Walsall Better Care Fund Plan 2016/17
Narrative as at 8 February 2016

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Walsall Metropolitan Borough Council**
Clinical Commissioning Groups	**Walsall Clinical Commissioning Group (CCG)**
Boundary Differences	**The boundaries are within the Borough of Walsall.**
Date agreed at Health and Well-Being Board:	**29 February 2016**
Date submitted:	**tbc**
Total agreed value of pooled budget: 2016/17	**The revenue sum via the CCG will be £21,653,000.** **The Disabled Facilities Grant will be £2,895,00** **The total BCF will be £24,608,000**

b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	**Walsall CCG**
By	***Salma Ali***
Position	**Accountable Officer, Walsall CCG**
Date	**8 February 2016**

Signed on behalf of the Council	**Walsall Metropolitan Borough Council**
By	

	Keith Skerman
Position	**Interim Executive Director of Social Care & Inclusion**
Date	**8 February 2016**

Signed on behalf of the Health and Wellbeing Board	**Walsall Health and Well Being Board**
By Chair of Health and Wellbeing Board	***Councillor Rose Martin***
Date	**8 February 2016**

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integration of Health and Social Care – Implementing the Better Care Fund	**Walsall Council Website - Reports to HWBB:27 April 2015; 22 June 2015; 7 Sept 2015; 7 Dec 2015**
The Health and Well Being Strategy for Walsall 2013 to 2016	**Walsall Council Website** **Walsall CCG website**
Walsall Joint Strategic Needs Assessment refresh 2013	**Walsall Council Website** **Walsall CCG website**
Walsall CCG Strategic Operating Plan 2014/19	**As submitted at 8February 2016**
Walsall Council Budget Consultation	**Walsall Council Website**

2) VISION FOR HEALTH AND CARE SERVICES

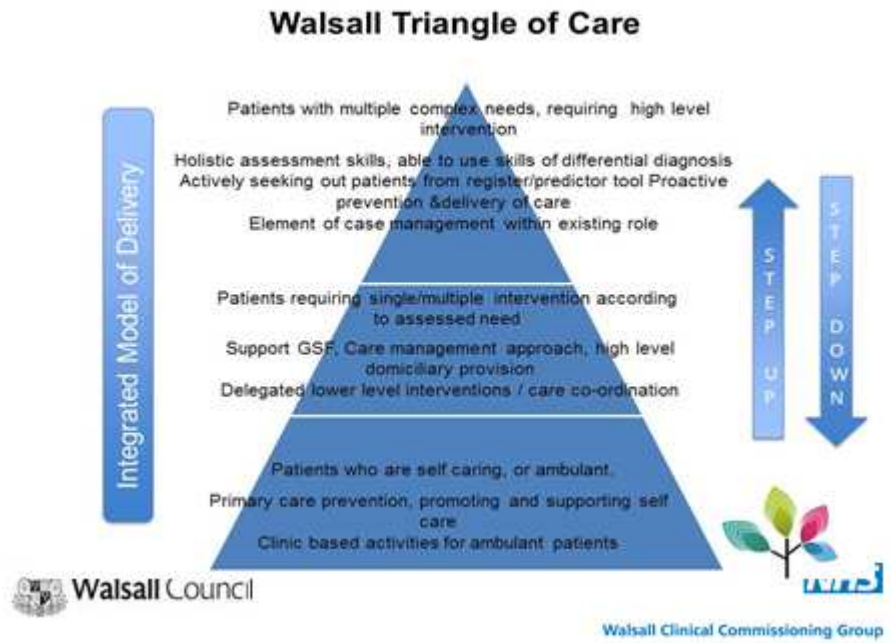
a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

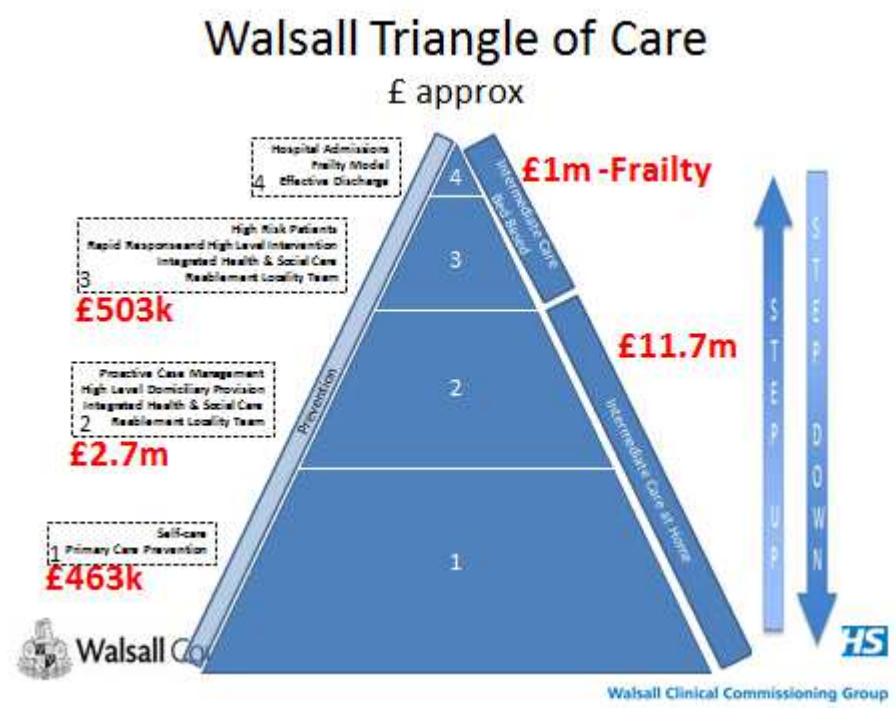
Our vision, as set out in our Health and Well Being Strategy and based upon our Joint Strategic Needs Assessment (see Walsall Council website) is to maintain and where possible improve the independence, health and well-being of the people of Walsall. In doing so we aim to reduce the prevalence of emergency admissions to hospital and to reduce the number of older people who are receiving on-going social care services, especially admissions to care homes from 2015/16 onwards as set out in our trajectories.

The two objectives of our vision are:

- Enable people to remain well and at home as long as possible
- Swift return home following episode of bedded care

Since 2014 we have enhanced our vision by recognising that our current system is overly reliant upon supported discharge of patients from hospital in order to create capacity within the hospital to meet demand from emergency admissions. Our vision has been developed to show how we need to be more successful with our admission avoidance measures to reduce demand on the hospital system, and thus be able to switch some of the system capacity that is currently being used supporting hospital discharge to be used for increased admission avoidance, thus creating a 'virtuous cycle' of increasing support for care at home services that maintain independence. This is represented in the following diagrams:





This shows how we currently have £11.7 million investment tied up in hospital discharge which should ideally be more focused upon admission avoidance.

b)What difference will this make to patient and service user outcomes?

The vision is one of ensuring multi-disciplinary ways of working that reduce crises, improve responses to crises in the community, and thereby target those most at risk of admissions to hospital and care homes. This will mean that fewer people are admitted to hospital in an emergency situation and fewer people are admitted to care homes.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

To keep people at home as long as possible we will create integrated local teams comprising the competences of primary care, acute, mental health, secondary and social care to combine with a range of other skills from other partners. These teams will utilise tools such as the single point of access to intermediate care, and risk stratifying patients using a range of health and social care data sets to understand the individual needs of people most at risk of hospital or care home admissions and target the services which best enable them to stay at home.

To deliver our first objective, there were three components of our new model of service each of which were currently being implemented to take effect from October 2014:

- a Single Point of Access for health and social care in the community
- multi-disciplinary locality teams with rapid response capability
- pragmatic use of risk stratification for people with long term, complex or

multiple conditions and frail elderly people to target proactive early intervention for those most at risk of hospital or care home admissions.

The second objective of the new model of service, that of swiftly and safely transferring people back to their own homes following an acute episode of care, requires a coherent and efficient joint intermediate care service which will be made up of the current separate health and social care services. This service will have the skills of hospital discharge and social care reablement, linking with the wider multi-disciplinary locality teams, to agree with people the packages of care they most need at home. Through the Single Point of Access, there will be a menu of packages of services ranging from at the most intense, our specialist intermediate care beds in the Hollybank Unit, through to at the least intense, 'reablement ' which is available within 24 hours of request and provided for a specified duration of days/weeks depending upon the recovery time needed.

We set out the detailed actions to deliver these objectives during 2014/15 and 2015/16 in Section 4 of the 2014 submission, and we have updated these actions in Sections 3 and 4 of this submission.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area:

Walsall's overall population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 12.9%, with the number of people 85 years and older increasing from 5,467 in 2008 to 8,109 in 2021 (Source: Walsall JSNA Refresh 2013).

With Public Health colleagues we have updated our 'Balance of Care' analysis of Walsall's population over the age of 55 to identify levels of need at local ward level, map service provision at local ward level, and analyse for gaps and priority areas for service development. Data sources included a range of Health Data; Social Care Service User data; and Insurance and Retail data and analysis was conducted using Mosaic Experian – a social marketing piece of software. A summary of the high level results was:

- An ageing population in Walsall shows a projected need to ensure suitable provision is in place.

- Ethnicity figures demonstrate a more diverse population in the Borough which is set to increase with a skewer towards more elderly dependent people from BME groups with a particular support need.

- The data suggests an increase in those suffering with Physical, Learning Disability and Mental Health need in particular for females.

- Long-term projections show a greater proportion of people over 85 requiring some form of support (either care provided privately or by a local authority).

- There is a predicted increase in the number of people who are aged over 65 and are also carers providing unpaid care.

In our 2014 plan we also set out a high level analysis of long term conditions in the population and this has continued to be updated since, and has informed work on risk stratification. This analysis is being used to guide the prioritisation of our work on integration of community services.

In broader terms we recognised that the urgent and emergency care system in Walsall was not working well for the people of the Borough or for the organisations responsible for health and social care services because:

- Too many patients were waiting too long for admission to hospital from A&E and the local NHS had not delivered the 95% 4 hour A&E waiting time standard since July 2013.
- The hospital was running at occupancy levels that were too high to cope with peaks in admissions leading to too frequent use of areas such as Endoscopy for inpatients, moves between wards and discharges that were too rushed.
- The whole system was over-reliant on institutional care whether in hospital, short-term placements outside the hospital or longer-term placements.
- There was a growing problem affecting all organisations with increased demand for mental health support by older people with mental health difficulties.
- There were a large number of clinically stable patients (circa 120 out of 520 hospital beds) ready for discharge but unable to leave hospital quickly.

We were clear that we had a whole system problem that required a whole system solution involving all four partners.

Since then, our targets to reduce the rate of emergency admissions to hospital and the rate of permanent admissions to residential care have not been met. We have continued to experience the same difficulties and we have set out our latest response in the form of a System Resilience Group Recovery Plan which identifies three key causes as follows:

Demand management:

- Acontinuing significant increase in emergency admissions to Walsall Manor Hospital (4.4% increase in 2015 compared to 2014, and an increase by 21% since 2012) see below:

	2012	2013	2014	2015
Walsall Healthcare NHS Trust	19,952	22,494	22,880	23,933
Royal Wolverhampton Hospitals NHS Trust	2,504	2,917	3,328	3,696
Other	3,483	3,404	3,778	3,849
Total	25,939	28,815	29,986	31,478

Annual Growth - Walsall Healthcare NHST	13%	2%	5%
Period growth - Walsall Healthcare NHST			20%

Annual Growth - All Hospitals	11%	4%	5%
Period growth - All Hospitals			21%

- Higher numbers of emergency ambulance conveyances; and
- Disorganised systems in ED (finding from recent CQC Inspection of Walsall Manor Hospital).

Hospital flow:

- Inconsistent ward processes;
- Reduced focus over weekend;
- Inconsistent hospital discharge planning processes at ward level;

Supported Discharge:

- High numbers of 'medically fit for discharge (MFFD)' patients
- Poor 'Discharge to Assess (DtA)' model
- Lack of alternative provision for complex patients

We have continued to analyse demand and capacity flows across the system and we report a dashboard on a monthly basis to the System Resilience group. The System Resilience Group Recovery Plan sets out ten high impact changes which are designed to bring our system to achieving the constitutional targets for urgent care by June 2016. These are:

Demand Management:

Action 1: Increase ambulance diversion via direct access for paramedics to patient GP at point of incident and enhanced access to Rapid Response Service.

Action 2: Support care homes to enable more end of life patients to die in the home rather than be admitted to hospital to die.

Action 3: Conduct therapy assessments in the Emergency Department (ED) or within 24 hours of admission aligned with therapy support for discharge to assess at home.

Action 4: Complete implementation of Frail Elderly Service (with social care and mental health input).

Action 5: Improved senior clinical decision making in the ED –improved ED

pathways including between Urgent Care Centre(UCC) and ED.

Hospital Flow:

Action 6: Complete Implementation of the 'SAFER' bundle consistently across all wards (Senior review, All patients have an expected date of discharge, Flow early from assessment units, Earlier discharge, Review long length of stay patients).

Action 7: Enhance weekend focus on discharge, review senior rostering.

Supported Discharge:

Action 8: Implement individual case management of patients on MFFD longer than 14 days.

Action 9: Continue enhanced flow management in SWIFT Ward.

Action 10. Halve the number of DtA beds in nursing homes (from 40 to 20) and transfer funding to additional social care reablement capacity to support home-based DtA mode and enhance specialist support.

These were derived following analysis of our system as set out in the 'High Impact Change Model for Managing Transfers of Care' issued by the Emergency Care Improvement programme (ECIP).

The following progress has been made on the actions that we set out in our submission in 2014:

Multi-disciplinary Locality Teams / Risk Stratification for Long Term Conditions

The objective was to implement a proactive coordinated integrated assessment and case management service. This supports bringing together health and social care workers who provide a rapid response assessment and subsequent on-going support to the most vulnerable older adult population in Walsall.

In order to ensure the outcomes from the new investment were maximised existing services and resources have also been re-modelled. This has included realigning and investing in existing community services to enable delivery of an enhanced model of care, assessment of risk of the frail elderly population and stratification of risk with a clear pathway of patient care delivered based on need. The model of care includes an integrated "Wrap Around" approach to patient care through collaborative work between Primary and Secondary care and includes Frail Elderly Services within Accident and Emergency, a "Rapid Response" Service for patients who are sub acutely unwell, acute 'In-reach' to support expediting hospital discharge, medical outreach support and robust community nursing teams, attached to each of the 4 Primary Care Commissioning localities, with enhanced case management and transitional patient care. A dashboard of data showing levels of activity is shown below.

Community Health Services have been re-organised in to five locality teams that

align with primary care across the Borough. Each team has implemented risk stratification for frequent flyers and those at high risk of admission since the summer 2014. From September 2013 Community teams have been analysing data each month for patients who have been readmitted 4 or more times in the previous 12 months. This work has been on-going until June 2015 when the sample was changed to patients who had been readmitted 2 or more times in the previous 3 months.The 4 or more admission work proved very useful and has helped to reduce avoidable readmissions for this cohort and also identified a population of patients whom despite community intervention require frequent acute intervention.

Social care will be integrated with community health locality teams by the end of March 2016 and work is underway to extend risk stratification to include social care issues. There has been limited progress with integration of the community mental health teams for older people to date, but a business case for additional investment to further reduce emergency admissions is currently included in the CCG QIPP programme for 2016/17 (see Section 4).

Rapid Response Service and Single Point of Access

Rapid response service and single point of access implemented from autumn 2014 with circa 130 referrals per month. The rapid response service aims to prevent patients being admitted into hospital if they become sub-acutely unwell and are safe to remain at home. The service is available for any adult (over the age of 18 years) if they are registered to a Walsall GP.

The Rapid Response Team(RRT) have access to an extended range of professionals via Intermediate Care, and the Re-ablement Team which is led by Social Care. The response by RRT is activated by a G.P, A&E or paramedic calling a single point of entry to alert the Rapid Response Team that a patient requires immediate support. Alternatively, patients could be stepped up to the RRT from the Long Term Condition teams within the community. The Rapid Response team have access to medical outreach support who will also visit patients within their own home environment to treat and stabilise patients who are sub acutely unwell. Medical Outreach will be available weekdays to take referrals from GP's, Rapid Response Team and Community Matrons.

The rapid response team operates between the hours of 08:30-10:00pm over 7 days per week. The multi-disciplinary team consist of;

- 1wte general practitioner
- 4.8wte band 7 rapid response lead nurses
- 5.8wte band 6 clinical sister/charge nurses
- 2wte band 6 physiotherapists
- 2wte band 6 occupational therapists.

The Rapid Response team responds within a maximum 2hour time frame to complete a comprehensive holistic assessment based on the principles of the comprehensive geriatric assessment, medication review and design of a sub-acute management plan. The multi-disciplinary team review patients as required for a period of up 14 days as they improve to restore optimum independence and functional ability. The response by rapid response team is activated by a GP, A&E or

paramedic calling a single point of entry to alert the rapid response team that a patient requires immediate support. Alternatively a patient could be stepped up to the rapid response team from the locality teams within the community.Following performing the comprehensive geriatric assessment, the rapid response team deliver the nursing care to the patients whilst on the virtual ward. The rapid assessment/intervention phase will be 48 hours and up to 14 days.

The Virtual Ward is an electronic data base, which is linked to Fusion and Lorenzo, of patients who are on the community nursing teams caseloads who are either at very high risk of hospital admission or have had an earlier than expected discharge or turnaround from Accident and Emergency.The key aim of the Virtual ward is to care for acutely ill patients within the community to prevent avoidable hospital admissions and deliver care within patients own home environment. This may also facilitate a reduced length of stay in the acute hospital where appropriate care pathways are available outside of the hospital environment. The ward serves as a communication hub ensuring the transition period from hospital/higher levels of care is safe and of high quality and patients are monitored and reviewed appropriately. It acts as a hospital at home where care is reviewed by multidisciplinary teams with discharge planning and optimising independence being an integral aspect of care. Admission to the Virtual ward is determined by clinical/medical judgement and/or predictive modelling. Patients will remain under the care of the virtual ward for as long as their medical condition requires. It is anticipated this should be up to a period of 3 weeks however, it will be determined based on each individual patient's clinical needs. The number of patients supported each month is between 320 and 380 with a Length of Stay of up to 3 weeks. This means that over 5,000 people are supported each year on this pathway.

There is a single point of access for health services in each of the 5 Locality teams. All referrals for the related GP practices attached to each team are taken by an experienced clinician who will be able to direct the referral to the most appropriate service. There is a Borough wide single point of access available out of hours.

Activity across all of these schemes is captured each month in the form of a dashboard as shown below:

COMMUNITY NURSING ADMISSION AVOIDANCE DASHBOARD (MONTHLY)

	Dashboard Descriptors ↑ Improvement → Stable ↓ Deterioration	**Bench-mark Sept 2014**	**July 2015**	**Aug 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Dec 2015**
1	Previous known high user patients, with long term conditions, following community intervention, having no re- admissions in 6 + months period	178	263 ↑	272 ↑	271 ↓	307 ↑	327 ↑	354 ↑

2	Previous known high user patients, with long term conditions, following community intervention, having no re- admissions in 12 + month period	9	110 ↑	118 ↑	124 ↑	133 ↑	143 ↑	151 ↑
3	Previous known high user patients, with long term conditions, following community intervention, having 1 readmission	60	67	49	43	54	62	64
4	Known high user patient, with long term conditions, continuing to be high users, despite intervention from community teams	72	59 ↑	62 ↓	73 ↓	62 ↑	51 ↑	56 ↓
5	Number of Patients admitted onto Virtual Ward	N/A	380	320 ↓	371 ↑	341 ↓	398 ↑	
6	Number of patients discharged from Virtual Ward	N/A	271	223 ↓	356 ↑	328 ↓	287 ↓	
7	Number/% of patients admitted into hospital whilst on the Virtual Ward (causative reasons for admission available on request)	N/A	13 3.4%	18 5.6% ↓	17 4.5% ↑	13 3.8% ↑	7 1.7% ↑	
8	Number of referrals to Rapid Response Team	103	135 ↑	126 ↓	133 ↑	154 ↑	190 ↑	191 ↑
9	Percentage of patients referred to Rapid Response and seen within 2 hours	79%	86%	91%	91%	72%	62%	57%
10	Number/percentage of patients referred to Rapid Response and admitted into hospital	2	8 ↓	10 ↓	10 ↓	1 ↑	3 ↓	1 ↑

Frail Elderly Pathway / Service

Frail Elderly Pathway nurses have been present in Accident and Emergency since

March 2015 to arrange support at home for older people as a means of avoiding admission to hospital. The success of this scheme has led to a further development whereby the FEP nurse team has been supplemented with additional capacity and skill mix to become a more comprehensive enhanced Frail Elderly Service (FES) spanning both acute and community. The enhanced FES provides MDT assessment/screening in ED including Consultant Geriatrician –a single model across hospital and community frail elderly pathways with rotational working of the staff – and availability of 8 beds in Ward 29 for 24 hour turnaround to prevent admission. The FES is linked to rapid response and the virtual ward. This enhanced service has been operational since 11th Janauary 2016. In he first week 88 patients were seen with 73 (83%) either being discharged to an appropriate community pathway same day or within 72 hours.

Support to Nursing Homes for Reducing Hospital Admission
Wrap around support to reduce admissions from nursing homes and care homes was implemented from spring 2015, with reduction in admissions. 1wte Band 6 Nursing Home Case Manager has been recruited to identify and undertake comprehensive holistic assessment of residents who are at high risk of hospital admission, develop a personalised care management plan and provide care co-ordination for an identified caseload. This role covers the 11 Independent Nursing Homes across Walsall. There are also 5wte Band 6 Case Managers who undertake the same activity in residential homes across the borough of Walsall. 1wte Band 6 case manager for residential homes has been aligned to each of the 5 Locality teams as there are in excess of 80 Residential homes in Walsall. Whilst the community nursing teams do visit the residential homes for care delivery, the case managers for the residential homes will also deliver nursing activity and provide enhanced case management for the most complex patients in residential care who are at risk of hospital admission. The case manager visits each nursing/residential home on a regular basis to:
1) Increase the number of early intervention/emergency passports in place.
2) Reduce the number of inappropriate 999 West Midlands Ambulance calls.
3) Reduce the number of patients being admitted into hospital inappropriately.
4) Improve access for Nursing Home staff to educate and training, in-order to enhance the quality and consistency of care that has been provided for patients and reduce avoidable patient harms.
5) Provide clinical assessment and deliver nursing care.

The CCG has commissioned a separate contractual arrangement for GP cover to nursing homes whereby there is the equivalent of twice weekly ‘ward rounds’ to review each resident on a pro-active basis.

The Emergency Care Passport (ECP) is a shared care plan between the resident, West Midland Ambulance Service (WMAS), primary and secondary care. Should WMAS attend to a resident with an active ECP who is not acutely unwell and does not require hospital attendance or admission but requires further support in the home to prevent admission then WMAS will contact the rapid response via the single point of access. This has been fully implemented across all five locality teams.

Early Supported Discharge
40 Discharge to Assess beds for patients who need supported discharge but are unsafe to return to their own home were commissioned across 5 nursing homes from

November 2014 with a social care support team. By November 2015, the average LoSwas circa 40 days which equates to 400 to 500 patients per year. One of the SRG Recovery Plan actions is to transfer half of this resource to a model of discharge to assess at home by reducing the number of beds commissioned from nursing homes from 40 to 20 and increasing the capacity of domiciliary care by 700 hours per week.

The Social Care Reablement Service is supporting between 75 and 90 people at any one time with intensive rehabilitation at home following hospital discharge. The average length of reablement episode per patient is 30 days. This equates to between 700 to 800 patients per year supported at home.This provides a baseline against which an additional investment of 700 hours from switching resource from the Discharge to Assess beds in nursing homes can be measured.

The contract for the Home from Hospital service has been fully utilised to date in 2015/16. The reprocurement exercise to renew the framework contract (joint between Council and CCG) for the full range of domiciliary care services -including for support of hospital discharge – is continuing with a current contract award at end of March 2016, and mobilisation from June 2016.

Hollybank House with 21 beds for step down intermediate care integrated service between health and social care - average LoS is circa 30 days so this equates to 250 to 300 people per year. This unit now provides support for people with dementia, and also for patients leaving hospital following a stroke.

WHT Community Health Intermediate Care Service provides support to patients going straight home from hospital or who need bed based care in nursing homes. Support at home is provided as part of the virtual ward – see above. Bed based step down support is provided in nursing home placements on a spot purchase basis which enables a flexibility to respond to different levels of escalation. There are times in the summer months where there is no one in need of this service ranging to upwards of high twenties who may be receiving this support in the winter.

A single point of access to the various supported discharge schemes is located at Hollybank House and is the main source of information on available capacity for supported discharge for a set of ward based ‘trusted assessors’ in the hospital.

Ambulatory Care in the Emergency Department of the Hospital
The Ambulatory Care Pathway went live in January 2015 and performance has varied since then. January and February saw consistent number around the 50 per week mark. A GP pilot was introduced in March 2015 where numbers initially went up to 55 – 60 per week and then dropped in April to the high 30’s to 40’s. This trend continued into May, with numbers in June around the 25/30 mark. The Consultant led service was re-established in July, where an immediate increase in numbers to the 50’s was seen. Numbers since then have varied between 14 and 53 dependant on the acuity of patients presenting in ED.

Delayed Transfers of Care
There has been a major effort to reduce the number and lengths of stay of patients on the Clinically Stable List from an average of around 80 patients to nearer 50,

based upon a set of actions that the Emergency Care Improvement Programme (ECIP) refers to as the SAFER Bundle (e.g. early discharge planning; ward and board rounds; discharge by lunchtime; trusted assessors, patient choice policy, etc). This practice has been extended to include the Clinically Stable numbers in the SWIFT Discharge Ward. This has increased the need for social care reablement capacity and 300 extra hours have been mobilised from November 2015.

Continuing with the implementation of the EPIC SAFER Bundle and with additional capacity for social care reablement are included in the ten SRG high impact changes – see next section.

Telehealthcare and Assistive Technology

Telehealth was included in the Assistive Technology work-stream of the 2014 submission, together with telecare, community equipment and Disabled Facilities Grants (DFG's). Walsall provides a Telehealth monitoring and triage service, and at the time of the previous submission there were 166 service users who had been identified as having a long-term condition such as chronic heart failure or COPD. Reviews of cases during 2015 to ensure that the service was till needed by each service user reduced the number to 130 and this is the current level.

There has been increased take-up of telecare and increased footfall in the Independent Living Centre since 2014. The Integrated Community Equipment Service (ICES) has maintained its high performance of delivery and recycling, and has faced additional demand for specialised nursing beds and mattresses. A full-time nurse was appointed to review over 800 cases of people with specialised beds and mattresses and providea quality assurance function over prescribing practice and this reduced take-up to enable the service to remain within budget.

To supplement the award of £1,632,000 Better Care Funding (BCF) allocation for DFG's in 2015/16, the council allocated a further £750,000 for 2015/16 with a further sum of £340,000 for expenditure on carry-forward commitments from 2014/15. At average costs of £6,640 per DFG this allowed 422 households to be assisted in 2015/16. This level of funding is being continued in 2016/17. Whilst applicants for statutory DFG's have up to 12 months to undertake their adaptations from grant approval, the vast majority are completed well within 4 months. Demand for DFG's is rising and without additional investment there will either be a need to increase thresholds for eligibility, or to introduce waiting lists. Partnership work is underway with Residential Social Landlords in the Borough to mitigate the impact of this.

Support for People with Dementia at Home

The number of Dementia Support Workers (DSW's) has been increased since the original 2014 submission with DSW's working within the hospital as well as community, and an increase in the number of dementia café's. Care home support and end of life (DSWs) became operational in May/June of 2015. Their role is to audit the quality and understanding of dementia care for every Walsall care home (residential and nursing) using Care Fit for VIPs and then support the home with their individual action plan to improve the quality of care for people with dementia.

The DSWs have received specialist training in end of life care in association with St

Giles Hospice who provide one of the tow DSWs. The DSWs are also introducing the Abbey Pain Scale and Namaste Care Programme (end of life dementia programme) to Walsall care homes.

At the end of March 2015, Walsall had achieved the national ambition for a diagnosis rate of 67% and achieved 68%. From April 1st 2015, NHS England introduced a new methodology for calculating prevalence that was supposed to take into account the positive effects of healthy lifestyle interventions. However, Walsall's prevalence of dementia actually increased by 3% when five of its neighbouring CCGs from the same Local Area Team have their prevalence reduced between 12 and 24%. This was not reported by NHS England until mid-October. The CCG challenged this data in October and despite several follow-up requests, has still not received a satisfactory explanation form NHS England.

Walsall's dementia diagnosis rate for December was 65.8%. This reduction was due to the increase in prevalence, deaths from the dementia registers and Memory Assessment Service performance.

Since April 1st, 130 people have been diagnosed with dementia and 106 have been removed from the registers due to death or moving out of area.

The Memory Assessment Service had a 25% reduction in staff which was not reported to the CCG and resulted in a waiting list of 152 people. The CCG issued a Contract Performance Notice and the Memory Assessment Service is due to be back on track by April 2016.

Commissioners have met with all four GP localities and encouraged them to use the tools provided to increase the diagnosis rate and specialist dementia support workers work with care homes to improve dementia care, end of life care with a view to reducing acute hospital admissions. Hospital dementia support workers continue to support care improvements in the acute hospital and the dementia cafés support carers to reduce the strain of caring which can often lead to acute admissions.

The national target remains at 67% and the Better Care Fund target at 70%. If the prevalence had not altered, a 70% diagnosis rate would have been achieved by August 2015.

BCF Planning since the 2104 Submission

During the period 2014 to 2106 we have been working with our providers under the auspice of the Healthy Walsall Partnership Board (see governance arrangements below) to consolidate our plans around the three primary headings of Demand Management (Staying well at home); Hospital Flow (Rapid Emergency Assessment and Treatment); and Supported Discharge (Getting Home Quickly and Safely). We are in the process of reconstituting our plan from being centred around the eight work-streams that featured in the 2014 submission to these three primary work-streams. This will largely reconstitute the first two of our eight work-streams: 'community integration' and transitional care pathways'. However, at the point of this submission as at February 2016, this is a work in progress and so this submission remains centred around the original eight work-streams as previously submitted.

Our overall aim for the Better Care Fund Plan in 2016/17 is to continue to work on the reconstituting of our work-streams around the three primary work-streams as identified by the Healthy Walsall Partnership Board and to build on and consolidate progress to date (as described above) by implementing the ten high impact actions in the SRG Recovery Plan and by applying a greater degree of integration in our commissioning of these services. We have a number of schemes and services that make up our whole system 'intermediate care offer' with an historical legacy of separate contracting arrangements. We will therefore explore the extent to which we can integrate the overall contracting and commissioning of all these services as an enabler to a higher level of integrated delivery and thus achieve more efficiency's, and further reduce the overall number of avoidable admissions and care home placements to achieve our revised targets.

Our plan for achieving this is shown in the next section.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Our actions for 2016/17 are as follows:

- **Implement the ten high impact actions set out in the SRG Recovery Plan:**
    - Increase ambulance diversion via direct access for paramedics to patient GP at point of incident and enhanced access to Rapid Response Service.
    - Support care homes to enable more end of life patients to die in the home rather than be admitted to hospital to die.
    - Conduct therapy assessments in ED or within 24 hours of admission aligned with therapy support for discharge to assess at home.
    - Complete implementation of Frail Elderly Service (with social care and mental health input).
    - Improved senior clinical decision making in ED –improved ED pathways including between UCC and ED.
    - Complete Implementation of the 'SAFER' bundle consistently across all wards (Senior review, All patients have an expected date of discharge, Flow early from assessment units, Earlier discharge, Review long length of stay patients).
    - Enhance weekend focus on discharge, review senior rostering.
    - Implement individual case management of patients on MFFD longer than

14 days.

- Continue enhanced flow management in SWIFT Ward.

- Halve the number of DtA beds in nursing homes (from 40 to 20) and transfer funding to additional social care reablement capacity to support home-based DtA mode and enhance specialist support.

- **Continue the development of multi-disciplinary teams at locality level comprising community health, primary care, social care, mental health and therapy workers based upon the locality structure of community health services;using a common approach to risk stratification and supporting frequent flyers and those most at risk of admission to hospital or care home with long term conditions;**

- **Implement a redesign of community mental health services for older people to provide crisis response and recovery services 7 days a week linked to the development of the community integrated teams (as above);**

- **Develop a combined specification for the current range of separate intermediate care services to become more integrated i.e. combines current/legacy specifications for social care reablement (bed and non-bed based); community health rapid response service; community health intermediate care service; CCG purchased intermediate care (i.e. spot purchased and Richmond Hall), with an explicit aim to utilise more of this capacity to support people at home – often in 'urgent' circumstances, and thus reduce hospital and care home admissions;**

- **Develop a combined specification for a single point of access/referral to the full range of intermediate care services bringing together current access points in WHT, DWMHT and Walsall Council (again drawing together existing separate specifications);**

- **Develop a 'Local Digital Roadmap' IT solution to support real time access for front line workers in the MDT to access the critical parts of patient held records in primary care, community health, hospital, social care and mental health that enables them to provide/arrange effective support. This will also need to create an opportunity to track and monitor the movement of patients through the system and the outcomes in terms of the extent to which individuals are supported in their own homes, or are admitted, readmitted to hospital or to care home placements, etc.**

- **Work with Walsall Strategic Housing Partnership to mitigate the impact of rising demand for DFG's and ensure that the provision of DFG's is tailored to those most in need, this to be delivered in partnership with the Registered Social Landlords in the Borough;**

- **Continue to develop our plan for the Better Care Fund to ensure alignment with the SRG Recovery Plan, the CCG Operational Plan, and the emerging plans of the Healthy Walsall Partnership Board in the**

context of the Walsall Health and Well Being Strategy.

- **Explore opportunity to add additional funding to the pooled fund from the Council or the CCG based upon identified benefits of a higher level of pooled funding leading to improved outcomes;**

- **Conduct work during 2016/17 to consolidate the 8 work-streams that comprised the original submission in 2014 to align with the priority work-streams identified by the Healthy Walsall Partnership Board, and bring forward recommendations to the Health and Well Being Board to transfer funding and services between work-streams to support this process as appropriate.**

- **Agree to a principle of performance related payment to be associated with specific initiatives which are funded to achieve a reduction in hospital admissions or care home placements.**

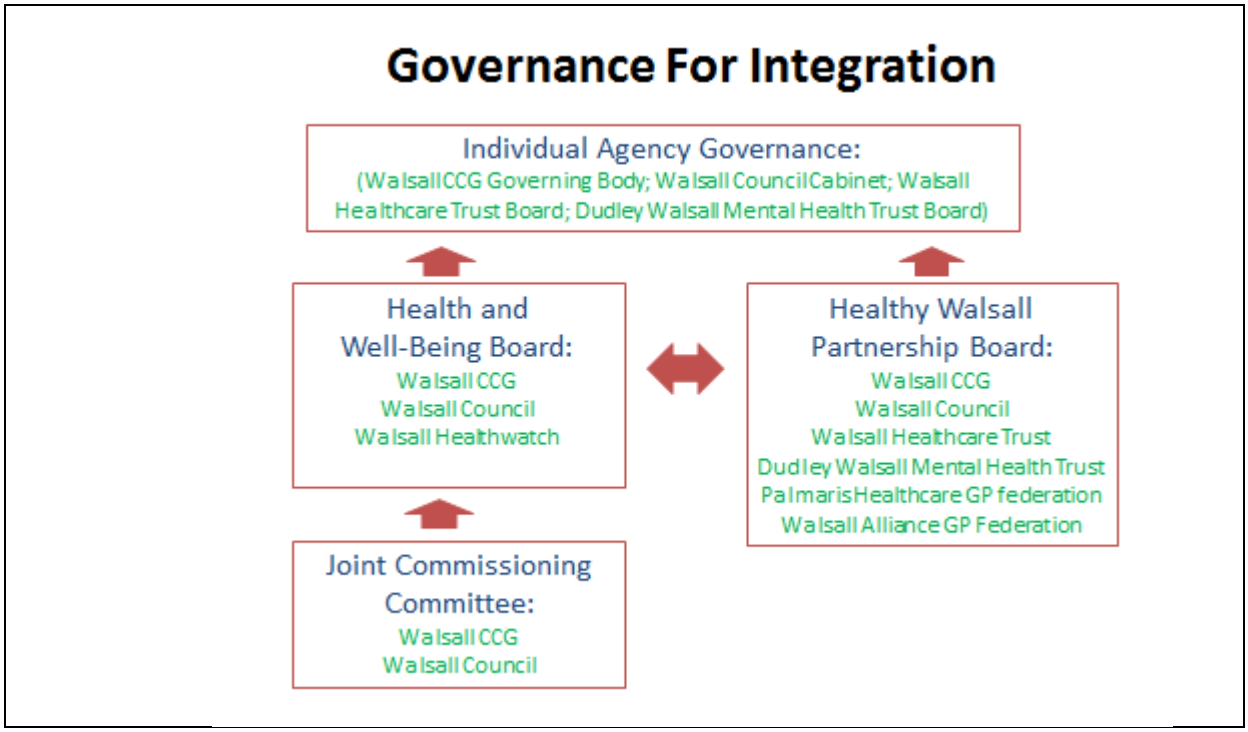
In line with our objectives we aim to bring a greater and more effective level of integrated working amongst this range of services leading to a point of maximum possible integration as soon as is practical and no later than 2019/20. We have agreed some general principles to guide our workforce planning and development.

b) Please articulate the overarching governance arrangements for integrated care locally

Since the original submission in 2014, the Vulnerable Adults Executive Board (est. 2009) has been renamed the Joint Commissioning Committee (JCC) with a revised Terms of Reference that incorporates the role of the Partnership Board for the BCF Pooled Fund, as well as continuing to oversee the joint commissioning arrangements for mental health and learning disability.

The JCC reports directly to the Health and Well Being Board, and decisions of the Health and Well Being Board are ratified by the Governing Body of the CCG and Walsall Council Cabinet.

Alongside the Health and Well-Being Board there is a Healthy Walsall Partnership Board where commissioners and providers sit together to work in partnership. This includes representatives of the recently formed GP Federations (Palmaris Healthcare Ltd and Walsall Alliance Ltd). WHT and DWMHT Boards also have a governance oversight role in respect of their directly provided services. This is illustrated by the diagram below:



c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, includingmanagement of any remedial actions should plans go off track

The Joint Commissioning Committee oversees the management and delivery of the plan for the Better Care Fund, reporting directly to the Health and Well-Being Board.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Integration of Community Services
2	Transitional Care Pathways
3	Assistive Technology
4	Dementia Care Services
5	Mental Health Services
6	Support to Carers
7	Long Term Social Care – Community and Residential
8	Voluntary and Community Sector Impact on Hospital Flows

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**

ID No.	Risk	Possible Outcome	Consequence	Likelihood	Rating	Mitigation	Owner	Residual risk score
1	Failure to reduce Emergency Admissions	Emergency Admissions continue current trends	Major	Likely	16	BCF Projects : SRG Recovery Plan; Integrated Intermediate Care; Frail Elderly Service;	SRG	12
2	Financial risk of failure to reduce Emergency Admissions	Financial risk to CCG under PbR/Tariff	Major	Likely	16	CCG Budget and BCF sum for contingency	CCG	12
3	Unable to implement 7 day working	Services not available 7 days per week	Major	Likely	16	Deliver 7 day working within budget where feasible	HWPB	12
4	Walsall Council unable to achieve budget savings due to rising demand for adult social care	Walsall Council would have to make adjustment to budgets impacting on other services.	Moderate	Likely	12	Ongoing monitoring and increased measures to reduce demand	WCC	9
5	Destabilisation of health care providers	NHS Providers would need to adjust financial	Moderate	Likely	12	Full engagement in BCF by provider units with early sharing of commissioning plans to identify	HWPB	9

		plans and capacity				risks and mitigations.		
6	Unable to achieve API data sharing	Unable to share patient data at front line	Moderate	Likely	12	Identify and pilot technical solution and then embed	HWPB	9
7	Workforce development unable to deliver integrated job roles	Unable to optimise MDT working	Moderate	Likely	12	Workforce Development plans		9
8	Unable to improve outcomes from MDT working	Continuing duplication between agencies	Moderate	Low	9	Co-locate service providers and agree single muti-disciplinary approach	HWPB	6
9	Quality of NH/RH Home Care fails to meet agreed Walsall Council/CCG Standards	Increase in suspensions and restrictions	Moderate	Low	9	Residential & Nursing Home providers are statutory regulated services and a set of quality standards have been agreed by providers	CQC Walsall Quality Board	6

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Within our finance plan for the BCF in 2016/17 we have retained just over a £1 million as a contingency for not achieving a reduction in emergency admissions or for over-spend on Council budget. The CCG has limited additional reserves to mitigate over performance of the acute sector, or over-spend in the Council, and there is a strong likelihood of both happening at the same time during 2016/17.

During 2016/17 £11,897 million of Council Adult Social Care expenditure will have been transferred to the Council via the BCF and £3,899 million of services will be commissioned from Walsall Healthcare Trust from the BCF (including £1.4 million which is transferred to the Council and commissioned from WHT).

BCF Risk Sharing Arrangements

Our risk sharing arrangements are built upon our Section 75 agreement for the BCF which includes specific clauses around over and under spends of budgets. The System Resilience Group receives a dashboard of weekly data used to closely

monitor the performance of the system. The SRG Recovery Plan sets out the actions currently underway to achieve the A&E 4 Hour wait target on a sustainable basis from the end of June 2016. Each of the 10 high impact actions havea specified individual lead and timescale for implementation. A monthly meeting of the SRG Operational Group oversees implementation of the plan reporting to a weekly meeting of the Chief Officers.

Financial performance of programmes in the Better Care Fund will be managed in line with financial regulations of each agency and this can be summarised as follows:

• Programme Directors will be accountable and held responsible for ensuring that their programme expenditure remains within the budget provision. Any change to required resources will have to be agreed by the Joint Commissioning Committee in line with the agreed Governance Arrangements;
• Program Leads will need to consider the full year effect of the commitments that they are making to ensure that the allocated budgets are not exceeded in future years;
• The program leads will be responsible for the budgets that have a number of pre-commitments. It will be essential that the Programme Leads gain assurance on any pre-commitments and to work with colleagues to ensure that the Better Care Programme resources are used effectively and efficiently;
• Program Leads will need to ensure that all of the commitments are supported by formalised contractual arrangements. These arrangements will include clear service specifications, financial commitments, contractual activity and key performance indicators (KPIs);
• All future commitments will need to be supported by a service specification and a contract with clear financial values, activity targets and KPI's;
• For 2016/17 the resources will be held as a pooled budget under the governance of the Joint Commissioning Committee reporting to the Health and Wellbeing Board.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The Better Care Fund Plan for 2016/17 incorporates the System Resilience Group Recovery Plan and is submitted as part of the CCG operational Plan. The plan is integrated across the health and social care economy with action elements across all agencies.

b)Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our close working relationship between Walsall Council, the Clinical Commissioning Group, Walsall Healthcare Trust and DWMHPT, means that we have developed our plans for the Better Care Plan and the CCG 5 year strategic/2 year operational plans at the same time with a high degree of coherence. The Health and Wellbeing Board has recognised the importance of a coherent programme of change across the

operational plans for the CCG and the BCF as a means of implementing the overarching Health and Well-being Strategy. Joint governance and performance reporting arrangements are in place to ensure this degree of coherence continues.

The Health and Well Being Strategy is strongly aligned to the Sustainable Communities Strategy within Walsall Council, which itself is a partnership document.

This Plan forms part of Walsall's 5 year Strategic Operating Plan being developed by Walsall Clinical Commissioning Group (see Section xxx and Appendix 7 of that Plan), and is in line with Walsall Council's Medium Term Financial Planning (MTFP) process.

c)Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG will take delegated responsibility for commissioning of primary medical services from April 2016on the basis that it will contribute to the 5 year strategy priorities of:

- Improving male life expectancy and reducing the gap in mortality between the most deprived and the least deprived 10% of the population.

- Bringing care out of hospital closer to home through developing new models of primary care.

In particular the CCG wishes to explore the following areas:

- opportunities for co-commissioning specific priority pathways for long term conditions such as diabetes; Initially, this will take the form of review and transformation of the diabetes care pathway, tackling health inequalities in the deprived areas of Walsall. The CCG would like to explore designing enhanced services that build upon the instructions within the Directed Enhanced Services. Full delegation under co-commissioning arrangements will support this work and allow consideration to be given to the development of new contracts and new models of care that are innovative and deliver improved health outcomes and improved patient experience

- The CCG aims to strengthen current working relationships with NHS England and NHS Property Services so that primary care premises in Walsall are able to deliver high quality care in a safe environment.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Our definition of protecting adult social care services relates to the extent to which we are able to sustain high quality social care services in line with rising demand and implementation of the Care Act (e.g. Increase support to Carers, Social Care Funding Reform, and prevention) whilst maintaining a balanced budget.

Delivery of our two objectives (improvement to multi-disciplinary local community services to support people at home; and integration of intermediate care services) will support the delivery of the Adult Social Care Operating Model which maintains investment in a range of prevention services including telehealthcare; community equipment; intermediate care and reablement; extra care schemes; neighbourhood support; information, advice and advocacy; dementia support; bereavement support; end of life care services; assessment and care management; and so on. This is in line with the requirements of the Care Act which are included in the scope of the BCF.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Savings include a reduction in planned expenditure on commissioning social care services for older people, on the basis that the current Operating Model supports older people to retain their independence, health and well being and thus reduce the level of need.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

During 2016/17 £11,956 million of Council Adult Social Care expenditure will have been transferred to the Council from the CCG via the BCF. This represents nearly 50% of the total BCF pooled fund. (Funding for DFG's is not included in this calculation because it is transferred to the Council as a grant directly from the Department of Health). This funding is invested across the sectors as follows:

£5.880 million	Council Services
£3.873 million	Private Sector
£1.486 million	Walsall Healthcare Trust
£0.717 million	Voluntary and Community Sector

A sum of £2.252 million is incorporated within the investment in private sector services and this is a direct subsidisation of Council Commissioning budget for care home placements and care packages. This represents nearly 10% of the total BCF pooled fund in 2016/17.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Walsall Council has implemented the Care Act with a series of project based work-streams as follows:

- Carers Assessment and Eligibility
- Market Shaping and Provider Failure
- Workforce Development
- Assessment and Eligibility
- Funding Reform
- Shared Implications of Care Act 2014 and C&F Act 2014
- Revised Charging Arrangements
- Advice and Information
- Preventive Services
- Market Shaping Non Regulated Services

v) Please specify the level of resource that will be dedicated to carer-specific support

The sum of £450,000 that was originally allocated to Walsall from the Carers Grant has remained withinour BCF pooled fund and there is an investment programme for supporting informal carers.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The Councils overall budget for adult care was developed with consideration of the Better Care Plan and underpinned by joint working with health partners. Walsall Healthcare Trust is reporting continuing financial pressures arising from increasing emergency admissions and Walsall Council has experienced a higher than planned rate of permanent admissions in to care homes and the £1,050 million in the BCF is unlikely to be sufficient to meet both of these issues. It is therefore likely that both Walsall Council and Walsall Council will face ongoing financial pressures during 2016/17.

The financial position of the Council for 2016/17 is for net growth to adult social care due to additional corporate support to address over-spends arising from increased demand for services, particularly a higher than planned rate of permanent admission to residential care, a significant number of which were to meet the needs of patients leaving hospital care.

The SC&I Net budget for 2015/16 is currently £57.888m. For 2016/17 there are approved savings of £5.574m. There is then ongoing investment to cover existing pressures of £9.024m, and a further £4m investment to cover additional costs from rising fee levels resulting from reprocurement of contracts with care homes and domiciliary dare agencies (including for Living Wage), plus a further one-off investment of £0.665m to support the implementation of savings. The outcome is a net cashlimit for 2016/17 of £66.003m.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Current 7 day services include social care reablement and social work services, as well as the Health Intermediate Care Team. A multi-disciplinary team to support week-end discharges has been in place since September 2014. This team holds 2 Consultant led MDTs at 08:30 and 13:00 to review and discuss a list of patients that will be able to be discharged following their intervention.A Weekend Discharge Co-Ordinator (from the Discharge Co-Ordinators Team) liaises with wards and fellow Discharge Co-Ordinators to compile the list of patients ready for the weekend. Therapy and Pharmacy services are incorporated in the arrangements, together with a focus on transport availability.

Standards 1 to 5 of the clinical standards forum for 7 day working were prioritised for joint review in the summer 2015 between the CCG and Walsall Healthcare Trust and a summary of the conclusions was as follows:

- Standard 1 Patient Experience: Patient involvement is evidenced in the Net Promoter Scores (NPS). Real-time feedback is not available and the trust has a performance display that includes partial evidence of what is required by the standard. The CQC Inspection conducted in September 2015 found that “Patients reported being involved in their care across the majority of services, with more work required in maternity services and the emergency department because with increased activity there was a decline in patient involvement”. Further work to assure that differences between weekday and weekend are understood is underway.

- Standard 2 Time to First Consultant Review: This is referred locally as the Early Senior Review and is operational from 8.00am to 22.00pm M to F and 8.00am to 14.00pm Sat/Sun. This mirrors the consultant on site presence within A&E. Our plan for coverage 24 hours 7 days is to establish the Early Senior Review Model with middle grades within the limited space available to have a dedicated area. There are no current plans to extend consultant cover within A&E.

- Standard 3 Multi-disciplinary Team Review: a multi-disciplinary team ward and board round processes are embedded at ward level, particularly in the MAU and medical wards, with social care input included. These take place on Saturdays, but currently not on Sundays.

- Standard 4 Shift Handovers: An electronic handover process is in existence. Handovers take place twice per day, and utilise the electronic spreadsheet and data from clinical systems. Further work is needed to standardise across 7 days per week.

- Standard 5 Diagnostics: 7 day diagnostics are available for the majority of diagnostic services.

Ongoing review of progress against the 7 day working standards is built in to the contractual arrangements with WHT. The Trust has completed the self-assessment tool on the 7 Day Standards website, and further progress will be added in to the self-assessment following a further review during March 2016. This review will include progress with Standard 9.

Discussions are underway with Dudley Walsall Mental Health Partnership Trust to extend community services for older people across 7 days.

c) Data sharing

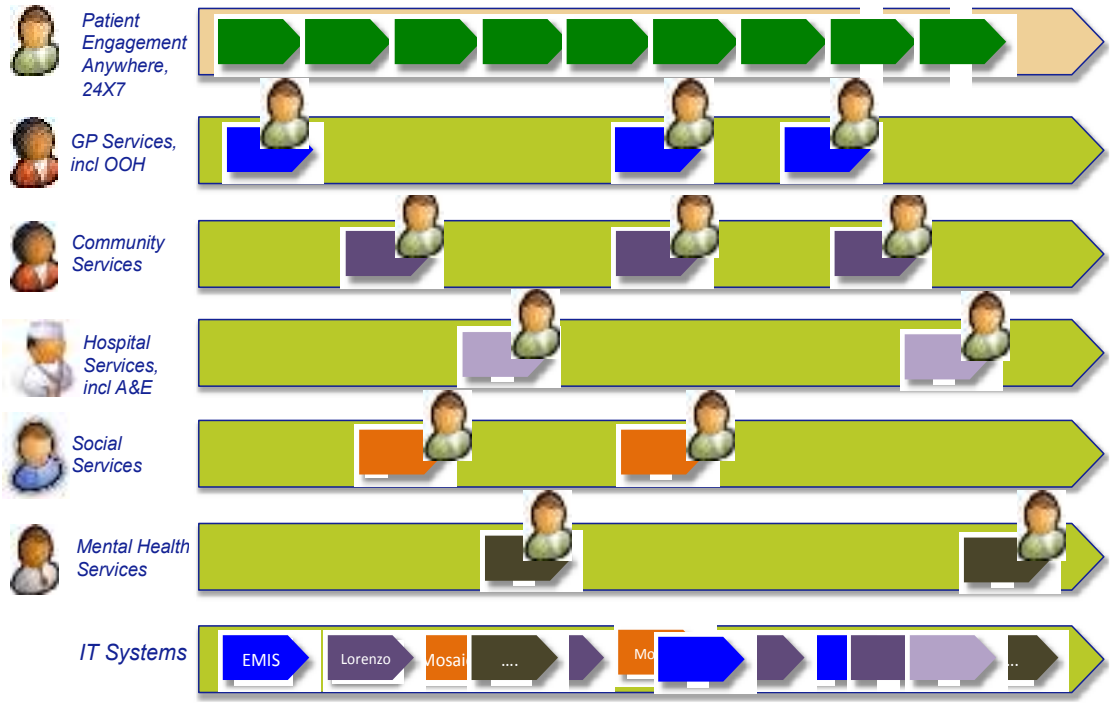
i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The use of the NHS number in all social care records has been in place starting from 1st April 2014. The NHS number has been the primary identifier since April 2015.

ii) Please explain your approach foradopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The Walsall Health and Social Care 'System' Digital Roadmap emphasises the key themes of partnership working across Health and providers, creating new relationships with patients and co-creating new models of care to meet the challenges of increasing demand within resource constraints.

The Digital Roadmap seeks to establish a more responsive system that allows Commissioners to design and implement enhanced service delivery models for our local population. This is underpinned by a significant increase in the use of technology to enable seamless information flows across the patient journey, help patients engage with their care plan, streamline communication and planning across health and service providers.

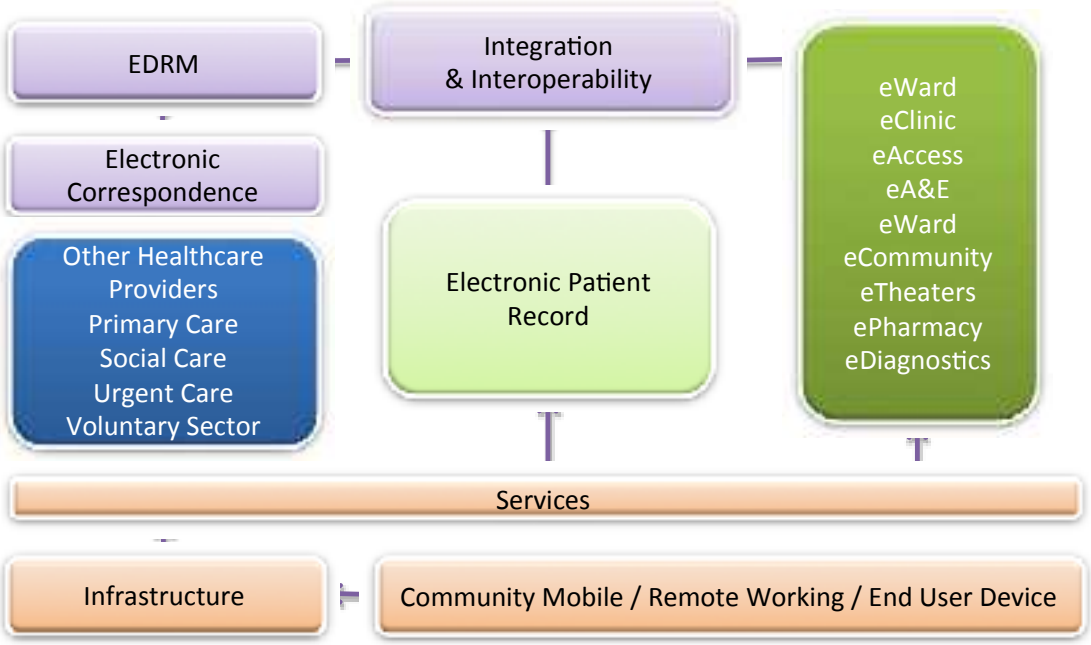


The following critical success factors will be implemented through the roadmap:

Critical Success Factors

1. Mobile working: Improve productivity through continuous access to functionally rich clinical systems coupled with user-friendly productivity tools to reduce travel time and effort on non-clinical activities to enable more time to be spent with patients.
2. Interoperability (with data sharing): Platform to integrate with multiple IT clinical systems e.g. Fusion Clinical Portal, EMIS, Lorenzo, eChemoetc and provide connected/disconnected capability to enable continuous 'access' to patient data/functionality for mobile workers. The NHS number will be used as the primary identifier in all settings when sharing information.
3. Operational reporting: Accurate and time activity reporting with financial reporting across different health needs
4. Business analytics: Determine the cause of ill health and the development of total cost data for individual patients across multiple health and care settings

The application architecture underpinning the Digital Roadmap is shown below:



The Digital Roadmap will make available these critical success factors across the Walsall System and be the technical foundation for service integration, streamline processes and enhanced patient care through access to rich patient data from across systems and decision support to increase the focus on the patient needs. In addition, it will enable the Walsall system to become agile to design and implement new models of care.

WHT Primary Care and Social Services enjoy more mature IT systems compared to the secondary care landscape. In particular, EMIS Web, deployed across all GPs, has rich functionality that has already enabled patient's to better engage with their health, for example:

1. Patients to have online access to their GP records contributing to a 'paperless' NHS (relevant for GP Practices only)
2. 3.Patients should have access to an easy-to-use electronic prescription service (relevant for GP Practices only)
3. 4.Patients should have access to online services, including extending online access to medical records and the availability of online appointments (relevant for GP Practices only)

The Walsall System IT services are working with partners and clinical leads to design and implement the enterprise architecture in line with current and future business requirements.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

We are committed to ensuring that the appropriate IG Controls will be in place. These

will cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and requirements set out in Caldicott 2.

We have a data sharing agreement in place between Walsall GP Practices and Walsall CCG and this is being extended to include Walsall Healthcare Trust.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Based on Walsall's GP population as at June 2015 there are 5,495 Patients (2% of 274,754) who are in our Risk Stratification cohort. Across the five integrated Localities in Walsall i.e. North, South, East, West and Trans, some 3,830 local residents have been identified as in need of preventative care, which is 70%.

This has been accomplished through community nursing redesign, integrating community matrons with district nursing teams and including the recruitment of 7wte Clinical Case Manager Transition Nurses this has enhanced integrated work with the Primary Care Teams, hospital wards, social care and many other key stakeholders. Through using risk stratification processes supporting identification of patients in GP Practice population who are older, frail and vulnerable with long term conditions and co-morbidities. Work has also progressed identifying patients who have been readmitted into Manor hospital frequently. This information has been used to provide "Wrap Around" services to support patients in their own home with a view to avoiding unplanned hospital attendance / admission. The team proactively manage this group of patients "the Virtual Ward" stepping up to the Matron, (who has advanced skills in disease management), when the patient is deemed unstable, or reviewing these patients on a more frequent basis to stop them going into crisis.

The clinical case manager role also includesproviding an enhanced visiting / assessment regime throughout the period of transition. This period is defined as 30 days following a period of hospitalisation, or transfer of care from rapid response or intermediate care services.As discussed above the recruitment of additional clinicians has supported workanalysing and implementing case management for patients who have multiple long term conditions and have been identified as having frequent hospital admissions into the Manor hospital.Patients who have had 4 or more admissions during previous 12 months are the cohort of patients investigated within this work

To validate outcomes for this admission avoidance activity we have rag rated patients who were/are known frequent admission patients. Rag rated Green if they have had no further admissions since community teams have been involved, Amber if just one more admission and Red if despite intervention they continue to be readmitted.

Figure 1 below illustrates the outcomes of this work commencing September 2013

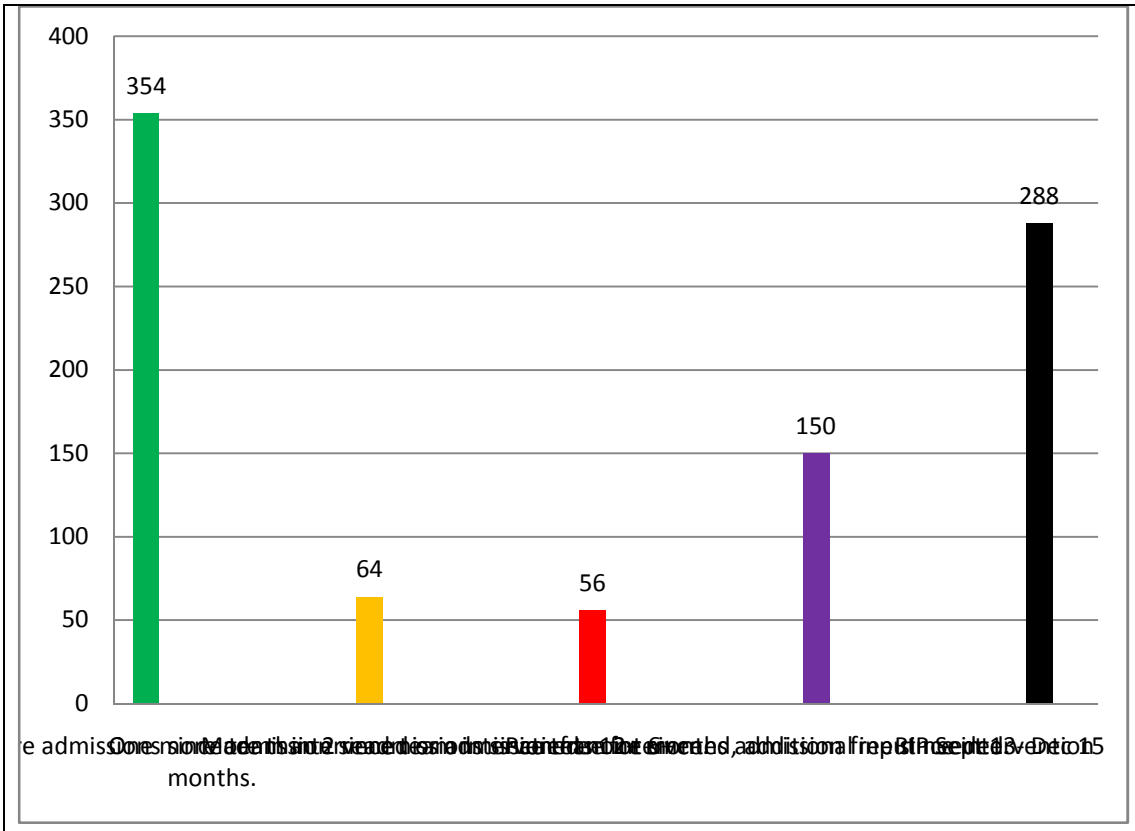


Fig 1 High user analysis – frequent hospital admission patients – following case management

October 2014 WHT has recruited to an admission avoidance administrative role who will continue to lead on the work described above and enhance this work further by including detailed work on patients whom have been readmitted within 30 days of discharge and frequent re-attenders into A&E.

Investment has also been utilised to recruit to a small team of Occupational Therapist and Physiotherapist who work with the community teams to provide assessment and interventions to keep patients safe in their homes and maximise their independence. The therapists are supported by therapy assistants who provide low-level equipment assessment and carry out therapy care plans under the care of the qualified therapists. This team are heavily involved with patients whom are deemed to be frequent hospital admission patients and are beginning to produce evidence of how their intervention is not only supporting reducing readmissions but reducing risk of falls.

We have implemented a Local Enhanced Service (LES) for GP case management of people aged over 75 years old which is different from and complements the Direct Enhanced Service (DES) that has been implemented at national level. The DES requires GP's to proactively case manage a minimum of 2% of the practice's adult population (aged 18 and older), identified as being at the highest risk of avoidable admission.

Our LES is for GP's to review 50% of all patients over the age of 75 years old by April 2015 including elements that are not included in the national DES as follows:

- The need for medication reviews
- Dementia screening using 6-cit
- Checking that immunisations are up to date
- Health and social care assessment
- Long Term Conditions assessment

The requirement to review 50% of all patients over 75 years old is well beyond the requirement of the national scheme. This is undertaken in partnership with community matrons (CM) and undertaken in formal meetings with GP Practices and CM. Each patient is risk assessed and a care plan with a named key coordinator is generated. The DES was originally for practices to look at the top 100 patients but this has now been extended. We are currently examining the impact of this scheme during 2015/16 and we will make adjustments to generate a greater impact during 2016/17 depending upon the outcome of this monitoring.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The community nurse team provide case management care for frail elderly patientsand proactively manage this group of patients in the “the Virtual Ward”, stepping up to the Matron, (who has advanced skills in disease management) when the patient is deemed unstable, or reviewing these patients on a more frequent basis to stop them going into crisis.

All the most vulnerable patients who are on the community nursing caseloads are linked to an alert in Fusion (an electronic information sharing software available to GPs, community and acute health care services) which informs the community teams if patients are admitted to or attend A&E. The key coordinator liaises with the discharge co-ordinator to arrange the appropriate aftercare / treatment. This works in conjunction with the existing jointly provided Frail Elderly Pathway which identifies those patients in A&E and turns them around in the department, where appropriate, to a safe and effective discharge.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Our approach to risk stratification (as described above) has identified 3,830 local residents who are in need of ongoing preventative case management (which is 70% of thise identified as at risk). Out of these 3,830 residents, 81% have been offered a Care Plan. We are aiming to increase this figure in 2016/17.

All the most vulnerable patients who are on the community nursing caseloads are linked to an alert in Fusion (an electronic information sharing software available to GPs, community and acute health care services) which informs the community teams if patients are admitted to or attend A&E. The key coordinator liaises with the discharge co-ordinator to arrange the appropriate aftercare / treatment. This works in

conjunction with the existing jointly provided Frail Elderly Pathway which identifies those patients in A&E and turns them around in the department, where appropriate, to a safe and effective discharge.

New National Condition Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care.

NB: Draft guidance states: Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund. This should be achieved by funding NHS commissioned outof- hospital services, , which may include a wide range of services including social care, as part of their agreed BCFplan (local areas should seek, as a minimum, to maintainprovision of NHS commissioned out of hospital services in amanner consistent with 15-16); orLocal areas can choose to put an appropriate proportion oftheir share of the £1bn into a local risk-sharing agreement as
part of contingency planning in the event of excess activity,with the balance spent on NHS commissioned out-of-hospitalservices;This condition replaces the Payment for Performance schemeincluded in the 2015-16 Better Care Fund framework.

Our plan for the BCF in Walsall has from the outset included a majority of investment in out-of-hospital services. Only £1,050,000 of the total of £23,977,000 in 2015/16 was allocated for acute hospital service as part of the financial recovery of Walsall Healthcare Trust following a continuing rise in emergency admissions. This represents only 4.4% of the total of the pooled fund.

The sum of £1,050,000 was allocated in 2015/16 on a non-recurring basis and so the same amount remains as a contingency for continued increasing emergency admissions in 2016/17. If the level of emergency admissions does level off, or start to decrease, then consideration can be given to investing this sum in out-of-hospital services to provide further support for reducing the rate of emergency admissions.

New National Condition Agreement on a local target for Delayed Transfers of Care (DTOC) and to develop a joint local action plan

NB: draft guidance states: Each local area is to develop a local action plan for managing DTOC, including a locally agreed target. All local areas need to establish their own local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the nationally reported metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue. The plan should also demonstrate engagement with the independent and voluntary sector providers and show consideration to how all available capacity can be effectively utilised to support safe and effective discharge.

The focus of our work in Walsall has been to manage the total of clinically stable patients (i.e. medically fit for discharge) rather than just the smaller sub set of these that meet the criteria for a DToC. As part of the SRG Recovery Plan (see section 3 above) there is an action to reduce the number and lengths of stay of clinically stable patients in the hospital and this represents our joint plan for reducing the level of DToC's.

During August and September 2015, joint work was undertaken to review the

reporting of Delayed Transfers of Care to ensure that the reporting systems were in line with the revised national guidance issued in July 2015. The outcome has been a significant shift in the level of days reported from an average of around 0.5% (delayed days per 100,000 population) to figures of 2.5% and 2.6% for the months of October, November and December. We have therefore agreed a 2.5% target for DToC's in 2016/17.

As a result of this work we are confident that the level of days being reported is now in line with the national guidance. However, within this higher level of reporting, there is a comparatively high percentage of days attributed to social care compared to national and regional averages, and so further work is underway to ensure that this element of the reporting is correct and signed off each week by the Local Authority. Until this review is completed the element of the regulations that allow for fining of the Local Authority by the Acute Hospital Trust will not be enacted.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

In 2014 we set out a public engagement and communications plan to be led by Walsall Healthcare Trust and taking learning from the 'Hot-House' programme developed by Coventry and North Warwicks CCG. We have made limited progress with implementing this plan to date, and will revisit our arrangements for patient, service user and public engagement during 2016/17.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Walsall CCG has incorporated the aims of the Better Care Fund in the commissioning intentions for the two main local NHS provider trusts (Walsall Healthcare NHS Trust (WHT), and Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT)).

All providers, Walsall CCG and Walsall Council have developed a shared view of the future shape of services, the impact of this Better Care Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made.

Our two main NHS providers have each signed up in their own right to our BCF Plan

and have played a major part in the development of our plan via the Healthy Walsall Partnership Board.

ii) Primary care providers

During the period since the original plan submission in 2014, we have seen the development of two GP led Federations (Palmaris Healthcare Ltd and Walsall Alliance Ltd) which will take responsibility for delivery of primary care services in Walsall. Both Federations are represented on the Healthy Walsall Partnership Board, and this has created an opportunity for meaningful engagement over the plan for the BCF.

iii) Social care and providers from the voluntary and community sector

Voluntary and Community sector organisations provide a range of services in Walsall and the funding for some of this is included in the Better Care Fund, for instance Home from Hospital schemes and Dementia Support services – see Annex 1 for more detail on Independent Sector Organisations. These services will continue to receive funding from the BCF during 2016/17.

During 2015/16 there has been a major review of the support to the Voluntary and Community Sector (VCS) in Walsall by Walsall Council. This has concluded that there is a need to take a more strategic approach to local commissioning of the VCS providing greater accountability and clarity on how Council monies are directed to support third sector activity, and to appropriately resource a lead organisation that will be able to exponentially increase funding into the sector. Walsall CCG has historically invested some funding for partnership working with the Council to support the sector, and will continue to make an investment as a partner in this review.

The aim will be to support the sector to develop to the point where it is more able to contribute a higher level of partnership working to achieve the aims of the BCF Plan, by for instance supporting more frail elderly people to remain at home with prevention type services such as home visiting.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

WHT and DWMHPT are committed alongside the CCG and Walsall Council to greater integration of hospital and community services to deliver care closer to home.

As service redesign delivers more integration of community services between community health, mental health, primary care and social care, our long-term plans include assumptions about a reduction in acute hospital activity for the population of Walsall (part of our agreed QIPP activity and finance modelling). These assumptions will be developed further in the next stage of our detailed planning for service change from 2016/17 onwards.

At this stage, however, WHT and DWMHPT have asked the Walsall CCG and Walsall Council to recognise the risks for local providers related to this scheme in particular:

- the detail of the operational changes required to deliver our agreed objectives are currently in development;

- some of the resources being committed to the Better Care Fund are already supporting services within the combined acute and community provider portfolio that are the subject of a major joint integration programme which is at an early stage;

- we are in the process of developing a shared model for the overall impact on WHT or DWMHT at sufficient detail to confirm that risks can be mitigated.

The BCF plans will be further tested and developed in 2016/17 to ensure the objectives are being met, and then extended to 2017/18 under the auspice of the Healthy Walsall Partnership Board. This provides an opportunity to develop a model of integration for community services that will have the right kind of favourable impact on the acute sector in both NHS Trusts and ensure that the impact on the acute sector will be controlled in accordance with plans that are agreed in advance. This will support the achievement of performance targets for reducing emergency admissions and sustaining a low level of delayed discharges as set out in the BCF metrics.