Social Care and Health Overview & Scrutiny Committee

08 April 2021

Walsall Together Update

1. PURPOSE

This report provides an update on the development of Walsall Together. It provides an overview of the work undertaken since the previous report was received in January 2020 and highlights some key priorities for the partnership over the next financial year.

2. RECOMMENDATION

The Board is asked to note the contents of this report.

3. BACKGROUND

Walsall Together is a formal partnership between Walsall Healthcare NHS Trust, Black Country Healthcare NHS Trust, Walsall Council (Adult Social Care, Children's Services and Public Health), Black Country and West Birmingham Clinical Commissioning Group (CCG), One Walsall (Council for Voluntary Services), Primary Care Networks, and Walsall Housing Group (representing the housing sector). The main purpose of the partnership is to integrate services within an evidence-based model that will help to reduce health inequalities and improve outcomes for the population of Walsall.

The partners have agreed to work collaboratively to:

- Promote equality and reduce inequalities by focusing on the wider determinants of health;
- Provide high quality and accessible care for all who need it;
- Improve the health and wellbeing outcomes for the population of Walsall;
- Develop a skilled, motivated, and happy workforce;
- Make the best use of partnership resources.

4. GOVERNANCE ARRANGEMENTS

4.1. Transition to an Integrated Care Provider (ICP) Contract

Following approval of the Business Case by statutory partner governing bodies in 2019, the contractual structure of the partnership was virtually integrated under an Alliance Agreement. Contractual accountability lines have since continued to be bilateral between commissioners and providers as in 2018/19. As per the business case, the commercial model from April 2019 to March 2021 was intended as a transitionary period to allow for the development of the necessary governance, payment and contracting environment in which an integrated care operating model can be designed and implemented. The direction of travel inferred in these

documents was to develop more formal contractual arrangements through which to plan, manage and deliver integrated care and reduce health inequalities as the alliance matures.

An Integrated Care Provider (ICP) contract is a formal contractual mechanism to deliver integrated care across primary, secondary, community and other health and care services. Under an ICP contract, the ICP is responsible for the integrated provision of general practice, wider NHS and potentially local authority services. The contract itself (currently in draft form) is a national specification, adapted from the standard NHS contract and with specific additional provisions related to integrated care, equality and health inequalities, and population health management. It is available to statutory bodies only.

There are a range of contractual models available in respect of establishing an ICP contract. The preferred option in Walsall is the Lead Provider model as this is most akin to the current Host Provider model. This model was the basis of the business case approved by each governing body in 2019 and further supported with the creation of the section 75 between Walsall Healthcare and Walsall Council in 2020. The involvement of Walsall Council in the ICP contract is limited to this section 75 agreement.

Work to implement an ICP contract is in progress. It is intended that Walsall will be operating in shadow form by the end of the first quarter of 2021/22. A full ICP contract will be implemented from 1st April 2022, following internal processes of due diligence for providers and commissioners, and assurance to NHS England & Improvement.

4.2. Population Health & Inequalities

NHS England has a number of legal duties related to equality and health inequalities, which extend to its development of the contractual arrangements for commissioning of ICPs. In addition to standard NHS contract terms and conditions, the ICP contract includes a range of other provisions specific to equality:

- Any providers that may be contracted under an ICP contract need to undertake an equality and health inequalities impact assessment of local population groups and service user needs;
- ICPs must implement a whole population model, as outlined in the NHS Five Year Forward View, that will focus on addressing the wider determinants of health and tackling inequalities;
- ICPs must have information systems and analytical capacity, supported by the use of a recognised risk stratification tool and, where appropriate, by data sharing arrangements with other providers of health and social care.

The partnership has established a workstream to oversee development and implementation of a Population Health & Inequalities Strategy. The Senior Responsible Officer (SRO) for this workstream is the Director of Public Health, to ensure there is clear alignment to the work of the Health & Wellbeing Board (HWBB) and the development of the Walsall Health & Wellbeing Strategy. The partnership is clear that the strategic ambition will be set by the HWBB, and the partnership will articulate its response to reducing health inequalities within the scope of its membership. This will include segmentation of the population within each of the 7 Primary Care Networks (PCNs) and identification of priorities for integration of care

and support. This work is expected to take shape during quarters 1 and 2 of the 2021/22 financial year and oversight is provided by the Clinical & Professional Leadership Group (see section 4.5 below).

4.3. Primary Care Networks

The ICP contract is specifically designed to aid the integration of primary medical services with other local health and care services. This is on the basis that a whole population approach is not possible without primary care. However, GP participation in an ICP is voluntary and local ICP proposals will not be able to move forward without support from general practice. As such, NHS England offers a partially integrated model in which existing contracts for core primary medical services will remain operational and GPs can participate in the ICP contract via an Integration Agreement (IA). The IA allows for shared objectives between GPs and the ICP, greater consistency of care across the whole population, achieved through shared clinical protocols, and common ways of working. This work has already commenced as a core product of the Walsall Together model.

Further discussions are required across our partners and particularly with PCNs to develop a shared vision for integrated care that all parties feel they can own and sign up to. The groundwork of this has been achieved through Walsall Together and now needs to be finalised within a robust governance framework, with clearly defined impact analysis on the risk profile for each organisation. Any perceived disadvantages or risks associated with the new contract will be articulated in the context of significant improvements to health inequalities and outcomes for the citizens of Walsall. It should be noted that this work is building on the sound foundations that already exist within Walsall Together and should not in any way be seen as a reset of the current arrangements. In a thriving ICP, partnerships are required and relationships with multiple providers must remain in place.

In Walsall, the 7 PCNs were confirmed in June 19. Representatives continue to engage in all levels of the partnership governance structure as reported to the Committee in January 2020.

4.4. Alliance Agreement

The Alliance Agreement formalises the governance arrangements within the partnership without requiring any contractual amendments. It describes the way partners will work together to deliver sustainable, effective and efficient services. The Alliance Agreement has been approved by the WTP Board and each of the partner organisations boards.

The current Alliance Agreement runs to April 2021. The partnership will renew the agreement subject to updating specific sections to reflect the maturing appetite for integration. These updates will include:

- Aims and objectives will be updated to reflect the current partnership objectives, recognising the prominence of reducing health inequalities as we move through COVID-19 recovery, and to reflect the objectives set within the Section 75 and ICP contract;

- Interim arrangements for the shared management of strategic and key operational risks will be formalised, including a clear rationale for the partnership approach to mitigations where there is added value in doing so.

4.5. Clinical & Professional Leadership Group

The Clinical & Professional Leadership Group (CPLG) was formerly known as the Clinical Operating Model (COM) Group. The role of CPLG has been reviewed in recent weeks in line with wider system developments including:

- Review of the Health and Well Being Board, refresh of the Joint Strategic Needs Assessment and creation of a Health & Well Being Strategy
- Local, regional and national learning regarding the restoration and recovery following COVID-19, particularly the need to ensure health inequalities are not exacerbated
- Transition towards an ICP contract and the increased focus on whole population health outcomes

Discussions within the membership of CPLG to date have continually focused on a desire to move away from the initial single-disease pathway focus to one that considers population segmentation, multi-morbidity and frailty. The revised Terms of Reference therefore reflect this broader approach and clarifies an offer of clinical and professional oversight across all aspects of the partnership and transformation programme.

The CPLG will retain its existing responsibilities in relation to citizen and communities' engagement and quality impact assessments.

In line with the overarching objective of the partnership to reduce health inequalities, the CPLG is proposing to organise its areas of responsibility and any specific programmes of work around the following themes:

- Reducing variation in outcomes
- Identifying and overseeing implementation of our priorities as anchor institutions
- Ensuring the COVID restoration and recovery does not exacerbate health inequalities

There is also a commitment to being data and evidence driven.

Work to date against each of the 3 key themes above includes:

- Population segmentation has been undertaken by health, public health and housing colleagues and includes both quantitative and qualitative data, including assets-based data. By June 2021, the partnership will have combined population profiles, at Primary Care Network level, to support priority setting. This work will be further complimented by the rollout of a Population Health Management digital solution (segmentation tool).
- whg has partnered with Walsall Healthcare NHS Trust to deliver an employment initiative whereby local people in long-term unemployment are given training opportunities via Walsall College alongside a volunteering placement at Walsall Healthcare with a guaranteed job interview at the end of the process. To date, 100% candidates have secured permanent employment.

4.6. Citizen & Community Engagement

Healthwatch has been commissioned to develop a Walsall Together User Group ensuring citizens can contribute to the identified priorities for service redesign. Strong engagement includes co-design and co-production with individual citizens and also with wider communities and the community and voluntary sector. Work is currently in progress to align the existing work through Healthwatch with wider place and system developments in engagement, particularly relating to health inequalities. This work will have oversight from the partnership's Resilient Communities workstream (more information on this is included below).

Direct engagement work with individuals and communities has continued through the pandemic. Healthwatch has undertaken surveys and held multiple virtual focus groups with service users that have lived experience of long-term conditions. Engagement reports have been produced for diabetes, respiratory and cardiology, with input from Public Health colleagues and clear responses from operational service leads. This information is reported formally to CPLG and translated into operational action. For example, in Diabetes, we have now established a Diabetes Peer Support Group in Walsall. It was firstly established through Healthwatch, supported by the Community Diabetes team, before becoming self-sustainable. Further recommendations, including those relating to COVID restoration and services for the BAME community are being discussed jointly with service leads, the BAME community network and Public Health.

The current focus of Healthwatch's engagement activities includes End of Life care, Outpatients redesign and health inequalities.

5. DELIVERY OF THE TRANSFORMATION

5.1. Resilient Communities

As the partnership matures and new whole-population-based contractual frameworks are introduced, there is increased scope to shift resources around the system and towards the lower end of the tiered model. To support such investment decisions, the Resilient Communities work stream needs to define a work programme that aligns to a set of clear outcomes with deliverables that demonstrate the evidence base and robust evaluation data.

The partnership is focused on reducing health inequalities, acknowledging the need to address the wider determinants of health. The COVID pandemic has compounded the challenges faced by many of communities and had a disproportionate impact on those most vulnerable. Our response to these challenges will be grounded within the Resilient Communities workstream.

A workshop was held in February to reset the partnership thinking and approach. There was agreement on the following points:

- Establishment of a Resilient Communities Steering Group

- Governance of the Steering Group will sit inside of Walsall Together, reporting formally to the CPLG to ensure alignment with population health and inequalities agenda, clear links to the HWBB, and the partnership Outcomes Framework
- Aligned approach with Walsall Council's Resilient Communities work, including membership from the Council's Director of Resilient Communities
- Clarity on specific outcomes and population health challenges that the Walsall Together Partnership (WTP) is able to influence
- Development of a set of principles for building resilience and engaging with communities
- Development of a set of principles for engaging with community and voluntary organisations via One Walsall

There are several existing initiatives that will be incorporated into the workstream, which will have a strong focus on delivery. These initiatives will be taken forward with immediate effect and will continue in parallel to the governance and strategic discussions:

- NHS Charities funding (awarded in January) covering the Kindness Counts project (reducing social isolation), health inequalities engagement, and coproduction training and development for the partnership
- Wider engagement workstream including the Healthwatch contract, Service User Group, CCG development of a Citizen Forum and STP Healthier Futures academy
- Wider consultation and engagement with the voluntary sector via One Walsall to find locality-based solutions for residents and map VCSE solutions (One Walsall's state of the sector survey and development tool are currently utilised to assess sector sustainability to meet demand)
- Social prescribing project group (membership includes whg, PCNs and Walsall Council)
- Anchor Institution Employment Initiative between whg and Walsall Healthcare, combining available entry level job opportunities together with whg's expertise with working in communities, is a strong step towards creating resilient communities
- Holiday and Activity Food programme (investment of £1.8m from the Department for Education during Easter, Summer and Christmas holidays in 2021 to 14,000 children on free School Meals)
- Exploration of how Resilient Communities can support expansion of the reach of the Family Safeguarding Model, in line with the proposals we included in the Changing Futures bid
- Living directory (identifying an innovative technological solution to support the development of social action through the provision of micro commissioning and adaptive training)

- Volunteering to support the statutory sector will be a key focus, building on from the pandemic and continuing the strides already made for volunteers supporting the health system

5.2. Workforce and Organisational Development

A formal workstream within the Walsall Together Transformation Programme has been established for Workforce and Organisational Development (OD).

An initial workshop took place in early March with representation across all partners. Membership and governance arrangements were discussed. A monthly Steering Group will be established and the scope of the workstream will include:

- Workforce challenges known and expected over the next 5 years
- Development of a People Strategy for Walsall that will address social exclusion and inequalities from a workforce and employment perspective. Aligned to the Population Health & Inequalities Strategy, the People Strategy will emphasise the role of Walsall Together as an Anchor Employer and describe a New Employer Model for Walsall.
- Identifying and creating local job opportunities, looking to expand on existing initiatives such as the work between whg and Walsall Healthcare, looking at how we can support apprenticeships in primary care, establishing integrated recruitment of additional roles in primary care, and ensuring a consistent approach to equality and diversity
- A clear strategy for addressing shortages in certain specialties through the development of new roles
- Development of an OD proposal to support integration at all levels of the partnership

5.3. Delivery of the Clinical Operating Model

The Walsall Together Partnership has made good progress in delivering service transformation across the Clinical Operating Model as outlined in the original business case and also in response to the COVID-19 pandemic. In the case of the latter, Walsall received recognition from the CQC and National Task Force in respect of how the level of integration strengthened our ability to provide enhanced support to our local population. The following list gives some examples of the work delivered in the last year:

- Multi-disciplinary team (MDT) working, which allows expertise and skills of different professionals to assess, plan and manage care jointly.
- Weekly MDT meetings to support people with one or more health or social care needs.
- Recruitment of social link workers within Primary Care, Locality Teams and whg
- Family Safeguarding Model across Walsall – a whole family approach which makes it easy for parents and children to access all the support they need from within one MDT team, to help them deal with the complex issues of domestic abuse, mental health and drug/alcohol abuse that harm their lives and those of their children.
- Extended mental health support services via phone and online session for those struggling with lockdown.

- Care Navigation Centre takes direct referrals from GPs and West Midlands Ambulance Service who have identified someone who is well enough to remain at home, but requires some additional support. The service has extended hours and is now a standalone service.
- Rapid Response Team set up to respond within 2 hours to urgent care needs within the community – reducing hospital admissions.
- Recruitment of multiple key worker job opportunities available in the Housekeeping Department at the Manor Hospital. Empowers residents with low aspirations to develop their confidence, skills and maximise their chances of success when applying for jobs.
- Saddlers Vaccination Centre – capacity to vaccination 5,000 a day if required
- Integrated Assessment Hub – staffed by integrated teams providing an alternative to A&E for patients who arrive but can be cared for within the community. The inclusion of social care makes it one of the first fully integrated assessment hubs in the country.
- Volunteer recruitment to support isolated or shielded with shopping and medication delivery, to those helping local families; supporting many local groups and charities, such as food banks and over the phone befriending services as well as on vaccination sites.

6. KEY PRIORITIES AND NEXT STEPS

The 2021/22 priorities for the integration of services will be

- Mobilisation of outpatients within the Walsall Together model and as part of our Population Health Management approach
- Integration of Primary Mental Health and IAPT teams, including the new roles expected through the Community Mental Health Framework and the primary care Additional Roles Reimbursement Scheme
- Further integration with PCNs to support additional roles recruitment and whole pathway development
- Integration of children's services and alignment of the wider children's agenda

A huge amount of hard work has already been done building relationships, trust and confidence across the partnership. The next steps are focussed on enabling the partnership to deliver fully integrated services that meet the needs of our entire population. The key focus is delivery of an Integrated Care Provider (ICP) contract that will move us to a whole population budget approach with one lead provider (Walsall Healthcare NHS Trust) receiving an annual budget based on population size from Walsall Clinical Commissioning group. From a wider partnership perspective, this supports a clear emphasis on outcomes rather than activity which in turn will mean more of a focus on prevention rather that treatment.

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