Appendix 3

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Better Care Fund planning requirements 2021-22

30 September 2021

Contents

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[1] for the implementation of the Better Care Fund (BCF) in 2021-22. The Framework forms part of the NHS mandate for 2021-22.

2. Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report.

3. As set out in the BCF Policy Framework, the requirements of the planning process have been kept simple and focused on continuity in 2021-22, while enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it. Collection of BCF plans will recommence in 2021-22 and plans will be assured at regional level. Use of BCF mandatory funding streams (clinical commissioning group [CCG] minimum contribution, improved Better Care Fund [iBCF] grant and Disabled Facilities Grant [DFG]) must be jointly agreed by CCGs and local authorities to reflect local health and care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

4. BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund. In the case of length of stay, these ambitions should align to local NHS trust plans to reduce the number of inpatients who have been in hospital for 21 days or over, and should be developed with hospital trusts. Further guidance on setting ambitions for these metrics is set out in Appendix 4.

5. From March 2020, in response to the pandemic, the Hospital Discharge Service Requirements suspended previous performance standards on delayed transfers of care (DToC) and set out revised processes for hospital discharges in all areas, including a requirement that people should be discharged the same day that they no longer need to be in an acute hospital; and implementation of a 'home first'

[1] Better Care Fund policy framework: 2021 to 2022 - GOV.UK (www.gov.uk)

approach. This policy is supported by additional funding in 2021-22 for health and social care activity to support recovery outside hospital and implement a discharge to assess model.

6. This additional funding is drawn down by CCGs separately to the BCF, based on incurred spend on eligible services. Policy and finance[2] guidance has been published setting out the arrangements. The guidance highlights that planning for discharge services should be done at HWB level and should be a joint process.

7. BCF plans must be submitted by 16 November 2021. Optional draft plans can be submitted to Better Care Managers (BCMs) by 19 October 2021 for feedback. Assurance will be carried out on final plans.

8. As in previous years, this guidance forms part of the core NHS Operational Planning and Contracting Guidance. CCGs are therefore required to have regard to this guidance by section 14Z11 of the NHS Act 2006. It is being published jointly with the Government to disseminate it directly to local government.

9. The Framework for the fund derives from the Government's mandate to the NHS for 2021-22, issued under section 13A of the NHS Act 2006, which sets an objective for NHS England to ringfence £4.26 billion to form the NHS contribution to the BCF. These planning requirements set allocations for each CCG from this ringfence and apply conditions to their use. BCF plans and their delivery should comply with the conditions as part of the delivery of CCGs' duties under sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency, etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

10. Improved Better Care Fund (iBCF) and Disabled Facilities Grant (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.

11. For 2021-22, BCF plans will consist of:

    - a narrative plan
    - a completed BCF planning template, including:
        - planned expenditure from BCF sources

[2] Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

- 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.

Mandatory funding sources

12. The following minimum funding must be pooled into the BCF in 2021-22.

Source	2020-21 (£m)	2021-22 (£m)	Percentage change
CCG minimum contribution	4,048	4,263	5.3%
Improved Better Care Fund	2,077	2,077	-
Disabled Facilities Grant	573*	573	-

*Including additional funding on £68 million announced in December 2020.

13. Allocations of the CCG minimum have been published alongside this document on the NHS England website. This document sets out contributions from CCGs to the BCF overall and also the ringfenced sums for each CCG that must be spent on CCG commissioned out-of-hospital services under National condition 3.

National conditions

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

A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.

NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.

Invest in NHS commissioned out-of-hospital services.

Plan for improving outcomes for people being discharged from hospital.

15. 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

16. National condition 1 requires that a plan for spending all funding elements is jointly agreed by local authority and CCG partners 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.

17. Plans must be agreed by the local authority chief executive and CCG accountable officer, prior to being signed off by the HWB.

18. 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.

19. Systems should review the assessment of health inequalities and equality for people with protected characteristics from their 2020-21 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.

20. Data on avoidable admissions and on discharge to be used in the BCF for 2021-22 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. CCGs will also need to take into account NHS England's planning expectations for implementing phase 3 of the NHS response to the COVID-19 pandemic,[3] issued on 7 August 2020. This letter set out eight actions for NHS systems to take to address inequalities, particularly those highlighted by the

[3] https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/

COVID-19 pandemic. The implementation guidance[4] for health systems for the first half of 2021-22 distilled these into five priorities.

Mandatory components of the Better Care Fund

CCG minimum contribution to the Better Care Fund

21. NHS England has published allocations[5] from this national ringfence for each CCG for 2021-22 as part of the main operating and contracting guidance.[6] The allocations for all mandatory funding sources are pre-populated in the BCF planning template at HWB and CCG level.

22. The national CCG contribution to the BCF has been increased in line with average NHS revenue growth from 2019 to 2024 (5.3%). Local allocations are based on the BCF allocations formula, which uses both the local government relative needs formula (RNF) and the core CCG allocations formula. This means that percentage uplifts at HWB level will vary from area to area.

23. The allocation for each CCG continues to include funding to support local authority delivery of reablement, carers' breaks and implementation of duties to fund carer support under the Care Act 2014. Local allocations of these elements of the CCG minimum are not set for each area, and it is for local government and CCGs to agree the funding to allocate to these services as part of their local BCF plans.

24. 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, such as those funded through the NHS Long Term Plan, to implement improved access to reablement and the two-day response standard, additional reablement services commissioned with Hospital Discharge funding, as well as council-funded reablement.

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

[4] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
[5] NHS England » Better Care Fund
[6] https://www.england.nhs.uk/operational-planning-and-contracting/

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

26. National condition 2 requires that, in each HWB area, the contribution to social care spending from the minimum CCG contribution is maintained in line with the percentage uplift in the CCG minimum contribution to the BCF in that HWB. The uplift applies to the minimum expectation for social care spend in 2020-21 plans for the HWB.

27. 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 CCG minimum contribution to the BCF.

28. As in previous years, the minimum expectations in each HWB will be confirmed in the BCF planning template. Any schemes where the spend type is 'social care' and the funding source is the CCG minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. CCGs 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

29. 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).

30. 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

31. A minimum of £1.121 billion of the CCG contribution to the BCF in 2021-22 is ringfenced to deliver investment in out-of-hospital services commissioned by CCGs, while supporting local integration aims. Each CCG's share of this funding is set out as part of the CCG allocations to the BCF 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 CCGs from the CCG minimum contribution.

Grant funding to local government

Improved Better Care Fund (iBCF) grant

32. The grant determination for the iBCF was issued in May 2021. 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. Overall allocations for BCF revenue and capital grants to local government for each local authority remain the same in cash terms as in 2020-21.

33. The grant conditions remain broadly the same as in 2020-21.

34. 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.

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

36. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required through BCF reporting.

37. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (National Condition two).

Disabled Facilities Grant

38. 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.

39. 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.

40. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to help 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.

41. 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.

42. Since 2008/09, the scope for how DFG funding can also 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 and Foundations websites.

43. 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 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.

National condition 4: Managing transfers of care

44. Local partners should ensure that they have an agreed approach to support safe and timely discharge, including ongoing arrangements to embed a home first approach.

45. BCF plans already include expenditure to support discharge and plans for 2021-22 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of discharge. This should include:

- how collaborative commissioning of discharge services is supporting this. Systems should have regard to the guidance on collaborative commissioning published by the Local Government Association (LGA), in partnership with the BCF Programme[7]
- providing details in the BCF planning template of planned spend on discharge-related activity. Scheme types have been updated to collect better information on discharge expenditure in the BCF
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (reducing the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days).

46. Additional funding of £1.072 billion has been made available by government to support hospital discharge in 2021-22. This funding is drawn down from central funds by CCGs, based on eligible spend and is not a mandatory funding stream in the BCF. The finance guidance that supports this funding advises areas to consider using section 75 arrangements for commissioning using these funds, particularly where one body acts as a lead commissioner. BCF section 75 agreements can be used for this and, if planned spend from the hospital discharge policy (HDP)[8] funding is pooled, it should be shown as an additional contribution from the CCG.

47. Local authorities and CCGs are expected to continue to pool pre-existing expenditure on discharge alongside the separate funding for additional costs linked

[7] Top tips for implementing a collaborative commissioning approach to Home First | Local Government Association
[8] Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

to the HDP. 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.

48. The BCF Policy Framework sets out that NHS England will focus its oversight on approval and permission to spend from the CCG ringfenced contribution, particularly on plans linked to National condition 4. This will include confirmation that ambitions set for reducing the proportion of hospital inpatients with a long length of stay are sufficiently stretching.

49. 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. Detailed narratives and progress against individual elements of the High Impact Change Model for Managing Transfers of Care will not be collected in 2021-22, but systems should note that this model[9] remains best practice and underpins the revised Hospital Discharge Policy.

Agreement of local plans

50. National condition 1 requires that plans for use of all mandatory pooled funds are agreed by local authority chief executives and CCG accountable officers, and are signed off by HWBs.

51. Areas will need to agree a short narrative plan and confirm agreed expenditure and compliance with the requirements of the fund in the BCF planning template. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans. Plans for hospital discharge and ambitions for discharge metrics should be developed and agreed with local NHS trusts.

52. Final narrative plans and completed planning templates should be submitted by 16 November 2021. Optional draft narrative plans can be submitted to BCMs by 19 October 2021 for light touch review and feedback.

53. Narrative plans should reflect how commissioners will work together in 2021-22 to:

[9] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

- continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
- overarching approach to support people to remain independent at home
- a narrative on the approach in the area to jointly improving outcomes for people being discharged from hospital, and for reducing the percentage of hospital inpatients who have been in hospital for more than 14 and 21 days. (**National condition 4**)

54. Narrative plans will not be collected in the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas are not required to use this.

BCF planning template

55. The planning template will be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met.

56. The template will be pre-populated with

- minimum funding contributions for all mandatory funding sources
- minimum ringfenced amounts from the CCG minimum for:
  - the contribution to social care (National condition 2)
  - spend on CCG commissioned out-of-hospital services (National condition 3).

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

58. 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 sub type
   - brief scheme description
   - amount of spend in 2021-22
   - area of spend (ie 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.

59. 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 duties and carers breaks have been identified in spending plans.

60. The specific scheme types and subtypes have been updated to reflect the revised Hospital Discharge Policy and collect information on how BCF funding streams support discharge and implementation of the home first policy. This information will support future policy development and areas should aim to record these scheme types as accurately as possible in their spending plans.

61. 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. With narrative scheme descriptions and metrics plans stripped out from the planning process, the clarity of the remaining information is important in being able to account properly for the effective use of the funding pooled into the BCF. Local areas may be asked for further information on spend classed as 'other’ through the assurance process.

Metrics

62. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22. Ambitions should be agreed between the local authority and CCG(s) and signed off by the HWB. The framework retains two existing metrics from previous years:

- effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)

- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

63. The previous measure on non-elective admissions will be replaced with a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). Areas should agree expected levels of avoidable admissions and how services commissioned through the BCF will minimise these.

64. The LGA recently published a high impact change model for reducing preventable admissions to hospital and long-term care which may support local systems in considering these issues.[10]

Discharge metrics

65. In June 2021, updated hospital discharge service guidance was published. The guidance set out revised processes for hospital discharges in all areas, including implementing a 'home first' approach. The revised policy also suspended reporting of DToC (from March 2020). New measures have been introduced to reflect the revised policy more clearly.

66. From May 2021, revised metrics to track the implementation of the discharge policy are being collected via the Acute Daily Situation Report.

67. This data is not currently collected at a local authority footprint in national reporting. Discharge metrics for the BCF will therefore be based on information available through hospital patient administration systems, available through the Secondary Uses Service (SUS) database (which is available on a local authority footprint). Local systems should agree a plan to improve outcomes across the HWB area for the following measures:

- reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- improving the proportion of people discharged home using data on discharge to their usual place of residence.

[10] https://www.local.gov.uk/reducing-preventable-admissions-hospital-and-long-term-care-high-impact-change-model#:~:text=Reducing%20preventable%20admissions%20to%20hospital%20and%20long-term%20care,need%20for%20acute%20hospital%20or%20long-term%20bed-based%20care.

68. Areas should agree plans for improving outcomes against these measures and include ambitions within their final plans. These ambitions should align to local NHS trust plans to reduce the number of inpatients who have been in hospital for 21 days or over, and should be developed with hospital trusts. These should be stretching, and areas with above average numbers of inpatients with long lengths of stay should ensure that their ambitions aim to reduce this gap.

69. Reducing length of stay relies on action before and during a person's stay in hospital, with co-ordination at the point of discharge being only one element. Plans for reducing the number of long stay patients should involve HWBs and hospitals and reflect a whole-system approach to improving outcomes by supporting people to return home from hospital as quickly as possible and with the right support. HWBs also have a role, through their duty to promote the health and wellbeing of their residents; to ensure that hospitals are doing all they can to ensure that patients only stay in hospital as long as is necessary; and, working with hospitals, to ensure that internal and system-wide processes are being optimised.

70. Appendix 4 contains additional guidance for areas to support setting these ambitions. Data on historical performance in relation to length of stay at local authority and hospital trust footprints is available on the Better Care Exchange.

71. The BCF team will use the situation report and local authority level data to oversee progress and, in discussions with national partners, consider whether areas facing challenges may require additional support.

72. Hospital trusts, local authorities and CCGs should work together to continue to improve the use of situation reporting and other data to understand the effectiveness of their local implementation of the Hospital Discharge Policy. This should include analysis of discharges into each pathway, differences in delays by reason type, and outcomes for people discharged into intermediate care at a HWB level. NHS England will work with partners to support the process for collecting and reporting these metrics in this way, with an aim to have more detailed pathway and other information available on a local authority footprint from 2022.

73. As set out in paragraphs 19 and 20, in setting ambitions for these metrics areas should consider specific actions that they will take to address health inequalities and promote equality for people with protected characteristics under the Equality Act 2010.

Assurance

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

75. 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).

76. Recommendations for approval will be signed off by NHS regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations.

77. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the CCG minimum contribution to the fund, will write to areas to confirm that the CCG minimum funding can be released.

78. NHS England will focus its oversight particularly on approval and permission to spend from the CCG ringfenced contribution on plans linked to National condition 4 and ambitions for reducing long length of stay. This will include an assessment at regional level of the ambitions, with a further review of plans at national level. Plans will still need to meet all the requirements and national conditions to be approved.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB • Plan meets all national conditions • 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
Not approved	• One or more of the following apply: – plan is not agreed – one or more national conditions not met – no local agreement on use of local authority grants (DFG and iBCF)

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

80. Escalation will be considered in the event that:

- CCGs and local authority are not able to agree and submit a plan to their HWB or
- the HWB does not approve the final plan or
- regional assurers rate a plan as 'not approved'.

81. 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.

82. If a plan is not approved, the area should not proceed with the finalisation of BCF section 75 agreements.

Monitoring and continued compliance

Updating BCF plans in year

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

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

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

85. 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

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

87. 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 risking the national conditions not being met, 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.

88. The intervention and escalation process (outlined in subsequent sections) could lead to NHS England exercising its powers of intervention provided by the NHS Act 2006, in consultation with DHSC and DLUHC, as the last resort.

Reporting in 2021-22

89. 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.

90. These reports are discussed and signed off by HWBs (or with appropriate delegation) 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.

91. Quarterly reporting will recommence in 2021-22 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the national conditions of the fund. Timely submission of quarterly and end-of-year

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

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

BCF planning requirements published	30 September 2021
Optional draft BCF planning submission submitted to BCM	By 19 October 2021
Review and feedback to areas from BCMs	By 2 November 2021
BCF planning submission from local HWB areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	16 November 2021
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	16 November to 7 December 2021
Regionally moderated assurance outcomes sent to BCF team	7 December 2021
Cross-regional calibration	9 December 2021
Approval letters issued giving formal permission to spend (CCG minimum)	From 11 January 2022
All section 75 agreements to be signed and in place	31 January 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 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. The **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 and NHS Improvement • LGA. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant CCG(s) • senior officer(s) from 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 CCG as to how the minimum BCF allocation should be spent.

	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. NHS England has the ability to direct the use of the CCG funds where an area fails to meet one of the BCF conditions and NHS England considers that the CCG(s) in question is failing, has failed or is at significant risk of failing to discharge any of its functions. This includes the duties under sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency, etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006. If a CCG fails to develop a plan that can be approved by NHS England or if a local plan cannot be agreed, any proposal to direct use of the fund and-or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and DLUHC ministers. The final decision will then be taken by NHS England. Once a decision has been taken any directions would be made under section 14Z21 of the NHS Act 2006.

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. A BCF plan will not be approved, however, 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 CCG 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 CCG contribution in each subsequent year.

2. In 2021-22, 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 CCG(s) and local authority(ies) agree that the baseline is not correct.

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 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.
Definition	**Denominator:** Mid-year population estimates for England published by the Office for National Statistics (ONS) annually – National Statistics. Available in June following end of reporting year. **Numerator:** Hospital Episode Statistics (HES) admitted patient care (APC), provided by NHS Digital – National Statistics Final annual and quarterly HES data are usually released in the November following the financial year-end.
Source	NHS Outcomes Framework
Reporting schedule for data source	Monthly
Historical	Quarterly and annual data from 2003/04 Q1 for all breakdowns

Metric 4 Discharge Indicator Set

Outcome sought	a) Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days. b) Improving the proportion of people discharged 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. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. There is evidence that recovery and independence for people who have been admitted to hospital are improved if they are discharged to their own home. This indicator measures (a) percentage of hospital patients whose stay is 14 and 21 days or longer and (b) the percentage of discharges that are to a person's usual place of residence.
Definition	**Denominator:** The proportion of hospital patients whose stay is 14 and 21 days or longer and the proportion of discharges that are to a person's usual place of residence **Numerator:** All completed hospital spells recorded in SUS – calculation on monthly total.
Source	NHS Secondary Uses Service (SUS)
Reporting schedule for data source	Monthly
Historical	Monthly data from 2018/19 Q1 for all breakdowns.

Appendix 4: Setting ambitions for length of stay

1. Better Care Fund plans must set out ambitions at local authority level for reducing the percentage of hospital inpatients who have been resident for 14 days or more and 21 days or more. These ambitions should be based on:

   - **Local agreement:** ambitions should reflect a joint local government, CCG and provider agreement, and a co-ordinated approach to discharge.
   - **Trust-level ambitions:** for patients in hospital for 21 days and over, NHS England has agreed a 12% ambition. BCF ambitions in each HWB area should reflect the level of ambition agreed for local trusts.
   - **Current performance data:** A range of performance data has been made available on the Better Care Exchange showing recent data on 14 day and 21 day length of stay for people resident in each upper tier local authority. This data is taken from the NHS Secondary Uses Service (SUS) database and uses the local authority of residence shown on Hospital systems.

3. Ambitions should be set as the average proportion of long stay patients for quarter three and four of 2021-22.

4. The BCF planning template include space for a supporting narrative. This should set out:

   - a short rationale for the ambitions
   - how BCF-funded schemes and local approaches to commissioning will support performance
   - any other significant actions that will be taken by systems to minimise long length of stay in hospitals.

If you have any queries about this document, please contact the Better Care Fund 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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