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Better Care Fund planning requirements 2023-25

4 April 2023, Version 1

Contents

Introduction

Key dates

Optional draft BCF planning submission (including intermediate care and short term care capacity and demand plan)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government).	28 June

Better Care Fund Vision and Objectives

1. The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

2. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

    - **Enable people to stay well, safe and independent at home for longer**
    - **Provide the right care in the right place at the right time**

3. This document sets out the requirements for two year plans to enable areas to deliver tangible impacts in line with the vision and objectives set out in the Policy Framework. It is published by NHS England and Government to be actioned jointly by Integrated Care Boards (ICBs) and local councils. These requirements focus the use of BCF funding on the objectives of the fund and improving performance against

the metrics for working age and older adults. Intermediate Care Capacity and Demand plans will continue to be collected as part of BCF plans and should be used to estimate the existing or upcoming capacity deficits and inform the use of BCF pooled funding for delivery of the objectives.

4. BCF planning information in 2023-25 will be collected in a way that provides more data on the activity that BCF will fund, and the contribution of integrated working to improving outcomes for local people. This will include:

    - Expected outputs from scheme types related to discharge, intermediate care unpaid carers and housing.

    - Estimates of BCF spend on different services and activities as a proportion of all health and care spend on these services in the Health and Wellbeing Board (HWB) area. We are collecting this information to help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

5. Mental health, learning disability and autism continue to be an integral area of the BCF and should be considered on an equal footing to physical health. The objectives apply to all settings and contexts including preventative support or where a person may be discharged from adult or older adult mental health (including dementia), learning disability and autism inpatient settings as well as acute hospitals. People discharged from mental health, learning disability and autism inpatient services who need to access intermediate care services should be included in BCF intermediate care capacity and demand plans.

Legal framework

6. The Secretary of State for Health and Social Care has published a direction to NHS England under section 223B of the NHS Act 2006 to ringfence £5,059 million to form the NHS contribution to the BCF in 2023-24. This figure includes additional funding for discharge via ICBs (£300m) in 2023-24. The direction sets a requirement for NHS England to consult with The Secretary of State for Health and Social Care before giving any direction to ICBs under section 223GA(1) of the Act about designated amounts to be used for purposes relating to service integration, or before exercising any of its powers under section 223GA(5) of the Act relating to these designated amounts.

7. This document represents NHS England exercising its powers under section 223GA of the 2006 Act. It sets out the detail in relation to the conditions and requirements agreed with the government in relation to the receipt and use of NHS and local government contributions to the BCF, including details of how conditions and requirements will be monitored to ensure they are met. This guidance is also an annex to the NHS operational and contracting guidance for 2023/24. ICBs should ensure that plans for use of the NHS minimum contribution, discharge funding in ICB allocations and assumptions related to capacity and demand for intermediate care align to their wider activity and financial plans.

8. Grants to local government (improved Better Care Fund and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, with a condition that they are pooled into local Better Care Fund plans.

9. There will be an additional £600m in 2023-24, and £1bn in 2024-25 to support discharge from hospital and reduce delays, half of which will be allocated via ICBs in each year. The £300m NHS funding of the additional £600m in 2023-24 is included in the Secretary of State direction outlined in para 6. The other £300 million in 2023-24 will be paid as a grant to local government, under the condition that it is pooled into the Better Care Fund. Specific requirements and conditions in relation to this funding are included in paragraphs 41-51 and will be assured as part of wider BCF assurance.

10. The following minimum funding must be pooled into the BCF in 2023-25.

Source	**2022-23 (£m)**	**2023-24 (£m)**	**2024-25 (£m)**
NHS contribution	4,504	4,759	£5,029
Discharge Funding	500	600	1000
Improved Better Care Fund	2,140	2140	2140
Disabled Facilities Grant	573	573	573

National Conditions

National Condition 1: Plans to be jointly agreed.

11. BCF Plans must be agreed by the ICB(s) (in accordance with ICB governance rules) and the local council chief executive, prior to being signed off by the HWB. Once the plan is agreed and approved, the funding must be placed into one or more pooled funds under section 75 of the NHS Act 2006. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans, including the strategic approach to delivering the objectives of the BCF. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s) where they are assured that voluntary pooling provides value for money. These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

12. The planning template will collect data on use of BCF funding and ambitions for performance on BCF metrics (performance objectives) and activity to achieve these as well as on Intermediate Care plans for capacity and demand (see Appendix 2). All sections of the template must be completed in line with this guidance.

13. Narrative plans will collect the joint approach to delivering the objectives of the fund (see para 2) and should also set out:

    - A brief summary of the strategic approach to integration of health, social care and home adaptations to support further improvement of outcomes for people with care and support needs. As part of this local areas should explain why particular services and schemes have been prioritised and what outcomes they are trying to achieve. This should include a local scheme of governance for plans that demonstrates how the plan has been signed off, and how oversight of ongoing delivery and performance and the section 75 agreement, will be achieved.

    - Areas for development (based on learning from previous years).

    - Actions resulting from Intermediate Care Capacity and Demand plans.

    - Approach to supporting unpaid carers.

- Joint commissioning – how the local council and ICB will work together to further join up commissioning and develop the care market (in support of the local government duty). This should complement planning undertaken as part of the Market Sustainability and Improvement Fund (MSIF).

- How activity in BCF plans will support equality and address health inequalities.

14. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2022-23 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 (for example those experiencing homelessness) in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

15. Areas will also need to consider local government's priorities under the Equality Act and NHS actions in line with Core20PLUS5.

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

16. Areas should agree how the services they commission will support people to remain independent for longer, and where possible support them to remain in their own home. This might include:

    - embedding personalised care and delivering asset-based approaches

    - implementing joined-up approaches to population health management and proactive care, and how the schemes commissioned through the BCF will support these approaches

    - multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake where appropriate

- how work to provide additional support to those who need it, such as unpaid carers and people who require adaptations and improvements to their home, will support this objective

17. Whilst there is no specific requirement to fund implementation of the Fuller Stocktake, there are clear overlaps between the delivery of the vision for Primary Care Network (PCN) level multi-disciplinary teams supporting prevention and focussing on people in the Core20PLUS5 population, and the aims of the Better Care Fund. Many areas are already funding neighbourhood teams. When developing BCF plans, areas should consider the extent to which delivery through neighbourhood teams would be beneficial in the context of existing local priorities.

18. The LGA published a high impact change model for reducing preventable admissions to hospital and long-term care in 2021.

19. BCF narrative and expenditure plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - the approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community, mental health and social care services are being delivered to help people to remain at home.

    - providing details in the BCF planning template of planned spend on prevention-related activity. You should indicate whether schemes contribute wholly or partly to this objective.

    - how joint health and social care activity under this objective will contribute to the ambitions agreed against BCF national metrics, particularly unplanned hospitalisation for chronic ambulatory care sensitive conditions, people over 65 who are admitted to long term residential care and rate of admissions to acute hospital following a fall.

20. Activity to deliver this condition should take account of the capacity and demand plan for intermediate care.

National condition 3: Provide the right care in the right place at the right time

21. Areas should agree how the services they commission will support people to receive the right care in the right place at the right time. 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, in line with the Government's hospital discharge and community support guidance[1].

    - Implement the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

22. This should include details of how additional funding for discharge in 2023-24 will be used in line with the conditions set out in paragraphs 40-50 to improve outcomes for people being discharged and performance against the relevant metrics. Planning for 2024-25 discharge funding is provisional at this point as conditions will be updated according to the evaluation findings of the 2022-23 ASC Discharge Fund.

23. Areas should review the self-assessment of the area's implementation of the High impact change model for managing transfers of care and summarise progress against areas for improvement identified in 2022-23.

24. BCF plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - a narrative detailing how BCF spending will support the area's approach and details in the BCF planning template of planned spend on discharge -related activity, taking account of the capacity and demand plan for intermediate care

    - how joint health and social care activity will contribute to the improvements agreed against BCF national metrics particularly discharge to usual place of residence and reablement.

[1] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Funding sources

NHS minimum contribution to the Better Care Fund

25. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2023-24 and 2024-25 on its website. The allocations are pre-populated in the BCF planning template at HWB level.

26. As with 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 government delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£197 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.

27. The way services and local areas work in partnership with, and support, unpaid carers is critical. We know that poorer health and wellbeing outcomes can be associated with caring as the intensity of the caring role increases.

28. The narrative section of BCF plans should include a brief overview of how BCF funding available in their locality is being used to support unpaid carers with reference to funding to support carers' breaks and carer support under the Care Act 2014. Areas will also be asked to improve the clarity and transparency of spend on unpaid carers through our reporting requirements and activity data. Local areas should also highlight good practice examples through their narrative plans to help aid understanding and improvement of unpaid carers services delivered via the BCF. 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.

Grant funding to local government

Improved Better Care Fund (iBCF)

29. The grant determination for the iBCF in 2023-24 was issued on 4th April 2023. 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. The value of the iBCF in 2024-25 is indicative only. Final decisions on the 2024-25 iBCF, (including allocations) will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, areas should plan on the basis that allocations will be consistent with the approach taken in 2023-24.

30. 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.

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

32. The grant conditions for the iBCF also require that the local council 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 4).

Disabled Facilities Grant

33. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local councils. 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.

34. 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.

35. The funding allocations for DFG will be published soon. Once published, areas should input their figures into the relevant section of the income tab in the BCF Planning Template. Assumptions will be provided for DFG allocations in 2024-25.

36. 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.

37. Where some DFG funding is retained by the upper tier local council, plans should be clear that:

    - the funding is included in one of the pooled funds as part of the BCF
    - the DFG capital funding is used only for the allowed purposes as described in the DLUHC Guidance for Local Authorities.
    - 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.

38. The scope for how DFG funding can be used includes to support any local government 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 to help people live independently. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[2] and Foundations websites.

39. 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 councils 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.

[2] 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

40. The Government published updated guidance for local councils 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.

Additional Discharge funding

41. In 2023-24, the Government is providing £600 million (£300 million for ICBs, £300 million for local councils) to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. As in 2022-23 the ICB will agree with relevant local HWBs how the ICB element of funding will be allocated rather than being set as part of overall BCF allocations, and this should be based on allocations proportionate to local area need.

42. This funding is intended to provide increased investment in social care and community capacity to support discharge and free up beds. Areas can use this funding where appropriate to continue to support investments made in services from the ASC Discharge Funding in 2022-23 but should not use the new discharge funding in 2023-24 to replace existing expenditure on social care and community services.

43. Local areas should use the discharge funding as part of BCF plans, particularly in relation to National Condition 3, and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.

44. Local areas should plan how best to deploy this funding over the period April 2023 to March 2024, taking account of the capacity and demand work to identify likely variation in levels of demand over the course of the year, including winter pressures. Local areas should work with local providers to determine how best to build the workforce capacity needed for additional services.

45. Local areas should use the funding in ways that support the principles of ‘Discharge to Assess’: to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

46. Local areas should take account of learning from previous discharge funding, including the evaluation of the impact of 2022-23 discharge funding when available.

47. As part of the BCF plan, local areas will be required to set out how they intend to deploy the additional discharge funding, and submit fortnightly reports throughout the year, setting out – among other information – the additional services commissioned with the funding and the numbers of patients receiving short-term support following discharge. Detailed reporting requirements and templates will be published as soon as possible.

48. £1bn has been added to the BCF for 2024-25 to provide ongoing support for discharge. We intend to update the 2024-25 discharge funding conditions according to the evaluation findings of the 2022-23 ASC Discharge Fund. This may impact priority areas for spending and reporting requirements. However, our overarching objective for the funding will remain to reduce delayed discharges. Therefore, areas should provisionally agree plans and include this in the spending template. Final details regarding the 2024-25 additional funding for discharge will be published in due course and plans may need to be amended or updated to reflect any changes to conditions once these are published.

49. ICB allocations for the 2024-25 discharge funding have been allocated solely on a 'fair shares' basis. Final decisions on the 2024-25 local council share of the discharge funding including allocations will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, guidance will be given to what areas should include in the Planning Template for 2024-5 to support planning over the two year period.

50. As set out in the Delivery plan for recovering urgent and emergency care services, DHSC, NHS England, the Department for Levelling Up, Housing and Communities (DLUHC), Local Government Association, and Association of Directors of Adult Social Services, have introduced an integrated approach to performance improvement and support in local systems, bringing together local leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, and to rapidly identify and help spread innovative practice.

51. Information from this integrated approach to performance improvement and support will be made available to those involved in assurance. Systems that have been identified as requiring additional support and performance improvement in relation to discharge performance will be communicated to regional assurance teams and this will be considered in relation to BCF plans and metric ambitions. Additional

conditions relating to performance improvement and support may be included as part of approval of the discharge funding aspects of the BCF plan.

Spending related conditions

National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

52. In each HWB area, the minimum expected expenditure on social care spending and spending on NHS commissioned out of hospital services from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF. The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%.

53. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

54. For the purposes of the social care minimum spend - 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.

55. For the purposes of the minimum spend on NHS Commissioned out of hospital services, any schemes where the spend area is allocated to primary, community health, continuing care or social care that is commissioned by ICBs from the NHS minimum contribution will count towards this expectation.

Metrics

56. The 2023-25 BCF Policy Framework sets national metrics (performance objectives) that must be included in BCF plans.

57. The BCF planning process will collect agreed ambitions for 2023-24 only, including supporting rationales, plans for achieving these ambitions and how BCF funded services will support this. From Q3, areas will be required to set ambitions for a new metric that measures timely discharge (see below).

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

59. Ambitions for 2023-24 should be set based on:

    - current performance (from locally derived and published data)
    - local priorities and anticipated demand and available capacity. Ambitions should reflect demand and capacity planning for intermediate care as well as wider capacity planning as part of the Market Sustainability and Improvement Fund (MSIF) and the UEC capacity plan.
    - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

New discharge data collection

60. The discharge ready date field in the Commissioning Data Set 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 April 2023. This data will be used as a basis for a metric linked to delayed discharge, contingent on further testing and data quality.

61. As set out in the Delivery plan for recovering urgent and emergency care services, we will work with local systems to develop a new metric that measures the time from the discharge-ready date to the actual date of discharge. We will publish the new data as soon as possible ahead of next winter following trialling and testing with local providers and patient groups, in support of collaborative action across the NHS, local government

and the social care sector to improve discharge planning and capacity planning. Within the development of this metric we will consider how to include the clinically ready for discharge metric for mental health, leaning disability and autism services.

62. We have outlined expected changes to metrics for 2024-25 in the Policy Framework. Ahead of the start of 2024-25, local areas will be asked to review their metric ambitions in relation to BCF plans for 2024-25 in collaboration with health and social care partners. Metrics outlined for 2024-25 are designed to build on wider developments including the new Office for Local Government (OFLOG), client level data developments and the implementation of the new discharge delay metric. Areas will be required to submit metric ambitions for 2024-25 as part of this review. Further detail and the updated requirements and template will be published in early 2024. Monitoring and additional oversight is likely to be in place for areas where data shows that delayed discharges are significantly higher or increasing at a greater rate than the national averages.

63. It is recommended that systems update the Capacity Tracker with bed vacancy data daily, where possible, as this information can be used by local discharge and brokerage teams when planning patient discharges. It also helps ensure that patients are discharged to the right place for their specific care needs.

Process and Timeline

64. Final narrative plans and completed planning templates (including capacity and demand plans), should be submitted by 28 June. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 19 May for review and feedback.

Intermediate care capacity and demand planning

65. Capacity and demand planning for intermediate care is an integral part of the BCF this year and should be used to ensure areas are improving their performance against BCF metrics, as well as working towards the objectives of the programme and improving understanding of how funding could be best used locally. Intermediate care capacity and demand plans will need to be submitted as part of BCF plans and will form part of the assurance process. Assurers will review narrative plans and capacity and demand

information, looking at how estimates of capacity and demand have been taken on board and reflected in the wider BCF plans. Please see Appendix 2 for further detail and definitions.

66. The estimates of capacity and demand should be drawn up alongside, and influence, plans for delivering against national conditions 2 and 3, and plans for use of BCF funding. In relation to discharge, capacity and demand for Pathway 3 should also be captured where this is a short term placement prior to assessment for long term care. The template for collecting capacity and demand estimates is included in the main BCF planning template.

67. Areas will need 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 the financial year 2023-24 with a further review ahead of winter. Intermediate care capacity and demand plans for 2024-25 will be drawn up in the final quarter of 2023-24 so as to reflect the most up to date position and build on progress in 2023-24. There is no expectation that the BCF should be used to fund all services within this intermediate care capacity and demand plan.

68. Areas should work closely across all partners to produce the capacity and demand plan for intermediate care, and utilise data submitted by NHS organisations on acute, community and mental health hospital discharge pathway activity – as well as local government service data – as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans; and areas should build a shared understanding of the data and evidence. The plans should also complement and build on the capacity and demand sections of UEC recovery plan returns in the NHS planning returns – where these can be mapped to local council area and wider capacity and demand planning initiatives such as those through the Market Sustainability and Improvement Fund (MSIF) where possible. MSIF aims to capture long term social care capacity whereas the BCF intermediate care capacity and demand plans will capture short term capacity across health and social care.

69. Further guidance is set out in Appendix 2, and bespoke support will be available through the BCF external support programme. This support will include specialised support on intermediate care capacity and demand, including working across organisational boundaries and sourcing capacity and demand data across all discharge pathways and sectors.

Narrative planning

70. Narrative plans must be submitted alongside 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.

71. Two or more Health and Wellbeing Board areas can agree and submit a joint narrative plan, where approaches to integration and meeting the requirements of the BCF are aligned. In these cases, a separate planning template will still need to be completed for each HWB.

Expenditure planning

72. 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.

73. The requirement to indicate planned activity and the percentage of planned spend that BCF activity represents are new for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

74. 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.

BCF Support Programme

75. The Better Care Fund Support Programme will ensure that local areas have the right support available as they work towards the requirements, conditions and metric ambitions set out in delivering their BCF plans. This will include support in relation to

reducing delays in discharge, improving prevention, managing overall system flow and improving integration between health, housing and social care services.

76. The support programme has now been expanded and will be in place for the next two years. A contract is in place with the LGA working with ADASS and Newton to ensure responsive and comprehensive support is available to all systems that need it, as well as supporting the development of national tools and good practice guidance (including in relation to capacity and demand). Regular webinars and events will also be part of the support on offer.

Assurance

77. The regionally led assurance processes will confirm that the content of local areas' plans enable significant progress towards delivering against the BCF objectives and priorities outlined in the BCF policy framework and these Planning Requirements. Spending and reporting requirements relating to the additional discharge funding may be impacted by updates to conditions in 2024-25 (see paragraph 47).

78. As set out in para 50 assurance panels will be provided with information on systems that have been identified as requiring additional support and performance improvement in relation to wider discharge performance in order to take this into account. Assurance of final plans will be led by Better Care Managers (BCMs) for each region 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).

79. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region.

80. 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 subject to ongoing compliance with the conditions. There may be additional approval conditions relating to discharge improvement and support.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan meets all national conditions and planning requirements. Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local government grants (DFG, iBCF and discharge funding) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions
Not approved	• One or more of the following apply: – plan is not submitted – one or more national conditions or requirements are not met, including in relation to capacity and demand plans and metric ambitions. – no local agreement on use of local government grants (DFG, iBCF and discharge funding).

81. Where plans are not submitted or 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 (see Appendix 1).

Monitoring, reporting and continued compliance

Updating BCF plans in year and in 2024-25

82. 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.

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

84. 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.

85. Areas will be required to submit ambitions for BCF metrics and plans of intermediate care capacity and demand for 2024-25 in the final quarter of the 2023-24 financial year. Any changes to discharge funding requirements, or revisions to allocations for 2024-25 will also need to be included. Further information on these requirements will be published prior to 2024-25. These updates will be reviewed by BCF assurers at regional level.

Reporting

86. 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.

87. Quarterly reporting will recommence from Quarter 2 in 2023-24 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the requirements and conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. These reports need to be 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. Reporting will include confirmation that the section 75 agreement is in place. As set out in para 46 reporting requirements in relation to the additional discharge funding will continue on a fortnightly basis, further details and the templates will be provided as soon as possible.

Monitoring compliance with BCF plans

88. In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

89. Where an area is not compliant with the requirements and conditions of the BCF, or if metric ambitions are not being met, or if the funds are not being spent in accordance with the agreed plan and risk the requirements being unmet, then the BCF team, in consultation with national partners, including NHS England and the LGA, may make a recommendation to initiate an escalation process. Monitoring of the new metric on delayed discharge will be contingent on further testing and data quality. BCF monitoring will be linked to the integrated approach to performance improvement and support in local systems described earlier that brings together leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, particularly in relation to discharge. Any intervention will be proportionate to the risk or issue identified.

90. The intervention and escalation process could lead to NHS England exercising its powers of direction through section 223G/223GA/223GB to ICBs, in consultation with DHSC and DLUHC. Further information on this approach is outlined in Appendix 1.

Timetable

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

BCF planning requirements published	5 April
Optional draft BCF planning submission (including intermediate care capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) 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	28 June
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28 June – 28 July
Regionally moderated assurance outcomes sent to BCF team	28 July
Cross-regional calibration	3 August
Approval letters issued giving formal permission to spend (NHS minimum)	8 September
All section 75 agreements to be signed and in place	31 October

Appendix 1: Support, escalation and intervention

92. Where plan development is a concern or a plan is not submitted or in-year there are concerns over compliance with the requirements of the BCF or concerns about progress against metrics, the BCF team and BCM will take steps to return the area to compliance or support improvement. In relation to discharge, this process will work with the integrated approach to performance improvement and support outlined earlier to identify if BCF escalation is appropriate.

93. The purpose of escalation in relation to plan approval is to assist areas to reach agreement on a compliant plan and support local areas to use BCF funding in the best possible way locally to enable them deliver against the objectives of the fund. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team involving NHS England and local government. 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.

94. 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.

95. Broadly this will involve the following steps:

1. **Trigger:**	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.

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 d. Area is no longer compliant with their approved plan (in year) e. Area is not making progress against metrics	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 or national 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**	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 council.
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.

Appendix 2: Capacity and demand plans

Capacity and Demand Planning

Introduction

100. As in 2022-23, systems are expected to submit capacity and demand plans for intermediate care as part of their 2023-25 BCF plans. Areas are expected to agree estimated demand for intermediate care (rehabilitation and reablement) services, and other short term services lasting up to 6 weeks (including all other short term domiciliary services). This includes patients discharged from mental health, learning disability and autism inpatient services that need to access these services and before a long-term social care or health needs assessment is carried out (if necessary), covering demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent. In line with the rest of the BCF planning requirements, references to hospitals include acute, mental health and community hospitals.

101. Intermediate care (rehabilitation and reablement) services are provided to individuals, usually older people, after leaving hospital or when they are at risk of being sent to hospital. Intermediate care helps people to avoid going into hospital or residential care unnecessarily, helps them to be as independent as possible after a stay in hospital, and can be provided in different places (for example community hospital, residential home or in people's own homes). Plans should cover all short term care, which in some cases may be separate to intermediate care.

102. Areas should outline expected capacity and demand for their intermediate care services lasting up to 6 weeks and before a long-term social care needs assessment is carried out (if necessary). Plans should cover demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent, on a monthly basis for the whole of 2023-24. These plans should cover both BCF funded activity and non BCF funded activity.

103. Areas are asked to review actual demand and use of services from the previous year, expected changes, and use this to review capacity (including how utilisation of capacity could be improved). As set out earlier, these should initially cover the 12 months from April 2023 to March 2024, with refreshed plans required ahead of winter and before the start of 2024-25.

Aims of capacity and demand planning

104. For the commissioning of intermediate care to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care services and a comprehensive picture of capacity. The aims of capacity and demand planning in the BCF are to:

- Ensure that an integrated approach to capacity and demand planning for intermediate care is happening across health and social care in all systems. This will ensure local areas are commissioning sufficient capacity to maintain individuals' independence, support flow through urgent and emergency care services (including mental health, learning disability and autism services), and improve hospital discharge.

- Continue to improve understanding (locally, regionally and nationally) of the capacity required and potential gaps in systems, with the resulting business intelligence driving commissioning decisions to support and enable long term planning and solutions.
- 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 – with a view to increasing the number of people receiving support in their own home, where appropriate.

- Ensure that areas are able to allocate resources effectively and improve value for money of these services.

105. The capacity and demand plans should also build, as appropriate, on any assumptions made in development of Urgent and Emergency Care Recovery plan capacity and demand plans in the NHS planning round.

Content of plans

106. Capacity and demand planning should include consideration of work to improve commissioning, the plans will need to reflect:

- Reducing over-prescription.
- Addressing duplication in terms of service and referral route.

- Anticipating staffing and resource needs.
- Expected demand and planned capacity for services to help a person remain independent at home.
- Expected demand and planned capacity for services to help a person be discharged from hospital.

107. The demand sections will now include a comparison of the previous year's demand with expected demand for the next year. Information will be gathered via the main BCF planning template.

108. The overall process includes:

- Using BCF narrative plans to review demand for intermediate care from 2022-23, including:
    - referrals in 2022-23, compared to expectations;
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services); and
    - expected increases in demand based on demographics or other factors from 2022-23.
- Considering capacity, including:
    - current commissioned services;
    - use of different pathways against plan and potential gaps (impact of efforts to reduce bedded intermediate care and long term care, where a different service would achieve a better outcome; and
    - areas for additional investment (including use of additional discharge funding) to improve access to intermediate care and outcomes for local people.

109. The capacity and demand template for BCF plans collects information on capacity for the following types of service:

- Short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital.

- Reablement and rehabilitation provided to people in their own homes either to recover function and avoid admission to hospital/residential care (step-up), or to enable a return to home, following a spell in hospital (step-down).

- Reablement and rehabilitation provided in a bedded setting, either to recover function and avoid admission to hospital/residential care (step-up), or to facilitate an eventual return home following a spell in hospital (step down).

- Urgent Community Response (crisis response) to prevent hospital admissions.

- Low level support provided to a person to help them return home following a stay in hospital, or to help someone stay at home in a crisis. This could include voluntary organisations that provide social and practical support to people or other neighbourhood support that is less intensive than reablement or intermediate care.

110. For discharge, capacity and demand for Pathway 3 should also be captured where this is specifically a short-term placement prior to assessment for long-term care.

Assurance

111. These capacity and demand plans will need to be submitted as part of BCF plans and the assurance process will review whether the plans are robust and ensure that the narrative, spending and metrics elements of the plan have taken on board the findings in the capacity and demand estimates. Assurance will be focused on how the modelling has been taken into account in the main BCF plan rather than the estimates themselves.

Completing the template

112. Some changes have been made to the capacity and demand sheets to reflect learning from 2022-23. The structure of each collection and additional guidance is set out below.

Community demand

113. Systems will need to use this section to estimate demand for each type of intermediate care service from people currently living at home. ‘Home’ should include care homes where this is the usual place of residence.

114. Consider different routes of referral – e.g. 111/999, Single Point of Access (SPA), and self-referral. The table has been updated to collect referrals from different sources. The name of the source is not pre-populated. Referrers should be involved in the process to help understand unmet demand – i.e. where a person has received care from a service, but their needs could have been more appropriately met

elsewhere. In reviewing demand, systems should try to avoid assuming that the actual number of users or capacity of services reflects demand.

115. These considerations could include:

- People who are not offered the support, due to capacity constraints.
- Unplanned admissions for chronic conditions – could some have been prevented?
- People offered long term care or short term care without reablement instead of reablement or rehabilitation (this might be care in their current place of residence or admission to a care home).

116. These factors from 2022-23 will need to be considered when recording expected community demand for 2023-24, as well as any expected changes from the previous year.

117. Demand for low level support should include people whose short term needs could be met by social support from Voluntary sector organisations or similar services (those that fall short of the definition of Urgent Community Response with a two hour response time.)

Community capacity

118. When reviewing the range of commissioned services that support people in crisis, areas should identify services in the LA area that provide intermediate care by service type, and review data on planned capacity, actual referrals and time spent in the service. You should review information from providers, data on the Community Services Dataset (for example on Urgent Community Response) and data submitted on ASC activity to the Short and Long Term Care dataset.

119. These estimates should cover current expected commissioned capacity (not including spot purchasing, although use of spot purchasing in 2022-23 should be reviewed to try and improve capacity assessments going forward).

120. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

121. Where services accept community and hospital referrals, the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from the community.

Discharge demand

122. The discharge expected demand section should also review activity from the previous year, including:

- Average discharges per month at LA level (SUS).
- Adjustments for population and possibly higher turnover with additional funding.
- The pathways people were discharged into.
- Number/proportion discharged into rehabilitation at home (SALT/Trust data that feeds ASCOF on coverage of reablement).
- Include people waiting for onward referral from community hospital/nursing home for support at home.
- Do not include people moving from a hospital ward to a virtual ward, but do include people coming out of virtual ward into the community.

123. Pathway 0 demand should reflect only those cases where a person may require support from VCS or neighbourhood team for a short period. Do not include simple discharges or where there is no support other than outpatient or GP follow up, or where a person is returning to an existing care home or domiciliary care package with no additional support needs.

Discharge capacity

124. As with last year, areas will need to set out expected intermediate care capacity available for supporting discharge at the HWB level, covering both LA and ICB commissioned activity and taking into account expected demand changes. Areas will need to:

- Set out planned commissioned services for the 12 months – not including spot purchasing but reviewing the use of this in 2022-23.
- Include additional services funded with the additional discharge funding for 23-24.
- The template will collect data from individual services – e.g. a set of intermediate care beds, or a reablement team.

125. Where packages of care are commissioned at ICB level, the capacity should be apportioned to LAs based on locally held data on hospital occupancy and discharges and service provision.

126. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

127. Where services accept community and hospital referrals the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from hospital.

Low level support for simpler discharges

128. We are collecting information on the number of less complex discharges (classed as Pathway 0 i.e. do not need a full package of reablement or intermediate care) but where support from the VCS or local services is needed to help the person return home. You should estimate number of people that can be supported/facilitated by commissioned VCS capacity and also expected numbers of people that will be supported by community providers and the local council (short of reablement) that can be delivered.

Other sources of guidance

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.
- The NHS England Demand and Capacity Team have resources available to support with capacity and demand planning including models, guidance about fundamentals and principles and other resources here.
- 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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