disabled people.

National condition 4: implementing the BCF policy objectives

43. National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

i. **Enable people to stay well, safe and independent at home for longer.**

ii. **Provide the right care in the right place at the right time.**

44. For both objectives, areas should describe:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
- How BCF funded services will support delivery of the objective.

45. In addition to this, areas are asked to develop plans that outline expected capacity and demand for intermediate care services in the area, covering demand for both services to support people to stay at home (including admissions avoidance) and hospital discharge pathways 0–3 inclusive, or equivalent, for quarters 3 and 4 of 2022-23 across health and social care. This should cover both:

- BCF funded activity
- non BCF funded activity.

46. The NICE guidance on intermediate care defines it as “a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care”.

47. A system-wide understanding of demand and capacity across intermediate care is critical to enabling areas to maximise both people’s health, wellbeing and

independence, and utilisation of system resources. It enables areas to understand trends and variation, and so agree joint actions to anticipate demand more accurately across health and care in the medium and long term, and respond more effectively to shorter term or unpredicted demand or challenges.

48. While councils retain their Care Act 2014 duties in terms of market management, a joint approach to planning intermediate care enables areas to more effectively and holistically shape local health and care provision to develop the necessary capacity to meet anticipated demand. The Local Government Association (LGA) and partners' High Impact Change Model for managing transfers of care provides advice on developing effective capacity and demand systems.

49. As a first step, areas are asked to jointly develop a single picture of intermediate care needs and resources across health and social care funded by the BCF and other sources for quarters 3 and 4 of 2022-23. There is no expectation that the BCF should be used to fund all services within this capacity and demand plan.

50. Areas should work closely across all partners to produce the plan and utilise data submitted by NHS organisations on hospital discharge pathway activity as well as local authority service data as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans. Further guidance is available in Appendix 4, and bespoke support will be available through the BCF external support programme delivered by the LGA.

51. When estimating capacity and demand at local authority level, ICBs should make use of the discharge pathways model that is available on NHS Foundry and the projected activity levels submitted as part of NHS planning. Plans should also take account of planning carried out in preparation for the winter.

52. These capacity and demand plans will need to be submitted with main BCF plans, but the content will not form part of the overall BCF assurance process.

Objective 1: Enabling people to stay well, safe and independent at home for longer

53. This objective seeks to improve how health, social care and housing adaptations are delivered to promote independence and address health, social care and housing needs of people who are at risk of reduced independence, including admission to residential care or hospital. This might include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

54. The LGA published a High Impact Change Model for reducing preventable admissions to hospital and long-term care in 2021. The document sets out five actions for systems that areas should consider:

- population health management
- target and tailor interventions for those most at risk
- effective multidisciplinary working
- educate and empower people to manage their own health and wellbeing
- provide a co-ordinated and rapid response to crises in the community.

55. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on prevention-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics, including prevention (unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)).

Objective 2: Provide the right care in the right place at the right time

56. BCF plans should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this. Systems should have regard to the guidance on collaborative commissioning

published by the LGA, in partnership with the BCF Programme, and guidance produced following the evaluation of the Hospital Discharge Policy and Discharge to Assess.

57. The High Impact Change Model for managing transfers of care was refreshed in 2019 and has been further updated in 2020 to reflect changes to discharge introduced to support the response to COVID-19. Continued implementation of the model is integral to delivery of this objective and the requirements of the BCF. As part of developing their BCF plan, areas should review and self-assess their implementation of the model. Narrative plans should include confirmation of this review and the planned actions arising from this.

58. The national Hospital Discharge Fund came to an end on 31 March 2022.[2] NHS England wrote to systems in March to encourage them to continue to make best use of existing resources to support safe and effective discharges within local priorities. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on discharge-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (increasing the proportion of people discharged from hospital to their normal place of residence).

59. Local authorities and ICBs are expected to continue to pool pre-existing expenditure on discharge. Where this expenditure is from BCF sources, this should be indicated in the BCF planning template by selecting the appropriate scheme type and subtype in the expenditure worksheet.

Agreement of local plans

60. Areas will need to agree a narrative plan and confirm agreed expenditure and compliance with the requirements of the fund in the BCF planning template. Local

[2] https://www.england.nhs.uk/coronavirus/publication/funding-of-discharge-services-from-acute-care-in-2022-23/

NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

61. Final narrative plans, completed planning templates, and intermediate care capacity and demand plans should be submitted by 26 September. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 18 August for review and feedback.

62. Narrative plans should reflect how commissioners will work together in 2022-23 to:

- continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
- set out how the area will make progress against the two objectives set out in national condition 4
- an overview of how BCF funding is supporting unpaid carers (with particular reference to how funding in the NHS minimum contribution to fund carer's breaks and local authority duties to support carers under the Care Act 2014 is being used)
- priorities for promoting equality and reducing health inequalities.

63. Narrative plans will be collected separately to the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas can use their own formats.

64. Intermediate care capacity and demand plans need to be submitted alongside main BCF plans but will not be subject to BCF assurance.

BCF planning template

65. The planning template will continue to be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met. This will include information on discharge and non-discharge spend, as in previous years.

66. The template will be pre-populated with:

- minimum funding contributions from all mandatory funding sources for each area
- minimum ringfenced amounts from the NHS minimum for:

- the contribution to social care (national condition 2)
- spend on NHS commissioned out-of-hospital services (national condition 3) for each area.

67. The template will calculate spend applicable to each of these national conditions automatically.

68. Areas will need to confirm:

    a. That all mandatory funds have been pooled and agreed.

    b. Scheme level spend by:

        - funding source
        - scheme type and subtype
        - brief scheme description
        - amount of spend in 2022-23
        - area of spend (that is, social care, community health, continuing care, primary care, mental health, acute care)
        - commissioner type
        - provider type.

    c. Performance ambitions for metrics and how BCF activity will contribute to making progress against these metrics.

69. A separate confirmation sheet will collect yes/no confirmation that the following requirements are met:

    - In two-tier local government areas, that DFG funding has either been passed to district/borough councils, or that there is agreement with district/borough councils on the use of any retained grant.
    - Funding for reablement, Care Act 2014 duties and carers breaks has been identified in spending plans and the BCF narrative plan sets out the approach to supporting unpaid carers through the BCF (see paragraph 62).

70. The specific scheme types and subtypes were updated in 2021 to collect better information on how BCF funding streams support discharge. This information will support future policy development and areas should aim to record these scheme types as accurately as possible in their spending plans.

71. When completing the BCF planning template, areas should, as far as possible, avoid classifying scheme types as ‘other’ where a specific scheme category can be used. The clarity of this information is important in being able to account properly for the effective use of the funding pooled into the BCF. Areas may be asked for further information on spend classed as 'other’ through the assurance process.

Metrics

72. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022-23. The metrics for the BCF in 2022-23 are:

- proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)
- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)
- unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)
- improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).

Please see Appendix 3 for further detail.

73. Ambitions should be agreed between the local authority and ICB(s) and signed off by the HWB. The BCF planning process will also collect rationales for the ambitions set for each metric, plans for achieving these ambitions and how BCF funded services will support this.

74. The metrics tab in the BCF planning template has been updated to include two narrative sections; ‘rationale for ambition’ and ‘local plan to meet ambition’. The first of these should be used to detail how the target has been arrived at (including analysis of historical data) and expected impact of planned funding (including the impact of previous investment). The second should outline the local plan for improving performance against each metric, including changes to commissioned services, joint working and how BCF funding will support this.

75. Baseline data on discharge and unplanned admissions for ambulatory care sensitive conditions will be made available on the Better Care Exchange. Hospital trusts, local authorities and ICBs should work together to continue to improve the use of situation reporting and other data to understand flow.

76. Ambitions for 2022-23 as a whole should be set based on:

- current performance (from locally derived and published data)
- local priorities, including COVID-19 recovery
- expected demand
- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

Discharge metrics

77. Local systems should agree a plan to improve outcomes across the HWB area for the proportion of people discharged home using data on discharge to their usual place of residence.

78. The ambition should be developed with NHS trusts and foundation trusts. The ambition should be stretching and should build on performance from 2021-22.

79. From April 2022, the discharge ready date filed in hospital patient administration systems has become a required field and will be used to collect the date a person no longer meets any of the criteria to reside. From 2023, this data will be used as a basis for a metric linked to delayed discharge, as long as the data is robust and can be published. During 2022-23, systems should work together to improve data collection rates and quality with a view to being able to agree plans for performance on delayed discharge from April 2023. The measure of the percentage of acute hospital stays that are 14 days, or 21 days or over has been removed as a core metric for 2022-23, although length of stay remains a priority. Therefore, data on length of stay will continue to be made available on the Better Care Exchange for local areas and will continue to be monitored regionally and nationally with BCF support provided for areas facing the greatest challenges.

Assurance

80. Assurance processes will confirm that national conditions and planning requirements are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

81. Assurance of final plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

82. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. The purpose of the cross-regional calibration session is to:

- share the position on BCF plan assurance status across each of the seven regions
- provide confidence that the scrutiny during plan assurance has been consistent
- identify any variations between regions and discuss the approach taken to preserve consistency
- identify concerns that require clarity from outside the attendee group and determine next steps.

83. Following the calibration meeting, recommendation for approval will be made by NHS England regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB • Plan meets all national conditions and planning requirements (including but not limited to the requirement to submit an intermediate care capacity and demand plan)

	• Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local authority grants (DFG and iBCF) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions • Area has submitted an intermediate care capacity and demand plan
Not approved	• One or more of the following apply: – plan is not agreed – one or more national conditions are not met, taking into account the associated planning requirements – no local agreement on use of local authority grants (DFG and iBCF). – no intermediate care capacity and demand plan submitted

84. Where plans are not initially approved, the BCF team may implement a programme of support, with partners, to help areas achieve approval as soon as possible or consider placing the area into formal escalation.

85. Escalation will be considered in the event that:

- the ICB and the local authority are not able to agree and submit a plan to their HWB; or
- the HWB does not approve the final plan; or
- the NHS England regional director does not recommend a plan for approval.

86. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a national escalation panel meeting to discuss concerns and identify a way forward.

87. In instances where an area is unable to agree a compliant plan following a national escalation panel with support from BCMs and external advisors commissioned by the BCF team, NHS England, in consultation with departments, will consider enforcement action, including directing the use of the NHS funds under the NHS Act 2006.

Monitoring and continued compliance

Updating BCF plans in year

88. It is recognised that areas may wish to amend plans in-year, following sign off and assurance, to:

- modify or decommission schemes
- increase investment or include new schemes.

89. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local authority and ICBs and continue to meet the conditions and requirements of the BCF.

90. In both cases, revisions to plans should be approved by the HWB and confirmed in the end-of-year reporting template with an accompanying rationale. If the need arises to amend BCF plans in-year, please contact the relevant BCM in the first instance.

Monitoring compliance with BCF plans

91. BCMs and the wider BCF team will monitor continued compliance against the national conditions through their wider interactions with local areas.

92. Where an area is not compliant with one or more conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan and risk the national conditions being unmet, then the BCF team, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be proportionate to the risk or issue identified.

93. The intervention and escalation process could lead to NHS England exercising its powers of intervention, in consultation with DHSC and DLUHC, as the last resort.

Reporting in 2022-23

94. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy-making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

95. These reports are discussed and signed off by HWBs as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into section 75 agreements. Monitoring will include confirmation that the section 75 agreement is in place.

96. Reporting will recommence in 2022-23 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the national conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. Therefore, areas that do not comply with the reporting timescales and detail may be subject to the procedures set out in Appendix 1 on support, escalation and intervention.

Timetable

The timescales for agreeing BCF Plans and assurance are set out below:

BCF planning requirements published	19/07/2022
Optional draft BCF planning submission (including capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	18/08/2022
BCF planning submission from local HWB areas (agreed by ICBs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	26/09/2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26/09/2022 - 24/10/2022
Regionally moderated assurance outcomes sent to BCF team	24/10/2022
Cross-regional calibration	01/11/2022
Approval letters issued giving formal permission to spend (NHS minimum)	30/11/2022
All section 75 agreements to be signed and in place	31/12/2022

Appendix 1: Support, escalation and intervention

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

1. **Trigger:** a. Concern during planning process that a compliant plan will not be agreed b. BCF plan not submitted c. BCF plan submitted does not meet one or more planning requirement (eg requirement to submit an intermediate care capacity and demand plan) d. Area is no longer compliant with their approved plan (in year)	The BCM and regional partners in consultation with the BCF team will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or local government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal support	The BCM will work with the BCF team to agree provision of support.
4. Formal regional meeting	Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCF team to discuss the concerns, plans to address these and a timescale for addressing the issues identified.

5. **Commencing escalation** as part of non-compliance	If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, BCF national partners will be consulted on next steps. To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the escalation panel.
6. **Escalation panel**	The escalation panel will be jointly chaired by DLUHC and DHSC senior officials, supported by the BCF team, with representation from: • NHS England (as the accountable body for NHS spend and for plan approval) • The LGA, in its role as a national partner for the BCF. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant ICB(s) • chief executive from the local authority.
7. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter summarising the escalation panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the escalation panel, an update on what support will be made available will be included.
8. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCF team.
9. Consideration of **further action**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious, then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • agreement that the escalation panel will work with the local parties to agree a plan

	• appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan • appointment of an advisor to develop a compliant plan, where the escalation panel does not have confidence that the area can deliver a compliant plan • directing the ICB, eg regarding its use of resources. The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

2. If an area fails to develop a plan that can be approved by NHS England, or if a local plan cannot be agreed, any proposal to issue directions will be subject to consultation with DHSC and DLUHC ministers. The final decision will then be taken by NHS England.

3. The escalation panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. However, a BCF plan will not be approved if there is no agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue not to be met.

Appendix 2: Querying baseline for social care maintenance contributions

1. Required contributions to social care from NHS minimum contributions at HWB level have been calculated from locally agreed figures assured in 2016/17 BCF plans, uprated in line with growth in that area's ICB contribution in each subsequent year.

2. In 2022-23, if local areas believe that this baseline is not correct, they will be able to request that it be reviewed. A review can only be requested where the baseline is not correct because historical schemes have been incorrectly coded. A review can be requested because the current baseline overstates or understates social care spend.

Process

3. Areas should inform their better care manager (BCM) if they believe that the baseline for maintaining social care spend is incorrect, setting out their reasoning, confirming the miscoded schemes and any supporting documents. Areas must confirm that both the relevant ICB(s) and local authority(ies) agree that the baseline is not correct, and the HWB supports the request..

4. The query and supporting evidence will be reviewed by the BCF team with the BCM. Recommendations for amending a baseline will be made to the BCF Programme Board. If the BCF Programme Board agrees to amend a baseline, areas will be notified as soon as possible.

Appendix 3: Detailed definitions of BCF metrics

Metric 1: 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	Overarching measure: delaying and reducing the need for care and support.
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 admission to residential or nursing care homes can improve 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 NHS Digital. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework NHS Digital (SALT) Population statistics (ONS)
Reporting schedule for data source	Collection frequency: annual (collected April to March) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2014-15 following a change to the data source.

Metric 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

Outcome sought	Delaying and reducing the need for care and support. When people develop care needs, the support they receive is provided in the most appropriate setting and enables them to regain their independence.
Rationale	There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.
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 SALT collected by NHS Digital. **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 SALT collected by NHS Digital 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
Reporting schedule for data source	Collection frequency: annual (although based on 2 x 3 months of data – see definition above) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2011-12 (currently five years' final data available: 2011-12, 2012-13, 2013-14, 2014-15 and 2015-16).

Metric 3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Outcome sought	Improved health status for people with chronic ambulatory care sensitive conditions
Rationale	This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The numerator is given by the number of finished and unfinished admission episodes, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the denominator for the official published measure (mid-year population estimates for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template shows uses mid-year estimates for 2020-21 as a denominator).
Definition	**Numerator: Unplanned admissions by quarter for ambulatory care sensitive conditions.** Hospital Episode Statistics (HES) admitted patient care (APC). A fuller code and historical data is provided on the Better Care Exchange.
Source	NHS Outcomes Framework

Reporting schedule for data source	Data will be extracted monthly by the BCF team
Historical	Quarterly and annual data from 2003-04 Q1 for all breakdowns

Metric 4 Discharge to usual place of residence

Outcome sought	Improving the proportion of people discharged from hospital to their own home using data on discharge to their usual place of residence.
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. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.
Definition	**Numerator:** The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total.
Source	NHS Secondary Uses Service (SUS)
Reporting schedule for data source	Monthly. Data is extracted by the BCF team and updated monthly on the Better Care Exchange. SQL codes are available for systems on the Better Care Exchange.
Historical	Monthly data from 2018-19 Q1 for all breakdowns.

Appendix 4: Capacity and demand planning

Introduction

1. All systems must submit a high-level overview of expected demand for intermediate care and planned capacity to meet this demand alongside their BCF plans. The content of capacity and demand plans will not be assured in 2022-23 but their completion is a condition of BCF plan approval.

2. For capacity and demand planning to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care and a comprehensive picture of capacity.

3. This is the first time that capacity and demand plans have been required through BCF. As far as possible, areas should aim to use their existing data and plans to ensure alignment. For example, using ICS level projections for expected discharges per month and by discharge pathway. Areas can also make use of the Discharge Pathways Model Analytical Tool, available on the NHS Futures site. In both cases, these will need to be mapped to local authority footprints and agreed locally, making use of local management information data.

4. Plans should be agreed between local authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23. Service capacity should cover health, social care and jointly commissioned services. Plans should also consider the full spectrum of care supporting recovery, reablement and rehabilitation, such as from the voluntary and community sector.

5. A template is provided for areas to complete with this information, and guidance for filling this in is provided separately.

Services to be included in plans

6. All local authority and health commissioned intermediate care services, not just those funded by the BCF, should be included in capacity and demand plans.

7. The NICE guidance on intermediate care defines it as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care". The capacity and demand plans should cover:

   - reablement/short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital
   - home-based intermediate care, provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists
   - bed-based intermediate care involving therapy, either to recover function and avoid admission to hospital/residential care, or to return home following a spell in hospital
   - crisis response (two-hour response/short term) to prevent hospital admissions.

8. Where the source of demand is to support hospital discharge; this should be broken down by discharge pathway, as defined in the Hospital discharge guidance (2022).

Why capacity and demand?

9. Demand for services changes across a year, but comparing demand data against available resources, allows systems to model future demand and anticipate pressures before they arise. Capacity and demand modelling can help visualise performance and increase the likelihood that demand will be met, through service redesign and efficient use of resources, and help reduce the need for costly measures such as using agency staff and spot purchased provision.

10. The aims of requesting these plans are to:

    - ensure that an integrated approach to capacity and demand planning is happening across health and social care

- improve understanding (locally, regionally and nationally) in systems of how capacity is used and inform commissioning decisions – with a view to increasing use of support in a person's own home where appropriate
- inform nationally commissioned support (particularly BCF support) and policy
- provide insights regarding the potential to improve the impact and outcomes for people who use intermediate care.

Content of BCF capacity and demand plans

11. To develop capacity and demand plans, ICBs and local authorities will need to collaborate with input from providers (NHS trusts and social care providers) to review existing data, including NHS planning returns (this should include estimated discharge activity for 2022-23 and anticipated levels of urgent community response referrals). This should involve the following steps.

12. **Estimated current demand** – as a first step, expected levels of demand for intermediate care from a range of services will need to be reviewed and agreed. There is scope for areas to identify their own referral sources, but this section will likely include:

    - expected episodes of short-term care following community referrals for assessment (eg single points of access, 111, primary care, social workers)
    - current and expected demand for supported discharge by source (ie trust/site); these should draw on ICB-level data on expected discharge activity developed for NHS plans
    - referrals for rapid crisis response, again from data developed for NHS plans.

13. Expected demand levels should be projected on a month-by-month basis. Systems should review historical and current demand to identify the level of demand they will be expecting over this time period. We recommend that systems follow the guidance on the discharge pathways model. This involves:
    - Reviewing referrals that lead to short-term care (demand) by day across a period and ordering these in terms of increasing numbers of referrals.
    - Agreeing a level of demand that should be assumed to happen on a daily basis such that, if capacity were to meet this, it would enable people to commence their care package within the expected timeframe. The discharge pathways model recommends that assumed demand should be the 95th

centile (eg if looked at across 100 days, the 95th centile would be the sixth busiest). Depending on the source of demand, a different threshold may be set.

  - Repeat this for different sources of referral.

14. **Current commissioned capacity** – across health and social care. This will include:

    - service type (eg bed-based/home-based, reablement/rehabilitation)
    - where applicable, discharge pathway. Show pathway 0 discharges with no further support needs as a single service
    - capacity: this should show the number of new referrals the service could normally accept each month
    - for services that accept community and hospital referrals – expected split between discharge and community referrals.

15. **Estimated spend** – the template does not collect detailed spending on intermediate care at a service level, but areas are asked to estimate the total annual spend on intermediate care in the area from:

    - BCF sources – including additional voluntary contributions
    - other funding.

16. This information is being collected to improve understanding of current investment in intermediate care and to support policy development. As with the capacity and demand plans in general, this information will not be subject to assurance or used for performance management.

Narrative

17. Systems will be expected to include a narrative explanation of any assumptions they have made in their plans – for example:

    - changes in demand over winter
    - assumptions about services in scope
    - mapping figures from an ICS onto a local authority footprint
    - data gaps

- support needed, eg to help improve demand modelling or to agree action to reduce capacity gaps.

18. It is expected that, especially this first year, many systems could encounter some difficulty with projecting expected demand because of, for example, masked unmet needs and the impact of COVID-19. This narrative section should be useful for summarising data gaps, limitations and assumptions systems have had to make to complete their plans.

19. The narrative section should also include an overview of expected demand and planned services, likely gaps in provision and any changes as a result of the planning process.

Other sources of guidance

20. Further guidance and advice on capacity and demand planning is available.

- Report for the LGA on developing a capacity and demand model for out-of-hospital care by Professor John Bolton, based on work with seven systems.
- NHS England guidance on capacity and demand modelling for health.
- The Better Care Exchange, where some additional supporting documents including an FAQ will be published.

Contact us:

If you have any queries about this document, please contact the BCF team at: england.bettercarefundteam@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

For more information and regular updates on the Better Care Fund, sign up to our fortnightly bulletin and the Better Care Exchange by emailing england.bettercarefundexchange@nhs.net

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