The Better Care Fund:

Operating Guidance

For 2016-17

Gateway Approved: 05552

The Better Care Fund

CONTENTS

PURPOSE

1. This document provides guidance to partners for local Better Care Fund plans – Clinical Commissioning Groups, Local Authorities, and Health and Wellbeing Boards – on the operational requirements for these plans in 2016-17.

2. In particular it sets out:

    - the legislation underpinning the Better Care Fund (BCF);
    - the accountability arrangements and flows of funding;
    - the reporting and monitoring requirements for 2016-17;
    - how progress against plans will be monitored and what the escalation process will look like; and
    - the role of the Better Care Support Team in supporting delivery.

3. This document should be read alongside the BCF policy framework for 2016-17[1], published by the Department of Health (DH) and Department of Communities and Local Government (DCLG), and annex 4 of the Technical Guidance: BCF Planning Requirements for 2016-17[2]

4. This guidance has been co-developed by the national organisations which make up the Better Care Support Team with input from Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). It replaces the BCF Operationalisation Guidance for 2015-16[3] previously published by those organisations in March 2015.

5. In response to strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund, we have streamlined and simplified the planning and assurance of the Fund in 2016-17. This operational guidance reflects this, particularly the removal of the payment for performance scheme. It also reflects the two new national conditions around the requirement to fund NHS commissioned out-of-hospital services and the requirement to develop an action plan for managing delayed transfers of care. In addition other key changes are as follows:

    1. Addition of Risk Share Agreements for non-elective admissions
    2. Non-elective admissions (NEA) data will now be extracted from the SUS national repository
    3. The Clinical Commissioning Group to Health and Wellbeing Board data mapping process has been updated

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/annex4-bcf-planning-requirements-1617.pdf

[3] https://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance-1516.pdf

LEGAL POWERS

6. Under s.223G of the NHS Act 2006, NHS England has the power to set conditions around the payment of funds to CCGs. In relation to the BCF allocation, section 223GA states that this must include a condition that funds are paid into a section 75 pooled fund. In 2016-17, NHS England has set additional conditions which local areas will need to meet to access the funding. These are set out in the BCF policy framework for 2016-17 (page 8) and the BCF planning guidance for 2016-17 (pages 2-3).[4]

7. Where a condition is not met, s.223GA of the NHS Act 2006 enables NHS England to:
    - ***withhold the payment*** (insofar as it has not been made);
    - ***recover the payment*** (insofar as it has been made);
    - ***direct the CCG(s) as to the use*** of the designated amount for purposes relating to service integration or for making payments under s.256 of the 2006 Act.

8. The three powers of intervention set out above where a condition is not met apply to the £3.519bn of the BCF that is being routed through CCGs. The powers do not apply to the remaining £394m Disabled Facilities Grant that is paid by DH and DCLG directly to local authorities under s.31 of the Local Government Act 2003.

9. NHS England's functions in relation to the BCF arise if the Secretary of State for Health uses his powers to include in the mandate a requirement for NHS England to ring-fence some of its funding to fund integration. The mandate to NHS England[5] was published on 22 January 2016 with the relevant requirements around the BCF.

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

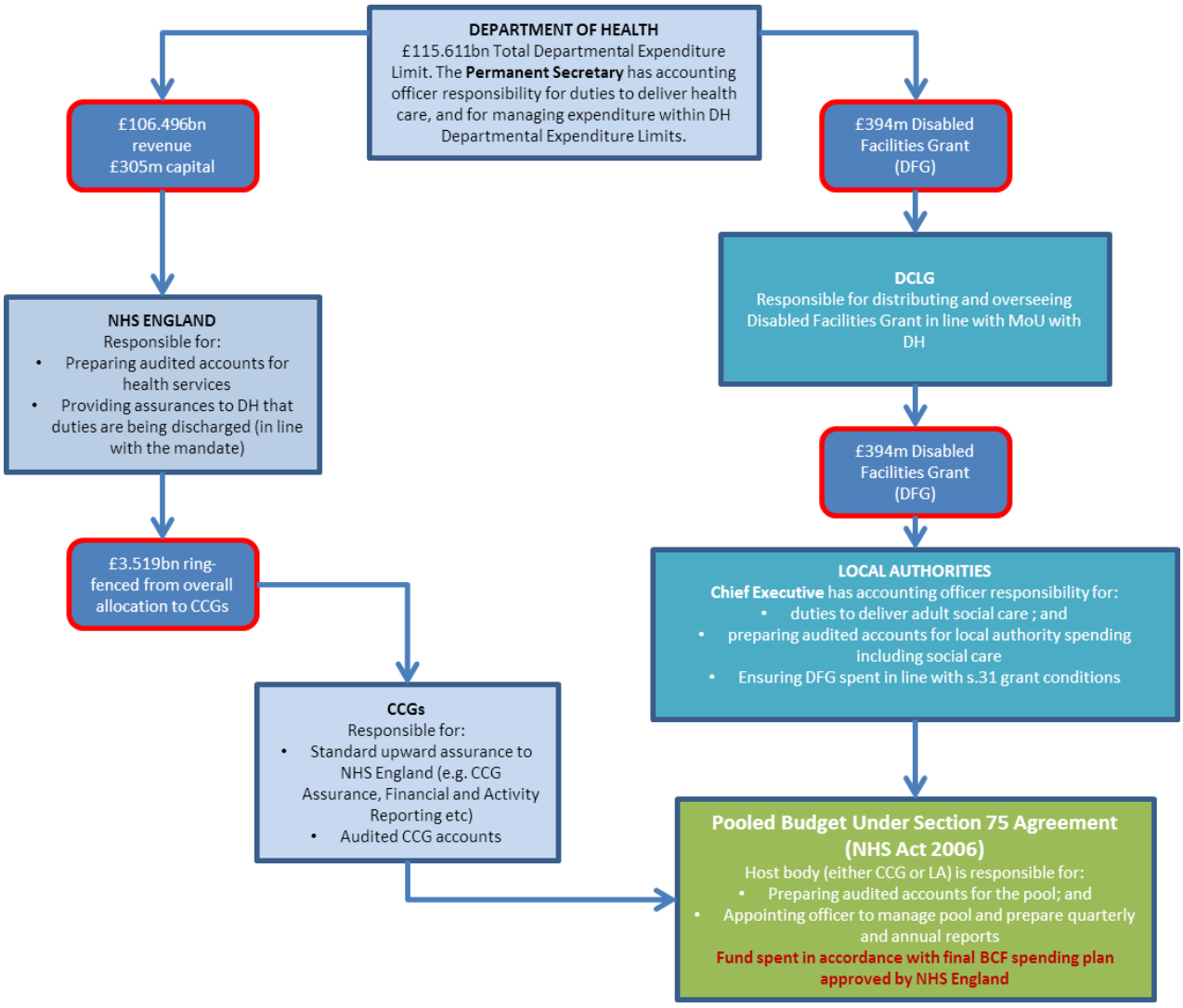
ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 2016-17

11. One of the recommendations of the 2014 National Audit Office report[6] on the BCF was to develop clear accountability structures for the fund, including how accounting officers will gain assurance on how local areas spend the Fund. Below is a diagram setting out the accountability arrangements and flow of funding for the BCF.

[4] https://www.england.nhs.uk/wp-content/uploads/2016/02/annex4-bcf-planning-requirements-1617.pdf

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

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



12. In summary, at national level:

- the full £3.9bn of funding will be part of DH's Departmental Expenditure Limit so overall accountability to Parliament will sit with the DH Permanent Secretary;
- DCLG will retain policy responsibility for the Disabled Facilities Grant (DFG);
- the NHS England Accounting Officer (the Chief Executive) is accountable for the effective use of the £3.519bn of the Fund which constitutes revenue grant;
- the £3.519bn will pass from NHS England to CCGs through 2016/17 allocations, and then from CCGs to pooled budgets (via section 75 agreements);
- the £394m for the Disabled Facilities grant will flow from DH to DCLG and then to LAs, and then into the pooled budget via s.75 agreements; and
- the monies will then be spent on services in line with their approved BCF spending plan.

13. At local level:

- CCGs (Accountable Officers) will be the accountable body for their share of the £3.519bn of the BCF allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
- LAs (s.151 officers) will be the accountable body, under the terms of their grant agreements, for the £394m of funding that is paid directly to them by DCLG (and any additional monies they plan to voluntarily add to the pooled fund).

14. At a local level, as legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the Fund in accordance with the approved plan.

15. HWBs are a valuable forum for stakeholders to come together to review performance of the BCF and consider future work. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners. Given they are a committee of the LA, HWBs are accountable to the LA and ultimately to the LA's electorate. HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with[7]. Particularly where members of a HWB include providers delivering care that is or could be commissioned under BCF, care will need to be taken to ensure that any conflicts of interest are appropriately dealt with.

16. In terms of operational oversight of the BCF, the regulations[8] governing s.75 agreements require the agreement to set out (amongst other provisions):

    - the arrangements for monitoring the delivery of the services that it covers;
    - who the "host" organisation is that will be responsible for accounting and audit; and
    - who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

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

18. The Better Care Support Team has released updated guidance and support[9] for local areas developing their local s.75 agreements. The updated documentation, published

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

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

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

in June 2016, includes a template s.75 agreement and explanatory memorandum. It is strongly recommended that areas use this as a basis for developing their local agreements. The explanatory memorandum provides support for local areas considering their local governance and oversight arrangements. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that are signatories to the agreement. Each of those signatories should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

19. Where a risk sharing arrangement linked to NEA activity is put in place by the HWB through the planning process for 2016-17 local areas should ensure that arrangements for this are clear and there is a process in place monitoring this locally. This should be detailed within Section 75 agreements. If the local area uses the model for a risk sharing arrangement set out by NHS England in the planning guidance (and provided here at annex 3) then CCGs should ensure that they have withheld the funding related to NEA activity from the pooled fund at the beginning of the year as set out.

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

21. ***For 2016-17 NHS England again recommends to CCGs:***
    - ***that a partnership board is in place to govern the s.75 agreement;***
    - ***that a clause is included in the s.75 agreement that sets out what information should be included in the host partner's quarterly reports and annual reports to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to NHS England as to the appropriate use of the fund (this is explained in more detail in the next section); and***
    - ***that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.***

REPORTING AND MONITORING IN 2016-17

22. The BCF was embedded into business-as-usual processes within NHS England for planning, performance monitoring, assurance, and performance management as far as possible during 2015-16. However due to the unique nature of the BCF and the HWB footprint special arrangements have been put in place where required, in particular to include local government representatives in processes and

conversations. This will continue in 2016-17, whilst the legal powers continue to be routed through NHS England and CCGs.

Conditions of access to the fund

23. As in 2015-16 every CCG will have a set of standard conditions placed on its BCF funding in 2016-17 using powers under s.223G of the NHS Act 2006. These powers require that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG.

24. Under these powers NHS England established eight conditions that local areas need to meet in 2016-17 to ensure plan approval, as set out in the BCF Planning Requirements. Meeting these conditions, as set out in approved plans will in become a condition of access to the funds, which will be set out in plan approval letters. The eight conditions are:

    i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;
    ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.
    iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;
    iv. Better data sharing between health and social care, based on the NHS number;
    v. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
    vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
    vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
    viii. Agreement on a local action plan to reduce delayed transfers of care.

Quarterly reporting in 2016-17

25. As part of the enforcement of these conditions NHS England can require CCGs to:

    - explain the governance arrangements they have in place;
    - report on spending and provide evidence that the pooled fund has been spent in a particular way (in accordance with their approved plan);
    - report on their progress in meeting the eight conditions themselves.

26. To fulfil these requirements the Better Care Support Team has developed and overseen a national quarterly reporting process for the BCF in 2015-16 which will continue into 2016-17. The process will consist of the following steps each quarter:

    i. Better Care Support Team releases a quarterly reporting template to collect from local areas the information required to meet the above requirements, which is not already available through existing data collection in the system
    ii. All 150 HWBs submit a single signed off template by the stated deadline (usually 5 weeks after release of the template)
    iii. The Better Care Support Team collect and analyse the data provided, along other available data sources, and produced a BCF Quarterly Data Collection and Performance Report
    iv. The report is shared with NHS England regional leads, Better Care Managers and local government regional leads for follow up through conversations with local areas
    v. The report will then be published on the NHS England website.

27. The high level timetable for this process in 2016-17 is set out in the below table:

Quarter	Period	Activity	Date
1	April to June 2016	Template released	22 July 2016
		Template submission deadline	26 August 2016
		Data Collection and Performance Report published	07 October 2016
2	July to September 2016	Template released	21 October 2016
		Template submission deadline	25 November 2016
		Data Collection and Performance Report published	06 January 2017
3	October to December 2016	Template released	20 January 2017
		Template submission deadline	24 February 2017
		Data Collection and Performance Report published	14 April 2017
4	January to March 2017	Template released	21 April 2017
		Template submission deadline	24 May 2017
		Data Collection and Performance Report published	21 July 2017

28. Throughout 2015-16 the Better Care Support Team produced reporting templates against the key requirements and conditions of the Fund. The quarterly reporting templates aim to fulfil both the quarterly reporting and annual reporting requirements referred to earlier in this guidance document under the s.75 regulations. Using the standardised reports ensures there is a mechanism in place to monitor the totality of the fund at HWB level, i.e. the planning footprint of the BCF.

29. The Better Care Support Team and national partners will continue to ask CCGs and LAs to use the quarterly reporting template (example contained in annex 2) in 2016-

17. The template covers as a minimum reporting on: income and expenditure, the supporting metrics, and the national conditions. In a change from 2015-16 reporting local areas are no longer required to report on Non-Elective Admissions as this data will already be available nationally (see metrics section below).

30. It is suggested that these reports are discussed and signed-off by HWBs given their lead role in the BCF as part of discharging their duty under s.195 of the Health and Social Care Act (2012) to encourage commissioners to provide health and social care services in an integrated manner[10]. Furthermore, NHS England recommends to CCGs that this approach is built into their local s.75 agreements, and require CCGs to report back on this which should also include confirmation that the HWB has signed it off.

Reporting on the national metrics in 2016-17

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

32. In summary the metrics are:

    a. Non-elective admissions (Acute Specific previously General and Acute);
    b. Delayed transfers of care from hospital per 100,000 population.
    c. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population[11].
    d. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

33. Throughout 2016-17 NHS England will be using the temporary National Repository (tNR) as the agreed source of the non-elective admissions (NEA) data monitoring. The tNR has been created in order to provide NHS England and others with a country-wide view of activity data for reporting and analysis. It includes Secondary Care data relating to Accident & Emergency, Outpatients and Admitted Patient Care in the form of Spells and Episodes. The detailed definition of the tNR NEA metric was set out in the Planning Round Technical Definitions.[12]

34. The tNR is populated from the SUS Standard Extract Mart (SEM) which is extracted from the HSCIC each month. A timetable for extracting, processing and making the

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

[11] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.

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

data available for use in the tNR has been agreed and published on the HSCIC website.[13]

35. The BCF planning round established a HWB-level NEA activity plan by mapping the agreed CCG level activity plans to the HWB footprint. This was achieved by using the mapping formula provided in the planning return template. The HWB's were also asked whether they then wanted to plan for any additional quarterly reductions. If they did, then they were asked whether they would want to put in place a local risk sharing agreement.

36. Throughout 2016-17 the NEA progress against NEA plans, and where applicable additional reductions and local risk sharing will be reported quarterly. The same tNR data extract as used by NHS England to manage activity levels against the CCG operational planning process will be utilised. To enable HWB to monitor progress the extract will be reported using the same BCF planning mapping formula.

37. The detailed definitions of this and the three additional metrics are as set out in the BCF Technical Guidance annex 4.[14] A brief summary of the indicators can be found at Annex 2 of this document. HWBs were asked to set ambitious plans in relation to each metric. Progress against DTOC targets will be measured quarterly using the existing NHS England reported Local Authority level data, mapped to Health and Wellbeing Boards. The other two national metrics are reported annually and will be included in BCF reports when the data becomes available. In the meantime NHS England may request indicative progress reports in meeting targets for the these metrics, as well as local metrics, through the quarterly reporting process.

38. The progress against plan for all of the four national metrics at a HWB level will be reported as part of a BCF quarterly report based on the latest available data.

SUPPORT FOR THE BETTER CARE FUND IN 2016-17

39. A joint Better Care Support Team with representation from NHS England, the Local Government Association (LGA), DH and DCLG was established in 2015-16 and will continue throughout 2016-17. The purpose of the Better Care Support Team from April 2016 to March 2017 is to support local systems to successfully deliver their BCF plans and ultimately commission person-centred health and social care services which achieve improved patient and service user experience and outcomes.

40. The team aims to:

    1. Continue to maintain an overview of progress in the delivery of BCF plans and build an intelligence base to understand the real impact of the BCF on delivering integration;

[13] http://www.hscic.gov.uk/media/19421/SUS-R16-Submission-Timetable-v10/pdf/SUS_R16_Submission_Timetable_v1.0.pdf

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

2. Support local systems to enable the successful delivery of integrated care in 2016-17 by capturing and sharing learning, building and facilitating networks to identify solutions;
3. Provide a strategic direction of the BCF and be central in developing a common understanding of future integration goals.

41. The team will continue to work with and through existing regional structures and bodies within the NHS and Local Government, and will again make funding available to ensure there is sufficient capacity and resource within regional structures to focus on the Better Care Fund and Health and Social Care Integration more widely.

42. Through this funding ten Better Care Manager posts have been established around the country to date, to:
    - Build a picture of relative capacity, capability and confidence (in relation to both delivery of BCF plans and longer term system transformation) across the country;
    - Enable local areas to access appropriate and effective support required to overcome barriers around delivering better, integrated care;
    - Develop relationships between NHS and LG at a regional and locality level;
    - To ensure an appropriate and co-ordinated response to local areas which are struggling to deliver on their plans;
    - To identify emerging good practice from local areas that should be shared amongst peers, and to gather intelligence about the barriers and issues around implementation of integrated care.

43. These roles will continue through 2016-17 with the number of posts increasing to twelve to ensure sufficient capacity in all areas of the country. Better Care Managers have also played a critical role in the regionally led BCF plan assurance process for 2016-17 and will again fulfil this role in planning for 2017-18.

44. The plan assurance process has also established new arrangements for joint working between the NHS and Local Government at a regional and more local level. The Better Care Support Team recommend that these arrangements continue in 2016-17 to ensure there is joined up strategic oversight and support for local systems.

MANAGING PROGRESS

45. Performance management for the BCF will be led by NHS England and the local government regions, with the joint Better Care Support Team and Better Care Managers providing support and advice. Working with the Better Care Support Team, NHS England and the local government regions, Better Care Managers will monitor progress against plans from the quarterly reporting process described above and their wider interactions with local areas, and will determine whether areas are continuing to meet the standard conditions of the Fund as detailed in section 22 above.

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

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

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

	worse than the status quo of not intervening.
5 – Regional and national consistency	It will be important to ensure that peer review is sought through the assurance process consistently to ensure that the rationale for intervention is robust.
6 – Consultation with Ministers	NHS England consults with DH and DCLG in accordance with the 2016-17 Mandate
7 – Summary report and directions drafted for committee approval	Finally, the relevant evidence and legal wording needs to be submitted to NHS England's Assurance and Development Committee for consideration. Once approved the documentation, including any directions, will be passed to the Chief Executive for signature.

ANNEXES

Annex 1 – Example HWB quarterly reporting template

Annex 2 – Further information on national metrics

Annex 3 – Requirements for risk share agreements

Annex 4 – Updated Section 75 Template and supporting guidance

ANNEX 1 – EXAMPLE HWB QUARTERLY REPORTING TEMPLATE

1. The example quarterly reporting template (attached as a PDF) is to provide local areas with an early indication of what reports will cover. These are consistent with the approach in 2015-16, with the removal of self-reporting on Non-Elective Admissions and the now defunct Payment for Performance system.

2. The actual quarterly reporting templates will be issued by the Better Care Support Team at the points indicated in the reporting timetable set out at paragraph 25.

ANNEX 2 – FURTHER INFORMATION ON NATIONAL METRICS

Metric	Data Source	Frequency of monitoring
Non-elective admissions (Acute Specific)	**Description:** Total number of specific acute (replaces G&A) non-elective spells in a month. A Non-Elective Admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. **Numerator:** Specific Acute = Total activity minus Maternity, Mental Health & Learning Disabilities (replaces G&A)	Quarterly
Delayed transfers of care from hospital per 100,000 population	**Description**: Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate or projection (mid-year projection for 18+ population) This will be the 2014-based Sub-National Population Projections (due to be published 25 May 2016) or the mid-2015 estimate (due to be published 23 June 2016) dependant on the data period. *Note: this is different to ASCOF Delayed Transfer of Care publication which uses ‘patient snapshot’ collected for one	Quarterly (annual denominator)

	day each month.	
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC. **Denominator**: Size of the older people population in area (aged 65 and over). ONS mid-year population estimate or projection (mid-year projection for 65+ population) This will be the 2014-based Sub-National Population Projections (due to be published 25 May 2016) or the mid-2015 estimate (due to be published 23 June 2016) dependant on the data period.	Annual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from Short- and Long-Term Support	Annual

	(SALT) collected by HSCIC. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC. Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.	

ANNEX 3 - REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. Paragraph 30 of the Better Care Fund Planning Requirements 2016-17 sets out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2016-17. Where this is the case the arrangements should be described within narrative plans in line with the requirements set out in paragraph 31 of the same document to include an agreed approach to financial risk sharing and contingency. Additional requirements from the same document are set out in paragraphs 2 to 4 below.

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

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

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

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

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

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

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

4. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.