DUDLEY HEALTH AND WELLBEING BOARD

REPORT SUMMARY SHEET **Agenda Item No. 8**

DATE	**19th September 2019**
TITLE OF REPORT	**Better Care Fund and Transforming Care Partnership**
Organisation and Author	**Joint report of the Chief Officer, Adult Social Care, Dudley MBC and the Director of Commissioning, Dudley Clinical Commissioning Group (CCG)**
Purpose of the report	**To present the Better Care Fund (BCF) plan for Dudley for the planning year 2019/20 in line with the national approval process**
Key points to note	The national planning template has been issued for 2019/20 and is due for submission on 27th September 2019. Given the late release of the template, systems are not asked to submit a revised BCF plan, but to submit a spreadsheet covering: • Strategic narrative • Income and Expenditure plans • Delivery of the High Impact Change Measures • Delivery of the national key targets • Ambition to meet the 9 planning requirements for 2019/20 Whilst a refreshed narrative is not formally required, the attached plan demonstrates the continuity of the 2019/20 plan from the 2017-19 document previously agreed by the Health and Wellbeing Board, the financial plan for the year (which was agreed at the June meeting) and confirmation that Dudley has plans to meet the nine national requirements.
Recommendations for the Board	Approve the 2019/20 Better Care Fund and authorise the submission of the national planning return based on the enclosed assumptions.
Item type	Approval
H&WB strategy priority area	Integration

DUDLEY HEALTH AND WELLBEING BOARD

DATE **19th September 2019**

REPORT OF: **Joint report of the Chief Officer, Adult Social Care, Dudley MBC and the Director of Commissioning, Dudley CCG**

TITLE OF REPORT: **Better Care Fund and Transforming Care Partnership**

PURPOSE OF REPORT

1. To present the Better Care Fund (BCF) plan for Dudley for the planning year 2019/20 in line with the national approval process.

BACKGROUND

2. Integration & Better Care Fund Plans (I&BCF) provide the basis for integrated health and social care provision. The Dudley plan makes clear that this is happening in parallel with the emergence of the Dudley Multispecialty Community Provider (MCP). I&BCF activity will help establish the capabilities needed once the MCP is operational.

3. The Dudley Integration & Better Care Fund Plan 2017-19 was submitted to NHS England and the Local Government Association (LGA) for assurance on 11th September 2017 under delegated authority. The financial element of the plan was updated to reflect the budgets approved by the Council and CCG for 2018/19. These amendments were approved by NHS England.

4. The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2019-20. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The Framework forms part of the NHS mandate for 2019-20.

5. BCF planning and reporting will incorporate the separate processes for iBCF and Winter Pressures grants, removing duplication in collection and reducing the reporting burden overall. This will include:

   - Incorporation of narratives into a shorter single template.
   - Removal of the requirement to submit separate plans for Winter Pressures grant.
   - Removal of separate reporting on iBCF schemes and initiatives.
   - Single format for scheme level planning and reporting.

6. The new planning guidance for 2019-20 issued on the 18th July 2019 requires a refresh of the current plan rather than a new plan. The submission is a 1 year plan, with an expectation of minor changes from previously agreed plans and no changes to the national conditions. This was designed to reduce the burden of planning locally given the timing of the guidance.

7. The BCF continues to set expectations for all Health and Wellbeing Board (HWB) areas for reducing Delayed Transfers of Care (DToC). Health and Social Care commissioners in each area need to agree an updated plan for continuing to reduce delays. There are no longer local splits set between social care and NHS delays.

8. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. The Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

9. The Dudley system approved a budget for 2019-20 in April 2019 in the absence of formal guidance. The plan meets all of the national conditions for the BCF. The only significant change introduced by the planning guidance was an increase in the CCG minimum allocation in line with the overall CCG budget uplift. This has been reflected in the planned submission.

10. The Better Care Fund Policy Framework for 2019-20 provides continuity from the previous round of the programme. For continued approval of the plan, the 2019-20 programme must meet the following four conditions (which were requirements of the previous plan):

- That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.
- A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.
- That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, which may include seven day services and adult social care.
- A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

11. The 2017-19 national monitoring metrics will also continue

- Non-elective admissions (Dudley Group of Hospitals);
- Admissions to residential and care homes;
- Effectiveness of reablement; and
- Delayed transfers of care (DToC)

THE MAIN ITEM/S OF THE REPORT

12. The attached plan details:
    - The performance of the Better Care Fund for 2017-19 (which has previously been reported to the Health and Wellbeing Board),
    - The targets for 2019/20,
    - Confirmation that the plan meets the national planning requirements
    - Agreed financial budget for the year (Reported to the Health and Wellbeing Bard in June)

FINANCE

13. There are no financial implications in addition to main BCF budget signed off by the Committee in June. The Winter Pressures Grant and Disabled Facilities Grant are ring-fenced allocations.

LAW

14. As previously advised, the legislative framework is provided by The Care Act 2014 whilst planning conditions are set out in the Integration & Better Care Fund policy framework for 2019-20 and associated planning guidance. The use of the Improved Better Care Fund Grant to local government requires that local agreement over expenditure plans is reached and that the money is used only for permitted purposes.

15. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. The Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

EQUALITY IMPACT

16. There are no new equality impacts to be considered as all of the schemes in the 2019/20 plan have had equality impact assessment in previous years. There are no changes to the services or eligibility criteria which require new assessments.

RECOMMENDATIONS

17. Approve the 2019/20 Better Care Fund and authorise the submission of the national planning return based on the enclosed assumptions.

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Better Care Fund (BCF) 2019-20

1. Introduction

1.1. The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2019-20. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The Framework forms part of the NHS mandate for 2019-20. The framework sets an objective for NHS England to issue these further detailed requirements to local areas on developing and implementing BCF plans for 2019-20.

1.2. The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

1.3. BCF planning and reporting will incorporate the separate processes for iBCF and Winter Pressures grants, removing duplication in collection and reducing the reporting burden overall. This will include:

1. Incorporation of narratives into a shorter single template.
2. Removal of the requirement to submit separate plans for Winter Pressures grant.
3. Removal of separate reporting on iBCF schemes and initiatives.
4. Single format for scheme level planning and reporting.

1.4. The proposed BCF programme is based on a service model approved as part of the BCF plan for 2017-19, refreshed in 2018 based on performance delivery.

1.5. The new planning guidance for 2019-20 issued on the 18th July 2019 requires a refresh of the current plan rather than a new plan. The submission will be a 1 year plan, with an expectation of minor changes from previously agreed plans and no changes to the national conditions. This was designed to reduce the burden of planning locally given the timing of the guidance.

1.6. The BCF continues to set expectations for all Health and Wellbeing Board (HWB) areas for reducing Delayed Transfers of Care (DToC). Health and Social Care commissioners in each area need to agree an updated plan for continuing to reduce delays. There are no longer local splits set between social care and NHS delays

1.7. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. The Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

1.8. The national pooled fund for the BCF is £6.422bn.

1.9. The NHS has set out its priorities for transformation and integration through the NHS Long Term Plan, published on 7 January this year, including plans for investment in integrated community services and next steps to develop Integrated Care Systems. This includes a commitment for a new NHS offer of emergency response and recovery support through expanded multidisciplinary teams in primary care networks. This work will roll out from 2019-20. It is not a requirement that BCF funds are spent on this work, but it is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management. As the Dudley BCF is underpinned by the creation of a Multi-specialty Community Provider (MCP), the local strategy is fully compliant with this national direction of travel.

1.10. The Dudley system approved a budget for 2019-20 in April in the absence of formal guidance. The plan meets all of the national conditions for the BCF. The only significant change introduced by the planning guidance was an increase in the CCG minimum allocation in line with the overall CCG budget uplift.

1.11. The Better Care Fund Policy Framework for 2019-20 provides continuity from the previous round of the programme. For continued approval of the plan, the 2019-20 programme must meet the following 4 conditions (which were requirements of the previous plan):

- That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.
- A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.
- That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, which may include seven day services and adult social care.
- A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

1.12. The 2017-19 national monitoring metrics will also continue

- Non-elective admissions (Dudley Group of Hospitals);
- Admissions to residential and care homes;
- Effectiveness of reablement; and
- Delayed transfers of care (DToC)

1.13. The main change in the BCF Planning Requirements from 2017-19 is that separate narrative plans will be replaced with a single template that will include short narrative sections covering:

- the local approach to integration;
- plans to achieve metrics; and
- plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care.

1.14. BCF plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions and the condition to set the four national metrics, NHS England is also placing the following requirements for approval of BCF plans:

- That all funding agreed as part of the BCF plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- That all plans are approved by NHS England in consultation with DHSC and MHCLG.

1.15. NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF plans.

1.16. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

2. Local Governance

2.1. The Dudley Health Economy forms part of the Black Country and West Birmingham STP. The STP is made up of four 'places'. Each of the four 'places' are developing an Integrated Care Partnership and/or Integrated Care Provider (ICP), which incorporates local primary and community care and local mental health and acute services, and works together with local councils and public health services, and the local CCGs. A three-phased approach towards a single ICS and local place- based provider arrangements is being developed, with 2019/20 as our transition year.

2.2. During 2020/21, a single executive team will be established to serve the four CCGs. The four ICPs will then come together, with the collaboration of acute, mental health and ambulance services, at scale, to form our Black Country ICS by April 2021. CCGs will become leaner, more strategic organisations, which support providers to partner with local government and other community organisations on population health, service redesign, and Long Term Plan implementation. This will prevent avoidable hospitalisation and tackle the wider determinants of mental and physical ill-health.

2.3. The ICS will agree system-wide objectives with the relevant NHS England/NHS Improvement regional director and be accountable for their performance against these objectives. It is a pragmatic and practical way to deliver the "triple integration" of primary and specialist care, physical and mental health services, and health with social care. The combined CCG operational plans are designed to support the ongoing development of our ICS and are based upon four main themes from our wider system strategy:

2.3.1. Each CCG has set out their own operational plan to progress the development of their local ICP. This includes the development of the Better Care Fund to ensure social care integration.

2.3.2. The CCGs have agreed a suite of services which they are seeking to commission strategically, at scale

2.3.3. They are collaborating on key system-wide service review and development initiatives which are set out in the shared Black Country Clinical strategy as developed by the STP

2.3.4. The STP is collaborating with other West Midlands STPs to make a stepped-change in the way emergency and urgent care services is commissioned, with a focus on ambulance services as the key shared connecting service that operates across the system and its interface with all other providers, with an initial focus on the integration of 111 and 999.

2.4. Whilst there are differences in design and pace of development with each local ICP, there are also many common themes which we will be collaborating on increasingly as four CCGs. These themes include:

2.4.1. Health and care services being brought together as a means of responding to the needs of a growing frail elderly population displaying multiple co- morbidities

2.4.2. Creating a more resilient primary care system and placing the patient registered with general practice at the centre of the care model

2.4.3. A population health approach to the management of demand

2.4.4. A move away from activity-based contract models to our Integrated Care Partnerships/Providers being responsible for the delivery of a set of health and wellbeing outcomes

2.5. Each CCG has begun work on developing an Outcomes Framework to look at improvement in patient health over time. STP partners are committed to working together to align these frameworks, which predominantly focus on the health management of our local populations, with a view to agreeing an overall common Outcomes Framework for the Black Country ICS.

2.6. In terms of governance arrangements for the BCF plan, the system has created an Integrated Commissioning Executive (ICE) chaired by the Director of Commissioning for the CCG and supported by the Chief Officer for Adult Social Care in the Local Authority. ICE reports to the Health and Wellbeing Board on a quarterly basis and also to the Cabinet in the Local Authority and the Governing Body of the CCG as required.

2.7. The monthly meeting is facilitated by the Deputy Director of Commissioning at the CCG as a jointly accountable role. ICE receives performance and financial updates against national and local outcome targets. Any remedial action plans are agreed through ICE.

2.8. ICE is informed by system-wide thematic groups including A&E Delivery Board, CCG and Local Authority commissioning committees and the operational planning groups for both organisations.

2.9. As part of the annual planning process, ICE reviews all funded schemes annually to determine effectiveness and set the plan for the following year.

3. 2017-19 Plan

3.1. The plan was agreed by the Health and Wellbeing Board in 2017 and was centred on the development of enhanced integrated community provision to maintain independence and reduce attendance at the Emergency Department (ED) of the Russell's Hall Hospital and to reduce admissions for those who attend. This was coupled with a reablement programme post-

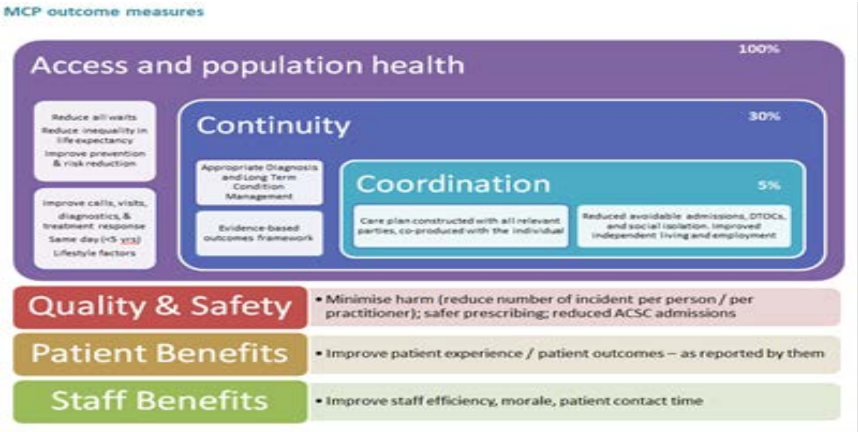
admission to maximise recovery and prevent, wherever possible, admission to long term care.

3.2. The plan was approved by NHS England on 27th October 2017.

3.3. The long term vision was to integrate into the Multi-specialty Community Provider (MCP) as part of one of the 13 national vanguard pilots. This work was integrated into the wider formation of the emerging Black Country Sustainability and Transformation Plan (STP) but recognised the importance of commissioning local place-based care built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs).

3.4. The model of integrated health and social care provision met the national strategy requirements for the BCF and involved:

- better communication with all patients and between staff;
- improved access to different types of consultation and diagnostics in the community for all residents when needed;
- continuity of care in supporting the management of peoples' long term conditions (c.30% of the population);
- effective co-ordination of care for the frail elderly, those with the most complex conditions and at the end of life (c.5% of residents).



3.5. The 2017-19 plan went significantly beyond the national minimum levels of investment representing the system desire to pool services and funding wherever this was in the best interest of the population.

	2016/17 (baseline)	2017/18	2018-19 (indicative)
Minimum NHS ring-fenced from CCG allocation	21,029,253	21,405,676	21,812,384
Additional CCG Allocation	17,181,570	18,965,113	18,379,112
Disabled Facilities Grant	4,373,000	4,818,360	5,263,333
Additional funding paid to local authorities for adult social care (IBCF)	-	8,463,460	11,641,252

Additional local authority allocation	19,427,801	18,809,265	18,809,265
Total	**62,011,624**	**72,461,874**	**75,905,346**

3.6. The MCP integrated care model is divided into 4 care elements:

- Whole Population Prevention / Population Health Management

  Our focus through this element is on prevention, self-care and patient activation – empowering people and communities by adopting asset-based approaches and helping people to live independently with support from their local community.

- Urgent Care Needs – Integrated Access & Rapid Response

  This element reflects a proactive and community-based approach to urgent care. We will enhance 24/7/365 crisis response capabilities to mitigate acute exacerbations and, subject to evaluation, will extend our pilot of the Care Home Telemedicine service to reduce avoidable admissions to hospital.

- Ongoing Care Needs – Enhanced Primary & Community Care

  The focus of this element is on the coordination of community health and care provision for people with long-term conditions, through the mutual network of care that underpins integrated multidisciplinary team (MDT) working in Dudley. We will support integrated personal commissioning through personalised care and support planning including the option of personal health budgets (PHB) or integrated personal budgets where applicable.

- Highest Care Needs – coordinated community-based and inpatient care

  This element is focused on the services and initiatives that are at the interface between community based and acute care, including the management of transfers of care. As such our investment in the High Impact Interventions model is incorporated within this element.

BCF Care Elements	**2016/17 (baseline)**	**2017/18**	**2018-19 (indicative)**
Whole Population – Prevention & Population Health Management	7,949,370	9,027,260	9,523,341
Urgent Care Needs – Integrated Access & Rapid Response	2,756,305	5,986,345	5,357,998
Ongoing Care Needs – Enhanced Primary & Community Care	29,866,476	33,366,548	32,561,508
Highest Care Needs – coordinated community-based and inpatient care	21,439,473	24,081,721	28,462,499
Total	**62,011,624**	**72,461,874**	**75,905,346**

3.7. By mid 2017 it became clear that a number of the services being commissioned through the BCF were not having the impact required, particularly in relation to DToCs. As a result, the Integrated Commissioning Executive took the decision to change the services associated with the discharge pathways and reinvest the money within Discharge to Assess Pathway 3 provision in the community.

3.8. In setting budgets for 2018/19, the BCF budgets from both organisations were significantly changed to mainstream the new service model, resulting in changes to the scheme by scheme profiles. In total the Better Care Fund resource for 2018-19 increased from £75.906m in the original plan to £77.687m in the refreshed plan.

3.9. The main increase in budget came from an increase in the CCG Allocation, although there were profiling changes throughout the fund. The opportunity was taken to refresh the budget profile for year 2 to reflect the changes made. There was no change to the targets or ambitions in the original plan.

Source of Funding	Original 2018/19	Revised 2018/19	Variance
Minimum NHS Ring Fenced from CCG Budget	21,812,384	22,525,486	713,102
Additional CCG Allocation	18,379,112	19,418,910	1,039,798
Disabled Facilities Grant	5,263,333	5,263,333	-
Additional Funding paid to LA from iBCF	11,641,252	11,641,252	-
Additional Local Authority Allocation	18,809,265	18,837,631	28,366
Total	75,905,346	77,686,612	1,781,266

3.10. The key investment decisions in the revised plan centred on the High Impact Change Model which are based on nationally evidenced services and initiatives proven to reduce demand on the hospital sector through maintaining independence and early intervention and reducing delays in transfers of care for those who do require hospital admission. These elements are primarily funded through the improved Better Care Fund (iBCF).

3.11. The key components of this model are:

3.11.1. ***The Emergency Response Team (front of house)***. Adult Social care staff moved into the Emergency Department of Russell's Hall Hospital (DGFT). The Team provide a social care response to Dudley residents who may need immediate support and assistance at home, alongside clinical intervention. The Social care team will also divert the person away from hospital (should this achievable and appropriate) to enable appropriate support in the most appropriate non-acute care setting.

3.11.2. ***Discharge to Assess (Pathways 1-3)*** - We have fully implemented Discharge to Assess (D2A), pathway 1 (straight home with domiciliary care), pathway 2 Intermediate care/reablement and pathway 3- complex discharges at Dudley Group Foundation Trust (DGFT). Pathway 3 provides a period of non-acute bed based assessment that provides stabilisation of needs and allows a period

of recuperation. The assessment period will gather clear evidence of support needs, to enable an accurate assessment of the long-term care support required. This enables people with complex needs to be discharged from hospital. Often this cohort of people would otherwise experience the lengthiest delays.

3.11.3. ***Improved Discharge*** Flow - We have increased the number of supported discharges for people who require non bed based social care input, in a more timely and effective manner with a target of 24 hr Length of Stay (LoS) for each discharge.

3.11.4. ***Single Handed Care*** - This service enables care for a greater number of people through maximising the use of carer and financial resources. The technology improves dignity, care and wellbeing by having more meaningful and satisfactory engagement in the care provided (one to one relationship). The service has supported individuals in the setting of their choice for longer and increased the amount of available care capacity in Dudley (reduces hospital delays, allow earlier intervention etc.)

3.11.5. ***Palliative Care -*** We have fully integrated Palliative care services. People at the end of life get multi agency support to remain at home (own home or a residential/nursing placement) to enable a dignified death.

3.11.6. ***Community Response team (CRT)*** works alongside residential and nursing home providers to improve long-term care planning and support people in the homes at a point of crisis.

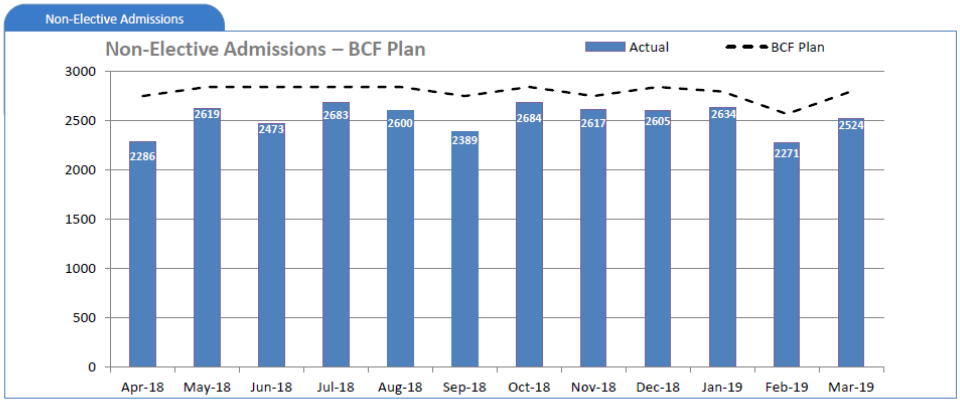
3.11.7. ***Reablement*** - we created a bespoke reablement service (home care) with the external provider market. This has increased capacity for reablement and incentives for providers to maximise independence through gain share payments. Three care providers deliver this work with a guaranteed number of hours (block) for providers and greater levels of autonomy for providers to deliver the service around the needs of the individual.

4. Current Performance

4.1. *Reduction in Hospital Emergency Admissions – met target*

Hospital admissions to Russell's Hall Hospital have been below the BCF plan for the whole of the 2018/19 year. There was a rise in attendances in ED of 3.92% over the same period but this did not translate into higher admissions. This suggests that the services at the front of house are being successful in supporting service users to have their needs met outside hospital.

Better Care Fund – Non-Elective Admissions



There were 2,524 Non-Elective (NEL) admissions in March for Dudley CCG patients; an increase of 253 when compared to March and 274 below plan.

The NEL plan, which forms part of the BCF planning requirements for 2018-19, is as follows;

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
NEL Plan	8,434	8,434	8,434	8,161
NEL Actual	7,378	7,672	7,906	7,429

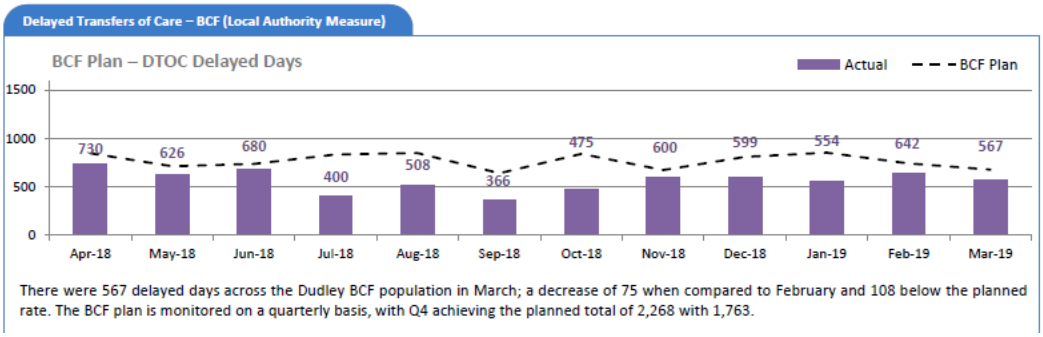
The plan for 2018/19 is shown as a black dotted line in the above chart.

4.2. Reduction in Delayed Transfers of Care – met target

The BCF requires commissioners to reduce acute bed delays to less than 3.5% of the average occupied beds in the hospital. At the start of the BCF planning cycle DToCs ran at a rate of >5%. However, following the changes to a discharge to assess model, the rate has consistently fallen and has averaged 2.3% over 2018/19.

The Dudley Group NHS Foundation Trust	2017/18					2018/19											
	Q3		Q4			Q1			Q2			Q3			Q4		
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Days delayed per month (UNIFY)	1054	605	626	574	540	380	456	628	424	431	136	427	448	575	416	371	358
Days In Month	30	31	31	28	31	30	31	30	31	31	30	31	30	31	31	28	31
Avg Delays per Day	35.13	19.52	20.19	20.50	17.42	12.67	14.71	20.93	13.68	13.90	4.53	13.77	14.93	18.55	13.42	13.25	11.55
Avg Occupied Beds per day (KH03 - Quarterly)	635	635	665	665	665	638	638	638	622	622	622	640	640	640	637	637	637
Delays as a % of Occupied Beds	5.53%	3.07%	3.04%	3.08%	2.62%	1.99%	2.31%	3.28%	2.14%	2.18%	0.73%	2.15%	2.33%	2.90%	2.11%	2.08%	1.81%

	2017/18					2018/19											
	Q3		Q4			Q1			Q2			Q3			Q4		
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Dudley Patients at DGFT	537	308	164	194	180	165	155	157	109	232	88	234	252	314	207	233	197
	2.82%	1.56%	0.80%	1.04%	0.87%	0.86%	0.78%	0.82%	0.57%	1.20%	0.47%	1.18%	1.31%	1.58%	1.05%	1.31%	1.00%



There were 567 delayed days across the Dudley BCF population in March; a decrease of 75 when compared to February and 108 below the planned rate. The BCF plan is monitored on a quarterly basis, with Q4 achieving the planned total of 2,268 with 1,763.

4.3. Service users aged 65+ discharged into reablement services still at home 91 days after discharge – met target

The services are required to support 87% of service users to remain at home after 91 days. This was achieved in all quarters for 2018/19

4.4. **Reductions in permanent admissions to nursing and residential care – met target**

There has been a significant reduction in permanent admissions in 2018/19 with 412 admissions against a target of 520.

Performance	Annual Target	Target for Period	Actual for Period	YTD Target	YTD Actual
Permanent Admissions to Residential & Nursing Care Homes (Quarter 4)	520	130	117	520	412

4.5. High Impact Change Model

There has been systematic embedding of the high impact change methodology throughout the year, with progress towards mature or exemplary practice in most areas.

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Mature	Mature	Mature	Complex discharge flow remains strong and DTOCs have stabilised at around 2.2%	Increasing acuity remains a challenge, but system has a better joint view on capacity. Challenges remain on non-emergency patient transport and TTOs. Consultant job plans hindering early identification of discharges	MDT working continues to flourish and system consistently reports low level of delays for Dudley residents. System has shared understanding of delays and has invested over winter to addeess blocks	NHSI/ECIST supporting hospital on internal flow
Chg 2	Systems to monitor patient flow	Established	Established	Established	Established		No real time reporting of capacity across the system, although regular discussion. CQC action plan makes additional data requests unhelpful. A system wide real time capacity schedule is in development	Joint production of daily reporting up to winter room. Daily sitreps shared regularly	No additional needs as several agencies already supporting on flow
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Mature	Mature	Mature	primary care MDTs regulary discussing patient. High Intensity User Service facilitating MDT on complex patients. Health and Social Care MDTs maturing in hospital setting	System reviewing overlap between primary care case management and frequent attenders	D2A Pathways in place with significantly fewer delays. 6 month review of High Intensity User programme has shown benefits in terms of users sources additional pathways and a reduction in cost	None
Chg 4	Home first/discharge to assess	Exemplary	Exemplary	Exemplary	Exemplary	D2A in place since 2016. Recent iBCF investment has now financed and established bed capacity for Pathway 3 patients. Additional capacity funded for winter	Flow at front door needs review to discharge from ED/MAU rather than ward base	Reduction in permanent admissions to nursing homes, with evidence of reablement in pathway 3. Increased admission avoidance at front door with support to return home	None
Chg 5	Seven-day service	Mature	Mature	Mature	Mature	We have had multi-disciplinary 7 day services in DGFT for at least 18 months and perform comparatively well on weekend discharges. For ASC supported discharges, Saturdays are our 3rd busiest discharge day and whilst total discharges at the weekend are lower than over the remaining days, we continue to add capacity to equalise performance.	TTO's still not completed as efficiantly as needed, Therapy not available for all areas at weekends- only availble for HDU and Urgent cases. Mediboxes are not availble 7 days. Winter investment has produced benefits. Monday discharge planning remains a challenge with weekend therapy gaps	Consistent weekend delivery on discharges with increased a&e flow most weekends	Equipment availability, TTO's and therapy required 7 days. Services are avaialble but it is fragmented.
Chg 6	Trusted assessors	Established	Established	Established	Established		Capacity needs to move from being a hopsital resource to being embedded in the care home support team that has been established.	Second trusted assessor in place	None
Chg 7	Focus on choice	Plans in place	Established	Established	Mature	Choice delays are reducing and all delays are known to the system	Availability of community specialist bed capacity to resolve disputes	New policy being implemented and discussions across agencies are improved	None
Chg 8	Enhancing health in care homes	Established	Mature	Mature	Exemplary	Investment in proactive team has made a step change. RCA on all admissions to identify learning. Working with top 18 homes	Seeking to integrate health and social care capacity into a single team	50% reduction in admissions from top 18 referring homes over winter. Expanding to a wider home pool	None

4.6. BCF Service Models

4.6.1. ***Emergency Response Team*** - 82.83% of the service users have not been admitted to hospital as a result of their attendance and 70.74% have not been admitted to hospital and have returned to their usual place of residence

4.6.2. ***Discharge to Assess Pathway 3*** – 53 beds have been commissioned to allow non-acute bed based assessment, with additional capacity commissioned when required. All of the service

users discharged to this capacity were identified as having a need for 24 hour placements. However, following a period of reablement 14.41% of the service users returned to their own homes.

4.6.3. ***Single Handed Care*** - Single Handed Care provides the ability to care for a greater number of people through maximising the use of carer and financial resources. Improving dignity, care and wellbeing by having more meaningful and satisfactory engagement in the care provided (one to one relationship). Maintaining the individual in the setting of their choice for longer and increases the amount of available care capacity in Dudley (reduces hospital delays, allow earlier intervention etc). These reviews have resulted in a reduction of 35.28% in hours of care

4.6.4. ***Delayed Transfers of Care (all providers)*** – The success of the reduction in delays at Russell's Hall Hospital has been extended to all neighbouring providers. All acute providers now have DToC delays below 3.5% for Dudley residents.

The highest number of remaining delays are at Dudley and Walsall Mental Health Trust. The total of Bushey Fields delays in March 2019 was 123 days (all responsibilities) compared to 212 from January 2019. Reduced from the highpoint in April 2018 of 324 days (all responsibilities), a reduction of 37.96%.

Dudley Delayed days of National Ranking (1 to 151, 1 Highest - 151 Lowest)																	
Ranking Type	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
DMBC ASC Ranking	121	▲ 110	▼ 131	▲ 105	▲ 77	▼ 101	▲ 60	▼ 72	▲ 59	▼ 72	▼ 115	▲ 101	▼ 109	▲ 108	▼ 125
DMBC Whole System Ranking	72	▼ 87	▼ 88	▲ 80	▲ 66	▼ 81	▲ 33	▼ 50	▲ 27	▼ 44	▼ 73	▼ 73	▲ 63	▼ 78	▲ 59

5. 2019-20 Plan

5.1. In developing the plan for the next 12 months, the CCG and Local Authority have built on the joint success of the last 18 months. Two years ago Dudley Council ranked 132 out of 152 Local Authorities (152nd being worst) for Delayed Transfers of Care. Over 9% of beds in the local hospital (Russells Hall run by the Dudley Group) were occupied by people who were ready to be discharged. The Council had a high proportion of older people entering permanent residential and nursing care. The pace and effectiveness of getting people independent or back home via reablement services was variable

5.2. The strategic vision underpinning the plan remains consistent with the Dudley 5 year vision:

5.2.1. **A Mutualist Culture** – recognising the mutual relationship between services and service users.

5.2.2. **The Structure of the System** – moving away from traditional

organisational boundaries and service categorisations to recognise the needs of individual service users in a modern world.

5.2.3. **Population Health and Wellbeing Services** – commissioning proactive population- based care.

5.2.4. **Health and Wellbeing Centres for the 21st Century** – providing the capacity needed to deliver our vision of population health and wellbeing services.

5.2.5. **Innovation and Learning** – investing in research, technology and information systems as a basis for improving our performance and the effectiveness of the system.

5.3. The key challenges facing the Dudley health and social care economy are:

5.3.1. A growing demand for healthcare from a population where, over the next two decades, the number of people over 65 will grow by 25,100 and the number over 85 by 9,900

5.3.2. The financial sustainability of NHS partners and the Local Authority

5.3.3. Budgetary challenges facing the organizational viability of Dudley Metropolitan Borough Council, which may impact upon the development of the MCP

5.3.4. The need to secure effective transformation in leadership and cultural terms at a local level to ensure our new model of care is capable of delivery

5.3.5. The need to secure full clinical engagement from clinicians across primary, community and secondary care

5.3.6. A primary care system that is under strain and requires radical change to becomes sustainable

5.3.7. An acute services provider facing challenges from the Care Quality Commission (CQC)

5.4. The system also faces a number of health inequalities challenges:

5.4.1. A higher proportion of people reporting a limiting life long illness or a disability than the national average

5.4.2. A female life expectancy rate (82.9) similar to the national average (83.1), whilst the male equivalent is 78.9 years, lower than the England average of 79.6

5.4.3. A gap in life expectancy between the least and most deprived areas of 8.2 years

5.4.4. 25% of deaths in the 40–59 age band being due to cardiovascular disease, smoking, obesity and lack of physical activity

5.4.5. The percentage of people with a high BMI being significantly worse than the England average

5.4.6. A rate of depression (11.7% of GP-registered patients) that is higher than the England average of 9.9%

5.5. A key focus of the next 12 months will be to integrate the successful elements of the BCF in the previous 2 years into the MCP model and the emerging primary care networks.

5.6. All practices in Dudley have a MDT. The teams are designed to work to the principles of shared responsibility for shared outcomes for a shared population, using a population health management approach. These teams bring together:

- GPs
- Community nurses
- Mental health workers
- Social workers
- Practice-based pharmacists
- Voluntary sector services
- Other specialist health services including heart failure, respiratory, end-of- life
- Specialist care consultants

5.7. Initially, we have six Primary Care Networks (PCNs) that we refer to as our 'localities'. This map sets out the configuration of each. They are organised geographically, and serve populations of between 50,000 and 70,000 patients.

health & wellbeing
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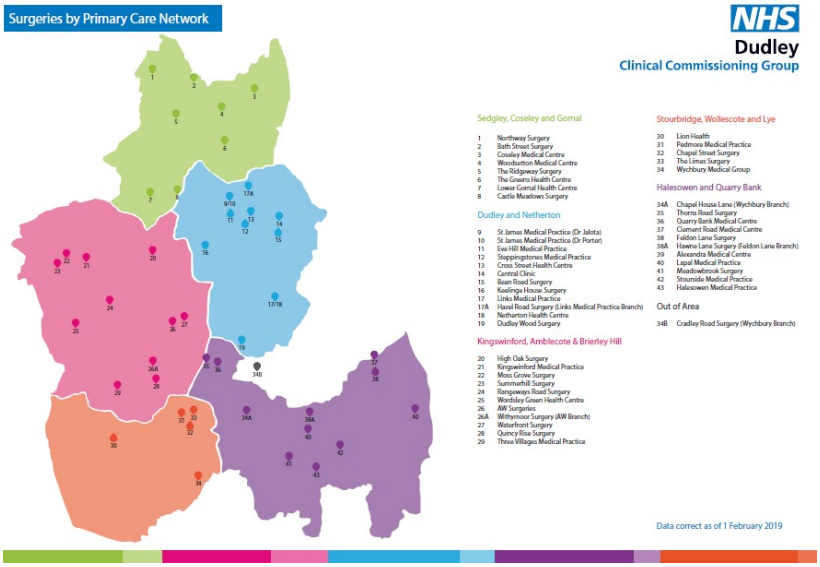
Dudley surgeries by Localities/Primary Care Network



5.8. Ultimately, PCNs will have Integrated Care Teams (ICTs) within them, serving a group of practices with a combined population of approximately 35,000 patients. PCNs will be led by an appointed GP integration lead from one of the practices within the PCN, who will co-ordinate the delivery of the MDT services for their population.

5.9. The ICTs bring together a group of staff to deal with population health management issues around a geographical area. Services are then operationalised to the same geography, operating under the direction of each PCN (with a dedicated GP lead). These ICTs will provide:

- Community-based physical health services for adults and children
- All mental health and learning disability services
- Intermediate care services and NHS Continuing Health Care
- End-of-life services
- Voluntary and community sector services
- Practice-based pharmacists

5.10. In addition, each PCN will have a range of additional services available to their population which will be operationalised following a transitional process within the MCP. These will include:

- Outpatient services for adults and children
- UTC and primary care out of hours service
- Primary medical services provided under existing GMS/PMS/APMS contracts
- Services commissioned by Dudley Metropolitan Borough Council's Office of Public Health, including health visiting, family nurse partnership, substance misuse and sexual health services

- Aligned adult social care services

5.11. Embedding the work of the Better Care Fund with the structure of the MCP will enable the level of the high impact change model to be delivered. The positive impact that has already been seen at the front door of ED and the discharge model at the hospital will be expanded into a full preventative model based on individual care planning. This will enable the HICM to achieve mature/exemplary across the Board

	Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020
Early discharge planning	Mature	Exemplary
Systems to monitor patient flow	Established	Mature
Multi-disciplinary/Multi-agency discharge teams	Mature	Exemplary
Home first / discharge to assess	Exemplary	Exemplary
Seven-day service	Mature	Mature
Trusted assessors	Established	Mature
Focus on choice	Mature	Mature
Enhancing health in care homes	Exemplary	Exemplary

5.12. The key elements of the 2019/20 programme in relation to the high impact change model are:

5.12.1. Early Discharge Planning – The system is trialling an enhanced use of the expected discharge date with agencies using this date to plan for discharges rather than awaiting referrals. This builds on the single discharge database currently in place and should enable community packages to be available on the date of discharge rather than awaiting offers of care from providers. This has the potential to save up to 48 hours on a discharge.

5.12.2. System to monitor patient flow – The system has a multi-agency operational meeting at 0930 to ensure that discharge planning is integrated across agencies. This is followed by a strategic level call at 1100 Monday to Friday to address any capacity constraints inside the hospital or with partners. This has been demonstrated to reduce delays on complex discharges and has significantly reduced the number of occasions when the hospital has escalated to level 4 protocols

5.12.3. Multi-agency discharge teams – The hospital based multi-agency teams are linked into primary care MDTs and the system-wide High Intensity User service to ensure that patients are safely discharged and any long term follow up is in place

5.12.4. Home First / Discharge to assess – Discharge to Assess capacity is in place and has demonstrated consistent performance for 18 months with low delays for bed placement. The service will be further enhanced for the 2019/20 winter plan with investment in a Own Bed Instead team to ensure that wherever possible home discharge is prioritised over a bed based discharge

5.12.5. 7 day service – 7 day working for discharge teams and community placements have been in place for 18 months and the system consistently records high complex and simple discharges over the weekend, with plans agreed by Friday. The system is still working to address referrals to community teams over the weekend which can reduce the discharge pathway for Mondays.

5.12.6. Trusted Assessors – The system has doubled capacity in the Trusted assessor model and linked to the Enhanced Care Home Team to address any delays in transfers for patients being discharged directly to Nursing and Care Homes.

5.12.7. Focus on choice – The system has amended the local choice policy and delays are reducing in length. The main limiting factor remains specialist placement capacity. There are a number of new homes bing built in Dudley over the next 6 months which may alleviate some of the pressure.

5.12.8. Enhancing health in care homes – The system has developed an Enhanced Care Home Team which has worked with the top 21 homes who have referred into the urgent care system. Support and training has been offered to all of the homes and there is evidence that emergency conveyance and admission is reducing. The team is contactable through the Dudley single point of access to avoid a conveyance to hospital, and there is now access to hospice sector capacity to support end of life patients who wish to die at their home rather than in the hospital

5.13. As part of the planning cycle, Dudley MBC has received £1.562m for winter capacity planning. The use of this money will be considered as a system as part of the winter planning process. This is the same process adopted in 2018/19 where the money was used flexibility to flex pathway 3 bed capacity and spot purchase complex discharge capacity in the EMI market.

6. 2019-20 Metrics

6.1. *Non-Elective Admissions*

The emergency admissions plan remains at the same level as 2018/19.

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	Significant work has been undertaken with the amblance service to refer patients who can be managed into the community to the Dudley single point of access. This has reduced ambulance conveyances to Russell's Hall Hospital by >12% since the scheme went live in March 2019. Work is underway with the Urgent Treatment Centre provider to increase the range of treatments offered to reduce referrals to ED. This should increase the clinical time in ED to develop plans for frail elderly patients increasing the opportunity to manage care outide hospital for those patients currently admitted for under 24 hours. The development of the front door social care model has reduced the likelihood of an admission once assessment has taken plcae. Although ED attendances were up 3.92%, emergency admissions remained below the BCF plan

6.2. *Delayed Transfers of Care (DToC)*

The target for DToCs is set nationally at 24.1 delays per day. The current system delivery has increased in June 2019 due to revised NHSE guidance on counting which has had the impact of increasing social care reported delays by 1%. However, performance remains within plan at 3.1% or 19.76 delays per day.

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	24.1	The iBCF allocation has been prioritised to support the DToC schemes and cash has been managed by the health economy over the 3 years of the BCF to ensure that funding can be maintained for services until March 2020. DToCs targets have been achieved since Dec 2017 and despite a 1% increase in delays attributed to Dudley MBC in June 2019 (as a result of tightening the reporting criteria based on the latest NHSE guidance), the target is on track to be delivered. June 2019 performance, the first under the new reporting, was 593 delayed days in total, equating to 19.76 delays per day (3.1%) The system has daily reviews of all delays at 0930 each day by operational teams with escalation to senior manaement on a system call at 1100. This ensures that any commissioning or operational delays can be addressed to maintain flow Winter monies in both health and social care are being prioritised to support the discharge pathways, incluiding flexing capacity in pathway 3 beds, commissioning additional placements for complex patients and ensuring that our placement partner How To Find A Care Home have sufficient capacity to find placements during times of pressure. Demand activity did not show a winter spike in 2018/19, although a stress test will occur in November to assess capacity in the event of a flu outbreak

6.3. *Long term support needs of older people (65+) met by admission to residential and nursing homes, per 100,000 population*

The health and social care economy delivered an 11.97% reduction in admissions in 2018/19 through improved reablement, particularly through the pathway 3 beds. Given the increasing complexity of this population, it is considered that a maintenance of this reduced rate will be stretching target. There will be a significant challenge to maintain reablement bed capacity in the system and to secure access to specialist beds when required.

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	718	626	The use of pathway 3 beds has shown that 14.41% of patients assessed as needing 24 hour care have been reabled to the point that they can return home. The health economy saw a significant reduction in the number of residential and nursing homes during 2018/19 and we have set a stretching target to maintain this performance despite the increased complexity
	Numerator	468	412	
	Denominator	65,175	65,791	

6.4. *Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services*

As with the reduction in long term residential admissions, maintaining this target is seen as a significant challenge given the rise in individual complexity, therefore the ambition is to maintain performance whilst strengthening the options for home reablement of specialist specialist placements.

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.0%	87.0%	The percentage ambition has not changed for 2019/20. However the complexity of patients is rising considerably and therefore we have set a stretching target to be able to absorb the complexity change whilst maintaining performance levels
	Numerator	383	383	
	Denominator	440	440	

7. As part of the 2019/20 there are 9 planning requirements which need to be met. All are met by the submission of this plan:

NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	The plan has been agreed as part of the budget setting process and was reported to the Health and Wellbeing Board at its Q1 meeting. This submission refreshes the plan to reflect the final budget allocations. The governance arrangements remain as in previous years
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	The plan builds on the 2017-19 plan which was developed by the partnership. The priorities meet the partnerships aspiration for integrated care and is aligned to the local priorities of the Council and CCG as well as the wider STP plan. The 2018 refresh of the plan (approved by the Health and Wellbeing Board) was built on lessons learnt from the original plan and has proved effective in delivering the 4 key targets for the plan

	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	The plan incorporates a DFG plan agreed with Housing and an action plan has been agreed to improve services over the life of this plan
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes

NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	All High Impact Change Model elements will be mature or exemplary by the end of the plan period, and the system has consistently delivered the target for Transfers of Care
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on?Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box)Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter?**Has funding for the following from the CCG contribution been identified for the area?**- Implementation of Care Act duties?- Funding dedicated to carer-specific support?- Reablement?	Yes, all elements have been used for their earmarked purpose. Winter pressures grant has been reserved to meet demand pressures as they are identified
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes

Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes. The ambition is to maintain current performance (as all are meeting target). This represents a stretching target due to the significant increase in complexity in the population being served

8. Financial Plan

8.1. The BCF has remained within the finance plans agreed by the Local Authority and the CCG during 2017-19

8.2. The 2019-20 financial plan has been set by the Local Authority and the CCG during their respective budget setting processes and have been signed off as part of their agreed budget approval processes.

Running Balances	Income	Expenditure	Balance
DFG	£5,679,451	£5,679,451	£0
Minimum CCG Contribution	£22,999,159	£22,999,159	£0
iBCF	£14,577,182	£14,577,182	£0
Winter Pressures Grant	£1,561,621	£1,561,621	£0
Additional LA Contribution	£15,692,841	£15,692,841	£0
Additional CCG Contribution	£19,216,344	£19,216,344	£0
Total	£79,726,598	£79,726,598	**£0**

8.3. The main changes from the 2018/19 financial plan reflect the increases due to the increased inflation in the CCG minimum contribution (£490,441) and the inclusion of the winter allocation for social care (£1,561,621). Both of these allocations are in services commissioned by the Local Authority. The CCG contribution has reduced slightly as a result of the Quality, Innovation, Productivity and Prevention (QIPP) programme:

Total BCF	Budget 18/19	Budget 19/20
Local Authority	£49,473,216	£51,978,321
CCG	£28,213,396	£27,748,277
Total	£77,686,612	£79,726,598

8.4. The increase in complexity of need is reflected by the increase in funding for the “highest care need” category. These services primarily support hospital discharge processes and assessment for long term needs. These services are primarily funded through the iBCF stream. There is evidence that although this expenditure is increasing, the impact is to increase the long term independence and reablement potential for service users reducing long term costs. As an example permanent admissions to residential and care homes reduced from 468 to 412.

Whole Population Prevention / Population Health Management	Budget 18/19	Budget 19/20
Local Authority	£9,336,780	£10,709,151
CCG	£0	£0
Total	£9,336,780	£10,709,151
Urgent Care Needs – Integrated Access & Rapid Response	Budget 18/19	Budget 19/20
Local Authority	£2,920,009	£1,837,300
CCG	£475,485	£516,637
Total	£3,395,494	£2,353,937
Ongoing Care Needs - Enhanced Primary & Community Care	Budget 18/19	Budget 19/20
Local Authority	£17,272,111	£15,338,643
CCG	£16,128,336	£16,851,113
Total	£33,400,447	£32,189,756
Highest Care Needs – coordinated community-based and inpatient care	Budget 18/19	Budget 19/20
Local Authority	£19,944,316	£24,093,227
CCG	£11,609,575	£10,380,527
Total	£31,553,891	£34,473,754

Geraint Griffiths-Dale
Deputy Director of Commissioning, Dudley CCG
(on behalf of Dudley Integrated Commissioning Executive)
9 September 2019