Background

This BCF Plan builds upon the Plan previously developed for the Dudley health and care economy in 2015/16.

In that Plan we described how we wished to integrate service delivery in response to a particular set of local needs as identified in our Joint Strategic Needs Assessment. We made it clear that our approach predated the advent of the BCF, with the BCF being a work stream of our overall integration programme. A programme designed to bring together all population based care into one set of integrated services, based upon populations registered with general practice.

Since the development of the original BCF Plan, Dudley has become one of the NHS Five Year Forward View’s Vanguard sites. It is our intention, as part of the Vanguard Programme, to develop and commission a Multi-Specialty Community Provider (MCP), delivering a full range of community physical and mental health, social care and primary care services currently the responsibility of a number of separate organisations. Services within the scope of the BCF will form part of the MCP delivery model.

The MCP will be operational by 1st April 2017, meeting the Comprehensive Spending Review’s requirement to integrate health and social care by 2020. As such, the 2016/17 BCF Plan forms part of the process to develop Dudley’s MCP and is a subset of it. Our New Care Model “Value Propositions”, as approved by NHS England, are enclosed. (KLOE B.1. ii)

A New Model for Health and Social Care

We are implementing a sustainable and replicable whole-system change, designed around the person, communities and clinically-led service delivery, which enables both mutual-networked care and best practice pathways of care – the Multi-Specialty Community Provider (MCP). (KLOE B.1.i)

This model is broader than just health and care. It is designed to support and sustain our communities, in partnership with the community and voluntary sector, and enable people to play a fulfilling role within their community. It is consistent with the “six principles” to support the delivery of the NHS Forward View.

- care and support is person-centred: personalised, coordinated and empowering;
• services are created in partnership with citizens and communities;
• there is a focus is on equality and narrowing health inequalities;
• carers are identified, supported and involved;
• voluntary, community, social enterprise and housing sectors are key partners and enablers;
• volunteering and social action are key enablers.

Measured against these principles, our care model:-

• understands the position, needs and motivation of people and communities;
• works with people and communities to hear their voices;
• engages with people and communities to build relationships and offer genuine opportunities for influence;
• embraces the assets of people and communities to create opportunities for co-production, building collaborative relationships that recognise that different roles and perspectives are a constructive force for change;
• empowers staff to lead service changes to benefit people;
• enables people and communities to put themselves at the centre of their care - so that they can make informed decisions about their health - be supported to manage their conditions and stay as independent and in control as possible;
• creates an environment to support people using health and social care to drive change themselves.

Taken together, these approaches will improve health and care outcomes and allocate resources more efficiently to areas of need and want – especially for those with long term conditions, complex health and care needs and mental health problems.

We have already made significant progress to implement the main components and key enablers of this care model in 2015/16. Work on this will continue in 2016/17 as we develop the contractual mechanisms and service specifications for all elements of the model.

There are three elements to the model based upon the fundamental principle of supporting population-based health and wellbeing. This starts with the patient registered with their GP – the main co-ordinator of their care. This is delivered through a mutual network of care, best exemplified by the work of the practice based multi-disciplinary team, linked to a series of other community based health and care services, including voluntary and community sector services. This, in effect, is the MCP, based on the principles of shared ownership, shared responsibility and shared benefits.

The first element of the model is the mutual network of care, to be delivered by the MCP, commissioned around the following themes and outcomes:-
better communication with patients and between staff;
improved access to different types of consultation and diagnostics in the community;
continuity of care in supporting the management of peoples’ long term conditions;
effective co-ordination of care for the frail elderly, including those with dementia, through our 7 dementia advisers (KLOE C.5.ii), those with the most complex conditions and those at the end of life.

Through the second element of the model, we will support people to remain at home wherever possible by developing evidence based best practice pathways of care. We will reduce variation, so that all services are commissioned and delivered in a way that incentivises optimum outcomes for the patient, shares risk, makes the best use of the resources we have available; and enables effective communication between all stakeholders.

The final element is a re-commissioned system of primary medical services. This will be commissioned through a refreshed outcomes based contractual framework, reflecting the themes of access, continuity and co-ordination. In particular, this will address the needs of patients with long term conditions and multiple co-morbidities identified in the risk stratification analysis below.

**Personal and Population Impact**

For patients, service users and the wider population this will mean (KLOE B.1.iii):

- an enhanced service experience where services are co-ordinated, “people tell their story once”, access is enhanced and people take more control over the management of their condition as equal partners in their care;
- reduced social isolation and dependency, as exemplified by our case study of Ivan’s experience which is attached;
- a better quality of life for patients with long term conditions;
- a reduced level of social care need, post reablement;
- a specific focus on health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band;
- reducing the life expectancy gap between the most and least deprived parts of our population, specifically in relation to cancer, heart disease, stroke and liver disease;
- better and systematic management of patients with long term conditions through primary care and community health services, leading to greater diagnosis and avoidance of exacerbation;
- the relationship between mental health, physical health and the management of long term conditions is privileged (KLOE C.6.iv);
voluntary and community sector services are used as an alternative to traditional interventions through a social prescribing approach, helping, amongst other things, to reduce social isolation and loneliness.

(KLOE B.1.iii)

Our Logic Model, developed to support our Vanguard Programme, is attached.

Our BCF schemes (see below) are designed to support the “co-ordination” element of our care model (see the attached value proposition), specifically providing co-ordinated care for the frail elderly population by focussing on:-

- support to care homes;
- falls in the frail elderly;
- carers;
- safe and timely discharge.

(KLOE B.1.iv)

BCF Pool and Funding Contributions

The total BCF Pool was agreed by the Integrated Commissioning Executive (the governing body for the BCF Section 75 Agreement) at its meeting in March 2016, prior to submission to the Health and Wellbeing Board. (KLOE A.3.iv). The changes from 2015/16 to 2016/17 are as set out below.

The changes reflect (KLOE A.3.v):-

- the outturn position of the BCF pool for 2015/16;
- the level of resource required to maintain provision of adult social care;
- the impact of implementing our new “discharge to assess” pathways on adult social care spend;
- a reduction in delayed transfers of care;
- improved performance in meeting the 4 hour ED target in 2015/16.
<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>2016/17 Plan £</th>
<th>2015/16 Actual £</th>
<th>Variance £</th>
<th>Impact of planned changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Minimum contribution</td>
<td>21,029,253</td>
<td>21,504,628</td>
<td>(475,375)</td>
<td>Greater capacity to manage impact of demographic change and acuity of presenting patients</td>
</tr>
<tr>
<td>CCG Additional contribution</td>
<td>17,919,990</td>
<td>15,360,951</td>
<td>2,559,039</td>
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<tr>
<td>LA Contribution</td>
<td>23,800,801</td>
<td>19,893,577</td>
<td>3,907,224</td>
<td>Greater capacity to manage the impact of demographic change and acuity of patients entering long term care.</td>
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<tr>
<td>Total BCF Pooled Budget</td>
<td>62,750,044</td>
<td>56,759,156</td>
<td>5,990,888</td>
<td></td>
</tr>
</tbody>
</table>

(KLOEs A.3iii-v)
**Risk Sharing**

In 2016/17, monies previously forming part of the pay for performance element of the fund (£1.62m) will now be used to support the implementation of an integrated discharge pathway. This has been agreed by the System Resilience Group on the basis of a joint analysis of admissions and discharges undertaken by the CCG, Dudley Group NHS FT, Dudley MBC. The balance of investment required to meet anticipated discharge levels is illustrated below

(KLOE B.5.i / ii)

This has identified the level of resource required to maintain a suitable level, of system equilibrium in relation to emergency admissions and the level of supported discharges then required by health and adult social care. This in turn impacts upon the level of delayed transfers of care in the system. A similar level of analysis is being conducted in relation to admissions to and discharges from intermediate care facilities. The partners have, in conjunction with Dudley Group of Hospitals NHS Foundation Trust, agreed to invest this resource in the pathway.

Performance of this pathway and the impact upon delayed transfers of care will be monitored on a quarterly basis by the System Resilience Group and investment adjusted appropriately as necessary.

This change to the use of the pay for performance monies will have no impact on CCG commissioned out of hospital services which will continue in 2016/17.
Use of current resources to support demand targets and gap to proposed MoU.

**DMBC Discharge Activity Per week**

- **Option 1**
  - 24 Per Week
  - £2.5 Million
  - Funding Stream: £2.5 Million DMBC base budget

- **Option 2**
  - 43 Per Week
  - £5 Million
  - Funding Stream: £2.5 Million DMBC base budget, £2.5 Million CCG Investment
    - £1.62 Million CCG Investment BCF performance fund
    - £880k CCG investment Value Proposition Bid

- **Option 3**
  - 63 Per Week
  - £7.3 Million
  - Funding Stream: £2.5 Million DMBC base budget, £2.5 Million CCG Investment
    - £1.62 Million CCG investment BCF performance fund
    - £880k CCG investment Value Proposition Bid

**46% Gap**

- 46% increase in funding to deliver MoU targets

**£2.3 Million Gap**
Continued investment in the pathway will be reviewed on the basis of performance. To the extent that this sum is at risk based upon achievement of performance, this represents the only agreement on risk between the CCG and Dudley MBC.

(KLOEs B.5.i –B.5.iv and C.7.i-C.7.iv)

The CCG have agreed a risk mitigation contract with Dudley Group NHS Foundation Trust. The contract value is £200.1m, capped at an over-performance value of £201.68m which will only be paid in relation to emergency activity.

This agreement will operate outside of the Better Care Fund pooled budget arrangements.

NHS commissioned out of hospital services and services commissioned and supported through the former “pay for performance” monies (essentially maintaining the protection of adult social care as described below), will continue (KLOE c.7.vi)

Responding To Local Needs

Analysis of the Joint Strategic Needs Assessment as set out in the CCG’s Operational Plan and reflected in the Joint Health and Wellbeing Strategy shows that:-

- the next two decades are forecast to see an additional 25,100 people over the age of 65 and an extra 9,900 over 85;
- the rate of delayed hospital discharge attributable to social care is higher than the national rate (see “integrated discharge pathway” below);
- with the ageing population there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities (see “carers” below);
- the rate of deaths at home or in care homes has fallen from 53.05% to 51.9% but there is a higher percentage of terminal admissions that are emergencies than England (see “care homes” below);
- the rate of falls related injuries which require emergency admission for people aged 65 and over is higher than similar CCGs and the national average (see “falls” below);
- nearly 20% of our population have a limiting long term illness or disability, this has increased since the 2001 census and is worse than the national average;
- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to CHD, COPD and lung cancer in men;
• female life expectancy is 82.7 years – similar to the national average, whilst male life expectancy is 78.5 years – lower than the England average of 78.9;
• male life expectancy varies across Dudley. Halesowen South has the highest at 82.1 years, Netherton, Woodside and St. Andrews have the lowest at 73.9 years – a gap of 8.2 years;
• female life expectancy varies across Dudley. Belle Vale has the highest at 86.7 years, Castle and Priory has the lowest at 79 years – a gap of 7.7 years;
• nearly a quarter of deaths in the 40 – 59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
• mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
• mortality rates for alcohol related diseases are significantly higher than the national rate and the years of life lost in the under 75s from chronic liver disease, including cirrhosis, is significantly worse than the England average;
• nearly two thirds of ED attendances are for people living in the 40% most deprived group in Dudley;
• disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence, however, these have improved – most markedly for COPD;
• the CCG is in the worst performing fifth of CCGs for the percentage of ED attendances that result in emergency admission;
• 20% of single person households are in the 60+ age group;
• Marmot indicators show that Dudley has a higher rate for long term claimants of Job Seeker’s Allowance than the rest of England and a higher percentage of high fuel cost households in fuel poverty.

(KLOE B.2.iv)

This demonstrates that:-

• needs are complex and cannot be solved by the intervention of health and social care, either alone or isolation;
• these needs are compounded by high levels of co-morbidity (see risk stratification analysis below);
• we need to manage long term conditions systematically with both health and social care interventions;
• we have a growing frail elderly population. We need to improve the care pathway to prevent unnecessary admissions, create the conditions to re able people and maintain their independence in their communities;
“one size fits all” solutions will not be sufficient to respond to the identified layers of complexity. We need to respond in a manner that reflects the individual need of the patient with co-ordinated input from relevant services.

BCF Schemes 2016/17

In 2015/16, our BCF schemes focussed on:-

- crisis and emergency intervention
- promoting independence
- stabilisation and maintenance
- support for people with dementia

These schemes are now being embedded as we develop the MCP model of care.

Based upon the needs analysis described above, for 2016/17, we wish to focus upon:-

- supporting care homes (where our rate of admission to secondary care is high with 61% of these admissions taking place out of hours and a high proportion are at the end of life), preventing unnecessary admissions to secondary care from care homes - including patients at the end of life — as part of the development of our local integrated care pathway for the frail elderly, including people with dementia (where our diagnosis rate remains low compared to our national target) and to the benefit of patient flow through hospitals (KLOE C.5.ii);
- developing an integrated discharge pathway to complement our work on implementing “discharge to assess” models, reducing delayed transfers of care (where our social care delays are above the national average) and promoting independence;
- redesigning our falls service (where our rate of falls related admissions for the over 65s is above both our statistical neighbours and the national average – see below) - integrating the commissioning of the CCG, social care and public health and taking a whole system approach so that we prevent avoidable admissions to hospital and increases in long term care costs;
- supporting and involving carers (where there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities) – one of the 5 key principles set out in the Five Year Forward View.
- the services in scope for the Better Care Fund in 2016/17 will be provided through the MCP from April 2017. The Better Care schemes will support the remodelling and improvement of services as we work to establish the MCP.
Age-standardised rate per 100,000 of Injuries due to falls in Persons aged 65 and over (2013/14), Dudley and its statistical neighbours (source public health outcome indicators set)

(KLOE B.2.i)

Risk Stratification

High level analysis using our ACG risk stratification has identified those areas where there are opportunities for service improvement and cost reduction as indicated below. **In addition, our attached New Care Model Value Proposition (June 2015 pages 16-24) sets out further analysis in relation to the opportunities that exist. This has informed our plans both in relation to the BCF and the development of our new model of care.**

- 90% of the population are very low risk and prime candidates for a primary prevention strategy *(see “falls”)*;
- low risk patients predominantly use out-patient services;
- emerging risk patients require secondary prevention through the systematic management of their long term conditions *(a key function of the MCP)*;
- established risk patients are at higher risk of inpatient spells and need to be targeted by admission avoidance schemes *(see “falls and care homes”)*;
- high risk patients are in poor health with multiple morbidities, they are prime candidates for management by an integrated health and social care team and with community-based support *(MDT working at the heart of the MCP)*;
- risk for high cost patients increases substantially over time driven by age and complexity of morbidity *(see “care homes”)*;
risk increases significantly around retirement age for men and women (see “carers”);
renal disease and heart disease are the most costly and patients with these conditions tend to have the greatest volume of co-morbidities;
over the next 12 months, cost and utilisation is predicted to increase for people with hypertension (£3.3m), metabolic disorders (£2.4m), renal failure (£2.2m) and diabetes (£1.6m);
levels of emergency inpatient care for the elderly in Dudley are increasing.

The segmented population is as follows:-

**Emerging risk** (n = 6273)
- 50% have 5 or more co-morbidities;
- majority are CVD, MSK and endocrine diagnoses;
- they represent 2.2% of the population but 11% of the costs.

**Established risk** (n = 4278)
- most have several established chronic conditions;
- majority are as for the emerging risk population but renal failure is now also prevalent.

**High risk** (n = 3136)
- frail and elderly, more women than men;
- 2/3 have 5 or more chronic conditions;
- as well as those conditions identified above, cancer is more prevalent;
- 1 in 50 may be candidates for palliative care.

**Impact of Co-Morbidity**
- 40% of patients have 1 or more morbidities. Patients with co-morbidities draw more upon both health and social care with each additional condition and depending upon the mix of conditions;
- in Dudley patients with hypertension display the highest level of other co-morbidities.

In effect, our stratified population is characterised by:-
- prevalence of long term conditions;
- high levels of co-morbidity;
- growth in the frail elderly.
All these factors can result in unnecessary admission to hospital, residential and nursing home care. Our BCF schemes, alongside our new care model and our new contractual framework for general practice, are designed to respond to these characteristics.

(KLOE B.2.iii/iv)

**Governance and Accountability**

Our governance arrangements are set out in the diagram below.

(KLOE B.3.i)

The Dudley Vanguard Programme has its own set of governance arrangements, led by a Partnership Board reporting to the Health and Wellbeing Board.

The BCF Programme has linked arrangements designed to:

- oversee the performance of the key BCF schemes;
- manage the pooled budget;
- identify opportunities for further integration of commissioning and services.

This is led by the Integrated Commissioning Executive, established as the governing body for the BCF’s Section 75 Agreement and to maintain oversight of scheme delivery and benefit realisation. The terms of reference for this body are set out in this Agreement and the membership consists of:

- Head of Commissioning – Dudley CCG
The Integrated Commissioning Executive reports to the Health and Wellbeing Board.

The BCF programme is supported by a Partnership Office jointly run with Dudley MBC. All BCF schemes are set out in individual PIDs and are subject to a monthly “confirm and challenge” process as a means of monitoring performance and ensuring schemes deliver their key objectives. Interdependencies between the BCF and the Dudley Vanguard Programme are managed within the Partnership Office and reported through both Partnership Board and Integrated Commissioning Executive.

The Health & Wellbeing Board receives periodic updates on both programmes.

(KLOES B.3.i/ii/iii)

Scheme Delivery Through Joint Working (KLOE B.3.iii)

Joint working is a key feature of each scheme, with health and social care colleagues collaborating over:

- shared intelligence, to inform local improvement priorities and evaluate impacts;
- development of a joint analytics function to serve the system rather than individual organisations;
- aligned commissioning practices, including agreements over joint and lead commissioning arrangements;
- joint delivery teams ensuring that each scheme delivers on time, within budget and to the required quality;
- single point governance and assurance through an Integrated Commissioning Executive;
- joint discharge teams working across health and social care to facilitate the timely discharge of patients;
- use of Multi-Disciplinary Teams (see attached specification) as the fundamental building block of the MCP, to deliver integrated responses to the needs of patients on the basis of shared intelligence and a single performance framework;
- Joint Partnership Office facilitating integrated project working and
- supporting joint governance.
BCF Plan Milestones

Our key milestones are attached (KLOE B.3.iv)

Risk Management

Our Partnership Office Lead acts as Risk Manager for the BCF, maintaining a Risk Register that reflects joint assessment and action planning (see below). Risk Actions are allocated to lead officers who are responsible for mitigation and risk reporting.

Scheme level risks are identified and managed by joint delivery teams, subject to oversight by the Partnership Office with escalation to the Integrated Commissioning Executive as necessary.

All BCF Risks are considered monthly by the Integrated Commissioning Executive, with escalation to the Health and Wellbeing Board as necessary.
Risk Register

Risk Status update 18th April 2016

Following submission of the initial draft narrative plan the risk register has been updated to reflect 3 categories of Risk:

1. Development – risks pertaining to the agreement and approval of the plan
2. Delivery – risks pertaining to the delivery of the plan’s schemes and objectives
3. Management – risks arising from factors arising during the currency of the plan.

The risk register has been reviewed and is summarised below:

<table>
<thead>
<tr>
<th>Better Care Plan 2016/17 Risk Register - Summary</th>
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<tbody>
<tr>
<td>ID</td>
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<tr>
<td>17</td>
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<tr>
<td>18</td>
</tr>
</tbody>
</table>

The full register is shown at Appendix 1

(KLOEB.3.v)
Stakeholder Engagement and Agreement

Our approach to the development of a new care model, of which this BCF Plan forms part, was jointly agreed by Dudley CCG; Dudley Group NHS Foundation Trust: Dudley and Walsall Mental Health Partnership NHS Trust; Black Country Partnership NHS Foundation Trust; Dudley registered GPs; Dudley MBC and Dudley Council for Voluntary Services. As indicated above, these bodies constitute the Partnership Board overseeing our new care model programme. This BCF Plan continues to reflect the main principles of integrated locality working across health and social care and engagement with providers has been at the heart of our work. Specific negotiations have taken place in relation to the operation of the BCF involving all partners identified above.

Impact on our NHS Providers (KLOE C.1.v)

The contracts agreed between the CCG, Dudley Group NHS FT and the West Midlands Ambulance Service NHS Trust for 2016/17 reflect our joint work on activity modelling that relates to the implementation of our plan. Our plans in relation to non-elective admissions have been shared and built into contracts as set out above. In particular, this deals with the impact of our plans on reducing non-elective admissions and ambulance conveyances. This is also reflected in our operational planning submissions to NHS England. We have specifically engaged with local providers in setting out our expectations of the MCP, initially in our published Commissioning Intentions for 2016/17 and 2017/18. This process will continue as we develop our proposals in advance of a procurement process.
Impact on the Role of Primary Care

Our new contractual framework with Dudley GPs, developed under our delegated commissioning responsibilities from NHS England and through a process of extensive engagement with our local GP community, includes requirements that are consistent with the development of our new care model and the model of integrated working across health and social care that is consistent with this BCF Plan. This includes the leadership of multi-disciplinary team meetings and the systematic management of patients with long term conditions and multiple co-morbidities as identified above. The model of multi-disciplinary working has now been fully implemented across all Dudley practices as originally described in our 2015/16 BCF Plan.

This Plan is also consistent with and informed by key pieces of enabling work led by the Partnership Board that have system wide implications and support the development of the new care model. These include:

- joint financial and activity modelling across all partners;
- workforce planning and organisational development;
- estates and infrastructure;
- information technology and systems;
- medicines management and consumables.

In terms of social care providers, engagement has taken place with the West Midlands Care Home Association, 120 care provider organisations through Black Country Partners for Care, the Domiciliary Care Provider Forum and the Micro Provider Network

Increasing specialism has improved outcomes and will remain the mainstay of hospital based care but in community settings, where complexity and chronicity are increasingly the norm, we need to redefine the workforce with community based consultant colleagues. New needs require new roles and new modes of access. We do not yet know the exact form this redesign should take; but we have some pointers from: previous pilots and existing roles (e.g. Dudley CVS’s Integrated Plus workers, who link MDTs to the wider voluntary sector); and from analogous roles where open access services have been developed (e.g. physiotherapy and counselling). We will therefore scope this out fully before producing a new, whole system workforce plan to inform requirements over the medium and longer term. This is a key component of our Vanguard programme with delivery oversight maintained through the Partnership Board. (KLOE C.1.iv).
Events have taken place with local voluntary and community sector organisations as part of the development process. The CCG has commissioned a specific social prescribing scheme from Age UK to support the model. In addition, following discussions with the voluntary and community services sector, the CCG has commissioned 5 locality link workers with responsibility for ensuring effective links and pathways from practice and locality based integrated teams into voluntary and community sector services, as well as facilitating the creation of additional capacity in residential care. Engagement has taken place with Dudley Healthwatch and at the time of writing partners are involved in an extensive listening exercise involving engagement with the Council’s Community Fora and a range of local community groups.

Dudley Council, as the local housing authority, has been consulted about the role of the Disabled Facilities Grant (KLOE C.1.vi) in delivering integrated care and is contributing additional money and resources, above the level of the DFG, to the BCF schemes. In particular:

- reviewing the current backlog for DFGs to determine the cost and feasibility of fast-tracking approved cases;
- investigating whether or not additional staffing capacity (OT) could be capitalised;
- exploring the potential to accelerate hospital discharge/target frequent hospital admissions through multi-disciplinary teams;
- considering accelerated investment in aids/adaptions/CES/telecare;
- reviewing the stair rails contract to identify potential for fast tracking;
- streamlining existing procurement processes to fast track work.

Delivery of an extensive DFG programme is dependent on a streamlined “referral to fulfilment” process. Reductions in OT assessment backlogs and time to deliver of home adaptations are key to ensuring that the programme meets demand and addresses local priorities to prevent unnecessary hospital admissions and to facilitate safe and timely discharge from hospital. The Health and Wellbeing Board and the Council’s Health Overview and Scrutiny Committee receive regular reports on both the development of the new model of care and the development and implementation of our BCF Plans. The CCG Board and the Council Cabinet have approved our plans to integrate health and social care by April 2017, as part of the implementation of the MCP.

(KLOE C.1.i-v)
Maintaining the Protection of Adult Social Care Services

Protecting adult social care services in Dudley means maintaining our target operating model in order to meet the current and future demand for social care and support within a sustainable system. Services that are being supported through the Better Care plan are aligned to our Customer Journey design and to the scope of the emerging multispecialty community provider.

(KLOE C.2.Vi)

Our Better Care Fund Plan allocates £36.8m to support adult social care services and maintains support from the CCG minimum BCF allocation in real terms. This investment enables us to continue to support the local adult social care services that have been prioritised within the scope of the Better Care Fund Plan in a manner that is consistent with 2015/16.

(KLOE C.2.vi)

Whilst this is an increase of £5.5m (17.4%) on our 2015/16 plan, our planned investment is for an increase of £2.1m (6.2%) against our full year outturn forecast and partners are satisfied that this will not destabilise the local social and health care system.

(KLOE C.2.vii)

These arrangements are set out in the table below:

<table>
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<tr>
<th>Source of Funds</th>
<th>Investment 2015/16</th>
<th>Investment 2016/17</th>
<th>Year on Year Changes Against 15/16 Plan</th>
<th>Year on Year Changes Against 15/16 Outturn</th>
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<td>Plan</td>
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<td>LA Additional allocation</td>
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<td>Total protection of ASC services</td>
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<thead>
<tr>
<th>Application of Funds</th>
<th>Investment 2015/16</th>
<th>Investment 2016/17</th>
<th>Year on Year Changes Against 15/16 Plan</th>
<th>Year on Year Changes Against 15/16 Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme 1 - Crisis &amp; Emergency</td>
<td>425</td>
<td>440</td>
<td>340</td>
<td>(85)</td>
</tr>
<tr>
<td>Scheme 2 - Promoting Independence</td>
<td>12,824</td>
<td>13,600</td>
<td>13,065</td>
<td>241</td>
</tr>
<tr>
<td>Scheme 3 - Stabilization &amp; Maintenance</td>
<td>16,290</td>
<td>19,262</td>
<td>21,896</td>
<td>5,606</td>
</tr>
<tr>
<td>Scheme 4 - Support for people with dementia</td>
<td>1,826</td>
<td>1,388</td>
<td>1,535</td>
<td>(209)</td>
</tr>
<tr>
<td>Total protection of ASC services</td>
<td>31,365</td>
<td>34,691</td>
<td>36,834</td>
<td>5,469</td>
</tr>
</tbody>
</table>

(KLOE C.2.viii)

In determining both the minimum allocation and the planned application of funds we have followed the 2012 Department of Health guidance to NHS England on the funding transfer from NHS to social care:-

- the CCG allocation includes the local proportion of the £1.1bn being transferred by NHS England from the Mandate to local authorities;
- the funding is being used to support adult social care services which also have a health benefit;
- there is full agreement between the Council, the CCG and the Health & Wellbeing
Board over the use of the money;

- spending plans are evidence-based and derived from our Joint Strategic Needs Assessment as described above;
- value-added outcomes are set out within detailed scheme plans;
- our BCF schemes support a mix of existing and transformed services that are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to Council budget pressures without this investment.

(C.2.viii)

7 Day Services

The health and social care economy has demonstrated its commitment to 7 day services through its work as a national pilot site for 7 day service transformation.

Our care model is constructed on the basis of providing a response on a 7 day basis and we are actively realigning our services to achieve this as part of our overall plan.

Our DToC Plan identifies 7 day services as a critical requirement for safe and timely discharge. The chart below shows the average net flow of patients across a 7 day period. We will aim to secure a more even distribution as a result of implementing 7 day services. (KLOE C.3.iii)

The following services now operate on a 7 day basis:-
- community nursing;
- dementia gateways;
- mental health crisis resolution;
- respiratory assessment;
- telecare;
- virtual ward;
- community rapid response team.

All these services support the avoidance of unnecessary hospital admission.

In 2016/17 the following services will move to a 7 day basis and be operational as indicated below:-

- **Intermediate Care and NHS Continuing Healthcare Assessment** – Q1 2016/17
- **care home nurse practitioners** – Q2 2016/17
- **palliative care team** – Q2 2016/17
- **community heart failure team** – Q3 2016/17
- **community mental health team for older people** – Q3 2016/17

(KLOE C.3.iv)

Intermediate care assessment and NHS Continuing Healthcare assessment have a particular impact on maintaining patient flow and facilitating discharge for patients with both physical and mental health needs 7 days per week.

A range of other services will be reviewed in terms of their potential to move to 7 day working in 2016/7. A delivery plan for the expansion of seven day services in Dudley is being monitored by the Integrated Commissioning Executive.

In order to ensure that the discharge process from acute care is managed effectively, 7 days per week, we have agreed a system wide plan for supported and unsupported discharges across health and social care. This defines the level of discharges expected for a planned level of admissions. This plan has been agreed by our System Resilience Group and is overseen by the Urgent Care Working Group. It acts as the key means of holding the system to account. In 2016/17, this will be extended to cover the range of community based beds commissioned for respite, admission avoidance and step down.

As part of our involvement in the 7 day service transformation programme, we have developed clinical standards for all our community services. These are reflected in our contractual service specifications. We have developed local standards in relation to:-

- patient experience – capturing post care and advanced care planning;
- speed of access and assessment in the community;
follow up – within 24 hours;
handover and communications;
diagnostics – access to scans, blood tests etc.;
mental health – access and for health and social care community teams to be educated in early signs of illness;
communication with relatives and carers;
re-ablement;
appraisal of care – MDT approach;
information access;
workforce satisfaction.

The Council has a long established track record of delivering 24/7 preventative support such as the re-ablement and telecare service.

Our new contractual framework for primary care is based upon securing 7 day access to primary care.

(KLOEs C.3.i-iv)

Use of the Disabled Facilities Grant

Consultation has taken place with partners in Dudley MBC in its capacity as the local housing authority.

Specific actions have been identified and agreed in relation to the management of the DFG in the context of this plan. This includes:

- reviewing the current backlog for DFGs to determine the cost and feasibility of fast-tracking approved cases;
- investigating whether or not additional staffing capacity (OT) could be capitalised;
- exploring the potential to accelerate hospital discharge/target frequent hospital admissions through multi-disciplinary teams;
- considering accelerated investment in aids/adaptions/CES/telecare;
- reviewing the stair rails contract to identify potential for fast tracking;
- streamlining existing procurement processes to fast track work.

(KLOE C.1.vi)

All these actions will support our priorities to prevent avoidable hospital admissions and to facilitate the safe and timely discharge of people from hospital.

Information Systems and Data Sharing

Interoperable information systems are at the heart of the delivery mechanism for our new care model and the operation of our MDTs. Our approach is “evidence based and data driven”, with data being made available to the MDTs to facilitate the
effective management of patient care and to monitor their own performance. (KLOE C.4.iii). Data sharing arrangements are subject to rigorous oversight and scrutiny whilst workforce development plans include frequent reminders and refresher training to support a culture of secure, lawful and appropriate sharing of data.

We have established a multi-agency working group to design and develop an IT architecture that:

- allows information to be shared across systems through open standard interfaces (supported by open APIs where appropriate) to create a single cross agency view of selected patient data;
- meets national standards including conformance to data security and information governance frameworks;
- supports integrated working within MDTs and across the whole system, supporting better coordination of care and continuity for the people of Dudley.

The development of interoperable systems and the associated information governance arrangements are a key work stream of our partnership arrangements. We have already put in place a single clinical information system for general practice, which includes a risk stratification tool. The single view of patient data builds on this foundation to provide agency wide role based access to information across the health and social care economy in Dudley.

The single view of data will be in place in its first form across primary care, hospital, community, mental health and social care services by 1 April 2017. Future year enhancements will be planned to extend the scope of shared data and the underlying functionality to support the operation of the MDTs.

To further support the operation of the MDT the use of mobile technology is being rolled out to provide secure access to data anywhere anytime and support workforce mobility. This technology is currently available to selected clinical staff but will be made more widely available across the MDT during 2016/17.

In addition the use of selected patient apps enabling patient self-capture of clinical and non-clinical data will further enhance the data available to the MDTs.

A comprehensive organisational development plan is in place to support the development of MDTs and associated services. This includes understanding the role and use of information to support “evidence based and data driven” service delivery and the associated governance requirements. An extract from this plan is enclosed (KLOE C.4.i and vi)

The use of the NHS number is embedded in NHS contracts for 2016/17. In addition 85% of social care records now include the NHS number with an expected increase
to 100% by the end of 2016/17. At this point the NHS Number will become the primary identifier across health and social care services. \(\text{(KLOE C.4.ii)}\)

In Dudley there are a number of specific arrangements which have been put in place through which Email can be sent externally via a more secure environment:

- a private link to NHS.Net has been established using stringent security at a N3 network level;
- a secure email service product called Sophos SPX Encryption;
- GCSX Secure email for mail transmission between any Central Government department, other local authorities and the NHS (where the Health users is a nhs.net account holder).

\(\text{(KLOE C.4.iv)}\)

We also utilise the facilities of the Council's Content Management System (CMS). This can be used to create secure portals that can enable sensitive information to be obtained and shared through a secure website. Our arrangements operate within appropriate Information Governance controls for information sharing and are in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA).

We have worked with our Patient Participation Groups and our service providers to co-produce posters and information leaflets to provide clarity about how data is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review). \(\text{(KLOE C.4.v)}\)

We are working with our Commissioning Support Unit to develop a combined data base of health and social care information to inform our commissioning process. In addition, we are ensuring that the delivered information systems architecture is based upon our integrated service delivery model, rather than being organised around traditional organisational boundaries.

**Joint Assessment and Care Planning**

Our model is based upon having a lead accountable professional at both practice and locality level. We have described above how we expect this to function. Our OD programme will embed this in the culture of our “teams without walls”.

1.1% of our population are at risk of hospitalisation as identified by the Johns Hopkins University All Care Groups (ACG) risk stratification tool (see above). The use of this risk stratification tool, extended to social care, is a pre-requisite for how we expect integrated teams to function, using this data to inform decision-making and monitor performance. \(\text{(KLOE C.5.i)}\)
Engagement with ACG risk stratification data will be a key item of business at MDT meetings. We will use risk scores for patients as a means of measuring the impact of interventions on reducing levels of dependency.

Our integrated service model will mean adopting the principles of common assessment within a joint process and a care co-ordination approach led by GPs in multi-disciplinary teams. These teams will link to our 7 dementia advisers as necessary (KLOE C.5.ii). In practice this will mean:-

- people will only provide their personal details and circumstances once;
- a named point of contact will coordinate and be in place throughout any intervention;
- personal choice, assets and skills will be the starting point of any support;
- assessment and support plans are not duplicated or completed in isolation;
- a culture of resolution and customer satisfaction are at the centre of all we do;
- support to carers will be accessible and tailored to the needs of the carer;
- the model will evolve and be responsive to the needs and feedback of local people;
- consent is obtained by the person or relevant person to provide care and treatment.

(KLOE C.5.iii)

The ACG risk stratification tool is used to risk stratify the population at GP practice level. The top 2% are assessed, a care plan developed and lead responsibility allocated by the practice team to the lead GP or a named care co-ordinator. All patients falling into the top 2% have a joint care plan in place and this is reinforced by the requirements of the new GP contractual framework. The requirement for a joint approach to assessment and care planning has been fully met through this approach and further milestones are not required. (KLOE C.5.iv)

Alignment of Plans

We have described above the engagement that has taken place across the system with all major stakeholders including NHS partners; the Council; independent sector providers; the community and voluntary sector; local people and patient groups.

Our planning assumptions are set out in both the CCG’s operational and financial plan and the Council’s Medium Term Financial Forecast. Activity changes are reflected in the plan of our acute hospital and community health service provider and the CCG’s QIPP plan.

Our planned levels of activity, based upon this BCF Plan, are reflected in our agreed contract for 2016/17 with Dudley Group NHS FT as our main provider of acute and community health services. (KLOE C.6.i and C.6.iii)
The CCG’s draft Operational Plan was approved by the CCG Board in March 2016 and submitted to NHS England. NHS England’s assessment of the plan is that it is “on track – no concerns about full plan submission”. This fully addresses the national planning requirements as they relate to the BCF, including “parity of esteem” for mental health services, our work on integrating physical and mental health crisis pathways and our work on improving dementia care, including dementia gateways and advisers. (KLOE C.6.iv).

This BCF Plan was approved by the CCG’s Board on 31 March 2016 and the Council’s Corporate Board on 3 May 2016. It will be submitted to the Council’s new Cabinet after the Council elections in May 2016.

As a local system these assumptions are being built into a wider piece of work on long term sustainability which will contribute to both a Dudley and a Black Country Sustainability and Transformation Plan (STP). Health and social care integration will be a key element of this and our MCP care model will form a centre piece of the Black Country STP. (KLOEs C.6.i-iii and v)

Delayed Transfers of Care

Based upon our analysis of data and other evidence sources, The System Resilience Group has identified the following 4 key strands to its agreed action plan for reducing and managing delayed transfers of care as follows:-

- reducing demand;
- safe and timely discharges;
- community capacity;
- management and oversight.

The action plan is attached as Appendix 2 (KLOE C.8.i) and identifies the relevant interventions, responsible management leads and performance metrics associated with each theme. Each lead is responsible for delivery to the System Resilience Group. (KLOE C.8.vii)

This is based upon achieving a target of a 10% reduction in delays (KLOE C.8.i) and is reflected in our Operational Plan (KLOE C.8.iii). The agreed target represents the aggregate effect of a range of interventions and initiatives being managed through our DTOC Improvement Plan.

At its meeting on 16 March, the System Resilience Group reached agreement on the level of admissions and discharges to be achieved to maintain the system in equilibrium. The analysis behind this is set out in the attached document on our local “Memorandum of Agreement”
This will be supported by the implementation of an Integrated Discharge Pathway as a key BCF scheme. Investment for the integrated discharge pathway is derived from the former ‘pay for performance monies’. The effectiveness of the pathway will be reviewed and investment revised as necessary. This represents the extent to which partners have agreed to share risk in this regard. (KLOE C.8.v) Further work will take place as part of this plan to reduce delayed transfers of care including the following:

- demand management – specific support to care homes and patients at end of life; a new falls service; community based geriatric and respiratory services; the use of social prescribing and voluntary/community sector services; enhanced medicines management;
- safe and timely discharge – engaging with neighbouring commissioners; speeding up assessment processes and using “trusted assessors”; clear protocols around patient choice; improving “flow” within the hospital; engaging our MDTs in the discharge process;
- community capacity – ensuring length of stay and timely discharge is supported by agreeing a target level of discharges; enhancing processes for accessing community equipment and DFG; enhancing community support for carers and enabling voluntary sector services to support the discharge process;
- management and oversight – mapping existing spend and provision to identify opportunities for better integration, investment, disinvestment; ensuring our data presents “one version of the truth”.

The System Resilience Group, bringing together NHS providers, social care and the voluntary sector, has previously commissioned work by the Emergency Care Intensive Support Team on system flow, received a report by the West Midlands Quality Review Service and assessed itself against the “8 High Impact Interventions”. The outcome of this work is reflected in this consolidated plan. The implementation of this action plan is the responsibility of the Urgent Care Working Group and they are held to account for delivery by the System Resilience Group.

The Plan attached at Appendix 2 was approved by the System Resilience Group on 3 May 2016. Engagement with the independent and voluntary sectors has taken place through Dudley Council for Voluntary Service as a member of the System Resilience Group. In addition, in terms of social care providers, engagement has taken place with the West Midlands Care Home Association, 120 care provider organisations through Black Country Partners for Care, the Domiciliary Care Provider Forum and the Micro Provider Network as described above. (KLOE C.8.i-ix)
Performance Metrics (Separate template enclosed)

Non-Elective Admissions

Our non-elective admissions target (a net reduction of 299 admissions) is based upon our analysis of historic demand and the impact of demographic growth. This has then been adjusted to reflect our 2016/17 QIPP Programme and associated BCF schemes designed to reduce admissions. This includes the impact of:-

- community rapid response team;
- actions to prevent admissions from care homes to secondary care, and other preventative actions identified within our DTOC Improvement Plan;
- impact of new service model, including multi-disciplinary team working and the new GP contractual framework for long term conditions.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Savings (GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Response Team</td>
<td>-375</td>
</tr>
<tr>
<td>This saving reflects the full year effect of a new service where ANPs intercept ambulance callouts preventing the need for a conveyance to hospital. The additional savings will arise through the recruitment of additional ANPs and service reconfiguration.</td>
<td></td>
</tr>
<tr>
<td>MDTs</td>
<td>-491</td>
</tr>
<tr>
<td>Multi-Disciplinary Teams have now been established within each of our primary care practices. Ambulatory Care Sensitive Conditions admissions performance reporting will be shared across these teams to enable them to identify areas for improved joined up care and upstream preventions.</td>
<td></td>
</tr>
<tr>
<td>Elderly Frail</td>
<td>-250</td>
</tr>
<tr>
<td>Improved service provision within care homes, increased education, new electronic palliative care system and improved discharges through a discharge to assess model.</td>
<td></td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>-350</td>
</tr>
<tr>
<td>Commissioning of a new fracture liaison service and development of a falls risk register will help to reduce the level of emergency admissions for falls.</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-1,466</strong></td>
</tr>
</tbody>
</table>
Delayed Transfers of Care

Our target in relation to reducing delayed transfers of care is based upon the impact of our Integrated Discharge Pathway described above and the combined effect of the actions set out in our action plan. (KLOEs E.4.ii and E.4.iii)

Admissions to Residential and Care Homes

Our target of 442 admissions is based upon maintaining the downward trajectory of previous performance of 480 admissions in 13/14 and 457 in 14/15. This takes account of demographic growth (a 1.6% increase in the 65+ population), the growing acuity of patients upon discharge and system performance in terms of the level of discharges required to maintain equilibrium and financial sustainability

(KLOEs E.2.ii and iii)

Effectiveness of Reablement

Our plan is to have 89% of the relevant population still at home 91 days after discharge. This remains a challenging target given the acuity of patients upon discharge from hospital and previous performance of 87.4% in 13/14 and 85.3% in 14/15. However, we consider that a challenging target needs to be maintained, given that reablement effectiveness is a key component of our DToC improvement plan priority to ensure community capacity and the sustainability of our new care model.

(KLOEs E.3.ii and iii)

Health and Wellbeing Board

The Health and Wellbeing Board received a report at its meeting on 2 March 2016 in relation to the implications of the BCF guidance for 2016/17 and its relationship with the development of a new model of care. A further report on the final BCF Plan will be made to the Board’s next meeting. This Plan was approved by the CCG Board at its meeting on 31 March 2016 and by the Council’s Corporate Board on 3 May 2016. A further report will be submitted to the Council’s new Cabinet following the May elections.

(KLOE C.1.i)
## Risk scoring and rating matrices

<table>
<thead>
<tr>
<th>Likelihood Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Very Likely</td>
</tr>
<tr>
<td>Frequency</td>
<td>This probably will never happen/recur</td>
<td>Do not expect it to happen/recur, but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
<td>Will probably happen/recur, but is not a persisting issue or</td>
<td>Very likely to happen/recur; possibly frequently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Very low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Very high</td>
</tr>
<tr>
<td>Operational</td>
<td>Minor reduction in quality of treatment or service</td>
<td>Single failure to meet national standards of quality of treatment or service</td>
<td>Repeated failure to meet national standards of quality of treatment or service</td>
<td>Ongoing non-compliance with national standards of quality of treatment or service</td>
<td>Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service</td>
</tr>
<tr>
<td>Strategic</td>
<td>Not relevant to the new model of care</td>
<td>Minor impact on achieving project / programme objectives</td>
<td>Moderate impact on achieving project / programme objectives</td>
<td>High impact on achieving project / programme objectives</td>
<td>Project / programme objectives will not be achieved</td>
</tr>
<tr>
<td>Financial</td>
<td>Between £5k and £25k</td>
<td>Between £25k and £100k</td>
<td>Between £100k and £250k</td>
<td>Between £250k and £1m</td>
<td>Over £1m</td>
</tr>
<tr>
<td>ID</td>
<td>Risk category</td>
<td>Project Name:</td>
<td>Financial or non-financial?</td>
<td>There is a risk that…</td>
<td>This is caused by…</td>
</tr>
<tr>
<td>----</td>
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</tr>
<tr>
<td>1</td>
<td>Development</td>
<td>Non-financial</td>
<td>Plan fails to meet assurance criteria</td>
<td>Inability to satisfy review team that all Key Lines of Enquiry (KLOEs) are met</td>
<td>Plan not approved or approved subject to ongoing support</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>Plan fails to deliver expected benefits</td>
<td>Sub-optimal delivery of Better Care schemes</td>
<td>Performance outcomes failing short of target</td>
</tr>
<tr>
<td></td>
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<tr>
<td>3</td>
<td>Delivery</td>
<td>Financial</td>
<td>The BCF Pooled Budget overspends</td>
<td>Sub-optimal delivery / implementation</td>
<td>Financial plans have to be revised</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>Delivery</td>
<td>Non-financial</td>
<td>In-year financial pressures elsewhere in the system divert resources from Better Care activity</td>
<td>Demand pressures</td>
<td>Performance outcomes falling short of target</td>
</tr>
<tr>
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<td>-----------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>Progress towards the National Conditions stalls or fails to meet requirements</td>
<td>Lack of agreement or prioritisation</td>
<td>Increased scrutiny from NHSE</td>
</tr>
<tr>
<td>6</td>
<td>Development</td>
<td>Non-financial</td>
<td>Governance arrangements are insufficient to provide strategic direction</td>
<td>Failure to agree or apply governance arrangements</td>
<td>Investment decisions are unsupported</td>
</tr>
<tr>
<td>7</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>The effort required to deliver the plan does not materialise</td>
<td>Partners focus on delivering organisational priorities over plan requirements</td>
<td>Performance outcomes falling short of target</td>
</tr>
<tr>
<td>8</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>Required level of workforce change does not materialise</td>
<td>Insufficient attention to workforce matters within BCF plans</td>
<td>Performance outcomes falling short of target</td>
</tr>
<tr>
<td>9</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>Provider &amp; community capacity is insufficient to meet demand requirements arising from BCF schemes</td>
<td>Failure to identify and/or support capacity within the local provider market</td>
<td>Performance outcomes falling short of target</td>
</tr>
<tr>
<td>10</td>
<td>Delivery</td>
<td>Non-financial</td>
<td>Failure to influence public patient behaviours</td>
<td>Insufficient attention to public engagement</td>
<td>Public unaware of the changes being made and the benefits available to them</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Management</td>
<td>Financial</td>
<td>Non-financial</td>
<td>BCF Performance fails to respond to management intervention</td>
<td>Inadequate / untimely management information</td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>-----------</td>
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<td>-----------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Management</td>
<td>Non-financial</td>
<td>BCF Performance fails to respond to management intervention</td>
<td>Inadequate / untimely management information</td>
<td>Performance outcomes falling short of target</td>
</tr>
<tr>
<td>12</td>
<td>Management</td>
<td>Non-financial</td>
<td>BCF scheme delivery destabilises the provider market</td>
<td>Inadequate engagement with providers</td>
<td>Provider failures</td>
</tr>
<tr>
<td>13</td>
<td>Management</td>
<td>Financial</td>
<td>Failings in neighbouring HWB economies puts additional pressure on the Dudley system</td>
<td>External factors</td>
<td>Financial / resource pressures</td>
</tr>
<tr>
<td>14</td>
<td>Management</td>
<td>Non-financial</td>
<td>Changes in political direction locally and/or nationally undermine the BCF</td>
<td>External factors</td>
<td>Disinvestment or deprioritisation of BCF activity &amp; resources</td>
</tr>
<tr>
<td>15</td>
<td>Management</td>
<td>Non-financial</td>
<td>Statutory or regulatory differences between health and social care lead to tensions</td>
<td>Strategic differences between partners</td>
<td>Failure to agree investment and/or operational priorities</td>
</tr>
<tr>
<td>16</td>
<td>Management</td>
<td>Non-financial</td>
<td>The terms of the Section 75 agreement are not adhered to</td>
<td>Inappropriate management of the pooled budget</td>
<td>Decisions not authorised / enacted</td>
</tr>
<tr>
<td>17</td>
<td>Management</td>
<td>Non-financial</td>
<td>Unintended consequences of BCF changes impact adversely on service quality</td>
<td>Failure to track wider system effects</td>
<td>Loss of credibility for BCF activity</td>
</tr>
<tr>
<td>18</td>
<td>Management</td>
<td>Non-financial</td>
<td>BCF changes conflict with wider system changes</td>
<td>Lack of alignment to strategic and integration plans</td>
<td>Disinvestment or deprioritisation of BCF activity &amp; resources</td>
</tr>
</tbody>
</table>