Health and Well Being Board
20 October 2014

Walsall Council

NHS
Walsall Clinical Commissioning Group

Better Care Fund – September Submission

PURPOSE

To summarise the overall vision and plan for the Better Care Fund in Walsall.

RECOMMENDATION

To agree the next steps for work on the Better Care Fund;

BACKGROUND

The September submission was comprised of a Narrative Template in eight different sections with two annexes, and a Finance and Metrics template. This report summarises the submission.

NARRATIVE TEMPLATE

1. Vision

1.1 Our vision 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.

1.2 The two objectives of our vision are:

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

1.3 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. To keep people at home as long as possible we will create integrated local teams of practitioners from primary care, community

health, social care and mental health services. These teams will have a single point of access and be able to respond rapidly to people in crisis and support them to remain at home.

1.4 The second objective of the new model of service, that of swiftly and safely transferring people back to their own homes from hospital, requires a coherent and efficient joint intermediate care service. 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 care and support they need to go home.

2. Case For Change

2.1 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 year and older increasing from 5,467 in 2008 to 8,109 in 2021 (Source: Walsall JSNA Refresh 2013).

2.2 The prevalence of people with long term conditions, often more than one, is increasing. This is particularly the case for:

- Coronary Heart Disease (CHD) - 4.02% of the Walsall population are on CHD registers;
- 8.1% of the Walsall population are on diabetes registers compared to a maximum for England of 8.3%;
- 14.8% of the Walsall population are registered with obesity which is comparable to the maximum for the all England population.

2.3 We recognise that the urgent and emergency care system in Walsall is not working well for the people of the Borough or for the organisations responsible for health and social care services.

- Too many patients are waiting too long for admission to hospital from A&E and the local NHS has not delivered the 95% 4 hour A&E waiting time standard since July 2013;
- The hospital is running at occupancy levels that are too high to cope with peaks in admissions leading to limited availability of hospital beds, moves between wards, and discharges that are too rushed;

- The whole system is over-reliant on institutional care whether in hospital, short-term placements outside the hospital or longer-term placements;
- There is a growing problem affecting all organisations with increased demand for mental health support by older people with mental health difficulties;
- Our Perfect Week experience highlighted the problems in our system but did not make a significant impact on them. The increased focus on processes within the hospital generated a large number of clinically stable patients (120 out of c. 520 hospital beds) ready for discharge but unable to leave hospital quickly;
- We are clear that we have a whole system problem that requires a whole system solution involving all four partners.

2.4 Our current difficulties have a number of different causes including increased admissions and difficulties with complex discharges:

- A big increase in emergency admissions to Walsall Manor Hospital (an 8% increase in 2012/13 and a 6% increase in 2013/14) caused by increased admissions from outside the Borough – especially from Staffordshire; and increased admissions from Walsall as a result of a combination of increased acuity / complexity of patients presenting at A&E and increase in decisions to admit;

- Increasing difficulties in discharging the more complex patients from hospital to suitable long-term care (home care and/or nursing or residential home placements) caused by:
  - increased complexity of long-term needs for some patients;
  - limitations in the provision of social care both residential and home care;
  - pressures on social care funding;

- Historical hospital discharge planning processes which required improvements across health and social care;

- Increased numbers of older people with mental health needs and/or challenging behaviour who are not always well served by current models of care.

2.5 The immediate pressure on our urgent care system means that we are starting our approach to the BCF from a very challenged position and need to be realistic about our prospects for change. Our major focus of

action at the time of submission is to immediately stabilise the position and achieve the A&E 4 Hr Wait Target from the end of October onwards and then to implement our plans for the BCF in a way that will make this sustainable going forward.

3. Plan of Action

3.1 Our plan for action is focused primarily upon 2015/16 and made up of a number of elements of community based change schemes and programmes that we have consolidated under eight main headings:

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

3.2 For each of these there is a more detailed account of the changes that are taking place that can be made available on request. In summary,

<u>By end of 2014/15</u>

- A “wrap around” model for multi-disciplinary community health and social care teams will be implemented – working with GPs and including therapy input, based upon risk stratification and focussed upon supporting frequent flyers and those most at risk of admission to hospital or care home with long term conditions;
- There will be expanded Rapid Response capacity linked to reablement as part of the integration of community health and social care services;
- A single point of access for urgent GP referrals to the integrated community rapid response service will be implemented;
- There will be more tailored support to nursing homes to reduce hospital admissions by pro-active case management of residents at high risk of hospital admission via multi-disciplinary community teams;
- The CCG will revise and implement a policy for GP support to nursing homes to provide for ‘ward round’ equivalent arrangements;
- We will commission additional ‘discharge to assess’ beds in nursing care homes as an addition to the current hospital discharge step-down ward (Operational from September 2014);
- There will be additional social care capacity to support the assess to discharge beds (Operational from September 2014);

- We will have an integrated transitional care service combining elements of health and social care into one jointly managed system with a common access point linking to community teams;
- We will further develop our joint health and social care Intermediate Care Unit at Hollybank to more effectively support people with dementia;
- Frail elderly pathway nurses in Accident and Emergency will identify older people who can be supported at home instead of being admitted to hospital;
- We will implement ambulatory care pathways that reduce admissions to hospital beds;
- We will further reduce delayed transfers of care via implementation of a ward based programme setting expected dates of discharge (EDD's) for all hospital patients and a formalised system of S2 and S5 referrals between the hospital and social care staff within the context of an integrated multi-disciplinary team in the hospital;
- We will further develop our ambulatory care pathways;
- There will be wider use of telehealth monitoring units, telecare and other assistive technology to prevent avoidable hospital admissions;
- More people will be supported at the point of hospital discharge via the Home from Hospital service;
- More people with dementia and their carers will be supported to remain in their own homes, particularly at times of crisis via expanded use of dementia support workers, dementia café's and other initiatives;
- We will have conducted a major joint communication and engagement campaign.

<u>By end of 2015/16</u>

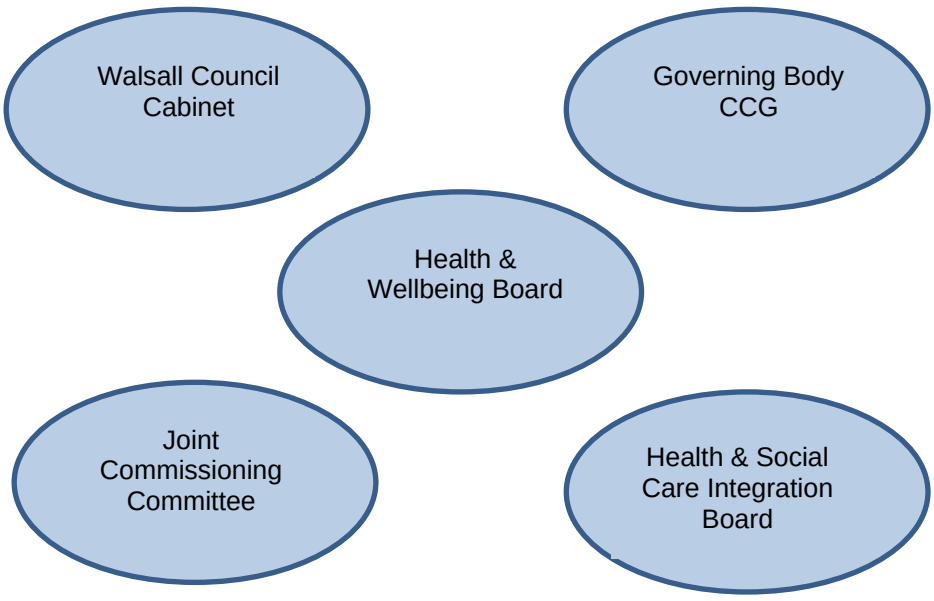
- We will have completed our integration of community based multi-disciplinary community health, mental health and social care teams based upon the locality structure of our current community health services working closely with primary care;
- We will have embarked upon a redesign of community mental health services for older people to provide crisis response and recovery services 7 days a week linked to the community integrated teams;
- We will have further developed our Frail Elderly Pathway to include a more formalised virtual ward of older people who would otherwise be in hospital;
- There will be a reduction in our bed based transitional care pathways on the basis that non-bed based transitional care pathways have reduced the extent to which we need bed based intermediate care pathways;

- We will have redesigned accident and emergency so that ambulatory care pathways have reduced bed based emergency admissions by 25% in 2016 compared to a baseline of 2015;
- We will have completed the re-procurement of the social care market for home care and care homes in to two joint framework contracts between the Council and the CCG via the Joint Commissioning Unit;
- A higher number of GP practices will have combined their services so as to provide improved access and a wider range of services;
- We will have deployed more capital (both BCF capital and aligned Council funds) for Disabled Facilities Grants, and other measures to enable more older people at risk of admissions to remain at home;
- There will have been a further reduction in the number of emergency admissions of older people to hospital and the number of care home placements and an increase in the number of people who are at home three months after an episode of reablement.

4. Governance Arrangements

4.1 Since 2009 we have had a joint governance arrangement to oversee our joint commissioning arrangements under S75 of the National Health Act 2006 in the form of a Vulnerable Adults Executive Board (now Joint Commissioning Committee). This enables us to agree strategic joint commissioning intentions for integrated services and will have an expanded role as a result of the Better Care Fund. It sits alongside the recently formed Health and Social Care Integration Board which is our operational governance mechanism for integrated working with our provider NHS Trusts.

4.2 Both of these report to and support the work of the Health and Well Being Board. Decisions of the Health and Well Being Board are ratified by the Governing Body of the CCG and Walsall Council Cabinet. This is illustrated by the following diagram:



5. Risk Sharing and Contingency

5.1 We have set out a risk register that identifies high level risks in failure to reduce avoidable emergency admissions to hospital, and cuts in Council social care services needed to meet financial savings targets.

5.2 Our risk sharing arrangements are built upon an historical Section 75 agreement over the Joint Commissioning Unit which includes specific clauses around over and under spends of budgets that are the responsibility of the JCU. The System Resilience Group receives a dashboard of weekly data used to closely monitor the performance of the system. An Urgent and Emergency Care Improvement Programme Plan sets out the actions currently underway to achieve the A&E 4 Hour wait target on a sustainable basis from the end of October 2014. Each of the 43 elements of the Programme Plan has a specified individual lead and timescale for implementation to achieve the target on a sustainable basis from the end of October 2014.

5.3 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 2015/16 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 Across Different Plans

6.1 The Better Care Fund Plan builds upon the Urgent and Emergency Care Improvement Programme Plan for achieving the A&E 4 hour wait target from the end of October 2014. This plan is integrated across the health and social care economy with action elements across all agencies.

6.2 Our close working relationship between Walsall Council, the Clinical Commissioning Group, Walsall Healthcare Trust and DWMHPT, supported by the Joint Commissioning Unit, means 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. These plans are then also reflected in the overarching Health and Well Being Strategy.

7. National Conditions

7.1 The Government has established some national conditions for all local Better Care Fund Plans to address. The position of Walsall in respect of each of these is as follows:

7.2 **Protecting Social Care Services:** 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 implementation of the Care Act (e.g. Increase support to Carers, Social Care Funding Reform, and prevention) whilst achieving a 17% reduction in expenditure in 2014/15 and 2015/16 compared to 2013/14. (i.e. £11.5 million savings programme in 2014/15 on a net baseline of £67 million).

Walsall Council has established a Care Act 2014 Board which is overseeing preparations for implementation of 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

Each of these work-streams has a project lead and is developing the approach and timescale for implementation based upon a standardised programme management arrangement. We have used the national Care Act cost calculator as the basis for estimating the costs of the implementation of the Care Act in Walsall at an additional £760,000 per annum.

7.3 **7 day services to support hospital discharge:** 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends are part of agreed local plans within Walsall Council, WHT, and DWMHPT. Current 7 day services include social care reablement and social work services, as well as the Health Intermediate Care Team.

Week-end discharge arrangements started from 19 September with a Multi-Disciplinary Team to work as a Weekend Discharge Team. The 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. Therapy and Pharmacy services are incorporated in the arrangements, together with a focus on changing transport availability.

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

7.4 **Data Sharing:** we have set out our plans for using the NHS patient number as the primary identifier for correspondence across all health and care services. Walsall Council is currently in the process of implementing a new case record system (Corelogic) and the NHS number is designed in to the implementation programme. In preparation for the above implementation programme the use of the NHS number in all social care records has been in place starting from 1st April 2014. The NHS number will be the primary identifier by April 2015. We will be using a system called Fusion as the basis for sharing information from case records.

7.5 **Reducing emergency admissions through active case management:** There has been a significant amount of work undertaken within Walsall Hospital to understand and scope emergency readmissions and there is a wealth of data available which evidences the range of emergency readmission types, patient demographics, disease co-morbidity and readmitting sources.

For the patients who were either already known to community teams or whose condition warranted a referral to the community teams a request was made to the teams/named nurse/ case manager to undertake a comprehensive assessment/reassessment and identify through MDT approach if any additional resources, enhanced case management would help to reduce the episodes of emergency readmission.

Over the past 12 months there have been 292 patients identified within this category with 139 new referrals to teams for active case management. 56% of the above patients have not been readmitted into acute care, 21% have only been readmitted on one further occasion. 23% of patients have continued to require frequent hospital admission and all efforts are being made to reduce admission episodes for this cohort of patients. Over the 12 months the episodes of admission each month for this cohort of patients has reduced by 44%.

7.6 **Joint process to assess risk, plan care and allocate a lead professional:** This is included within our plans for the development of community based multi-disciplinary community health, mental health and social care teams based upon the locality structure of our current community health services working closely with primary care. These teams will adopt single assessment working, pro-active case management and accountable lead professional as standard practice.

At the end of the assessment a named co-ordinator will be identified to be responsible for ensuring that ongoing management of the patients is carried out in a timely manner by the most appropriate care individuals. This will lead to improved outcomes and more cost effective service interventions, including lower readmission rates.

8. Engagement

8.1 **Patient, service user and public engagement**: We are developing a public engagement and communications plan based upon the 'Hot-House' programme developed by Coventry and North Warwicks CCG. This programme draws on social marketing principles and features an overall tag line encouraging responsible behaviours towards lifestyle and use of health services e.g. LTC self-management or smoking cessation, for an integrated approach to local heath social marketing i.e. 'Treasure your health, and your NHS', or similar. It is premised upon a single, simple brand representing all the main local health and social care organisations i.e. 'Health Walsall', or similar.

The programme focuses specific messages to particular groups ranging from some for everybody to groups such as parents of young children; young people/teenagers; transient populations; middle aged males; elderly people; ethnic minorities etc. and will use a range of communication channels including: email cascade: social media; surveys forms; posters and leaflets; merchandise; local media; etc

In particular we will be working closely with colleagues in Public Health to link this campaign to current programmes to improve the health of the population.

8.2 **NHS Trusts:** 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. The Communication and Stakeholder Engagement Plan described above also targets front line staff with specific messages about urgent care services and this will be a feature of the programme.

8.3 **Primary Care Providers:** Walsall CCG has a tier of four locality level committee's where primary care providers come together as part of the governance arrangements for the clinical commissioning process led by the Governing Body of the CCG. The Localities have received overall reports on the BCF and had the opportunity to comment upon the design work. The redesign of community health services and primary care at scale projects have each been reported separately to the localities. The Local Medical Committee has also received an overarching report on the BCF and specific reports relating to particular change schemes.

8.4 **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. A number of strategic development/workshop events have been facilitated by the Joint Commissioning Unit and led in partnership with Walsall Voluntary Action (WVA). At our last event December 2013 "Voluntary and Community Sector Commissioning" the Social Care Operating Model and financial challenges were shared by the Executive Director of the Council and the Accountable Officer of the CCG. The Chief Exec of WVA gave an overview of WVA's role in facilitating the local CVS responses to the challenges ahead for Commissioning in the community and voluntary sector, including urgent care.

Walsall Council has engaged with all social care providers and the third sector via Market Position Statements which have been developed with the CCG via the Joint Commissioning Unit. The Market Position Statements describe an operating model for Adult Social Care & Inclusion (ASC&I) in Walsall which is premised on maintaining independence, health and well being and supporting people to remain independent of social care services.

8.5 **Implications for Acute Hospital:** Walsall Healthcare Trust (WHT) and Dudley Walsall Mental Health Partnership Trust (DWMHPT) are committed alongside the CCG and Walsall Council to greater integration of hospital and community services to deliver care closer to home. For WHT the impact of the Better Care Fund in 2014/15 is included within the contract agreed with the CCG. This consists of:

- additional investment in community health services capacity in both 2013/14 and 2014/15 of £800k in each year;

- an agreed target reduction in admissions of 3.2% by the end of 2015 (c. 800 admissions) with an associated £1.2m reduction in

acute spend by the CCG as part of the agreed QIPP target for the Borough;

- this reduction in activity at average length of stay equates to c. half an acute ward at the Manor Hospital. The Trust is working on other initiatives to reduce LOS to release a ward's worth of acute capacity by April 2015 (c. 10,000 bed days);

- the CCG is supporting the Trust with non-recurrent resources to enable the trust to make the transition to a more community-focused model of care as smoothly as possible.

The Trust and CCG expect the impact in 2015/16 to be similar to that in 2014/15 and both organisations are developing their plans on this basis. 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 2015/16 onwards. WHT have completed and signed Annex 2 of the submission to demonstrate their agreement to the plan for the BCF.

FINANCE AND METRICS TEMPLATE

9.1 The Finance and Metrics template sets out the current allocation of funding that will be included in the Better Care Fund, and the planned allocation for 2015/16, and a set of five performance metrics that have been set at national level, with an additional one that has been agreed locally.

Allocation of Funding in 2014/15

9.2 A proportion of the funding which will be part of the Better Care Fund in 2015/16 is already itemised within the Social Care and Inclusion budget as set out in Table 1 below. Some of this funding transfers from the Clinical Commissioning Group to Walsall Council to become part of the Social Care and Inclusion Budget under the Section 75 agreement for joint commissioning and is agreed at the Joint Commissioning Committee.

9.3 This funding is part of a larger sum of £15.8 million that transfers between the CCG and the Council each year under the Section 75 agreement.

Table 1: Allocations in 2014/15 to become part of the Better Care Fund in 2015/16.

Expenditure	2014/15 Allocation (£)
Services required in the reablemement pathway for people with dementia and frail elderly	300,000
Integrated Community Equipment Service – Council contribution	877,538
Short term assessment, reablement and response service	2,075,628
Development of Intermediate Care service	500,000
OT posts to support Intermediate Care Service	250,000
Bed Based Reablement (Hollybank)	774,919
Integrated Discharge Team	569,418
Co-ordination of Personal Health Budgets pilot scheme	21,840
Short Term Residential Placements and Reablement Care Packages	1,193,000
Support to Carers	450,000
CCG Funding for Hollybank House	534,000
Integrated Community Equipment Service – CCG contribution	608,000
Swift Unit at The Manor Hospital	1,800,000
Additional Social Worker and Reablement Capacity for Winter 14/15 *	500,000
CCG funding for Independent Living Centre and Stroke Services	200,000
Total Spend	**10,654,343**

*Non-recurring in 2014/15

Allocation of Funding in 2015/16

9.5 Further work has been conducted since the April submission to align the funding for 2015/16 to the eight main change schemes in order to match the narrative template (see Para 3.1 above). Table 2 shows the distribution of funding across the eight change schemes.

Table 2: Allocation of the Better Care Fund in 2015/16.

Expenditure	2015/16 Allocation (£)
Integration of Community Services	2,170,000
Transitional Care Pathways	12,794,000
Assistive Technology	4,411,000
Dementia Care Services	220,000
Mental Health Services	519,000
Support to Carers	450,000
Long Term Social Care – Community and Residential	2,193,000
Voluntary and Community Sector Impact on Hospital Flows	170,000
Contingency Risk Reserve	1,050,000
TOTAL	**23,977,000**

9.6 These sums will be included in the Section 75 agreement for a pooled fund for the Better Care Fund in 2015/16. There is other funding within the budgets of the CCG and SC&I Directorate of Walsall Council that can be aligned to these headings and work and work is underway to complete that exercise. On completion, it will show the full extent of funding across the health and social care system that could be brought in to the pooled fund for the BCF in the future.

Metrics

9.7 The five performance metrics that were set by the government together with an additional one set locally for dementia services, together with the improvement targets are set out in the following table:

Metric	**Improvement Target**
The number of emergency admissions to the acute hospital	Emergency admissions to The Manor Hospital currently average around 550 admissions per week. This follows significant increases during the last two years as reported in para 2.4 above. The government has set a target of a reduction of 3.5% during the calendar year 2015 compared to the calendar year 2014 which would be a reduction of 1,000 during the year – or 20 per week.. Locally, we have set a target reduction of 3.16% in recognition of the increase in recent years. During the summer, the rate on increase has slowed down. This is the only metric that requires the target to be met in order to receive the Pay for Performance element of the Better Care Fund.
Permanent Admissions to Residential care	This is measured as Council funded placements only. There were 238 permanent placements during 2013/14 which is established as the baseline for a target reduction of 10% over the next four years. This equates to a reduction of 40 or so Council funded placements by 2018/19.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation	This metric is counted over a three month period from October to December each year. In 2013 there was a total of 430 people who entered the Council reablement services after discharge from hospital and of these 325 (75.4%) were at home 91 days after the reablement episode. In 2014 we plan for a slight increase in activity to 440 people and an increase to 78% of these who will be at home 91 days later.

services	
Delayed Transfers of Care	Current hospital discharge arrangements centre on the on-going management of a 'Clinically Fit to Go' list and do not align with national guidance for hospital discharge arrangements based upon Expected Date of Discharge (EDD) and Section 2 and 5 notifications between the hospital and social care. Reporting of the DToC metric has not therefore provided a baseline of metrics that can be used as a basis for improvement on this metric during the period of the BCF. Work has progressed on a joint project to implement EDD's across all wards in the hospital from July 2014 building up to full implementation during autumn 2014. This will make it possible to establish a baseline in time for the end of March 2014.
Patient/Service User experience	This will be based upon a patient survey conducted at national level for which guidance is yet to be received. For our submission we have examined the results of the most recent GP Patient Survey for Walsall which shows that 42% gave a rating of 'very good' for overall experience and a further 42% gave a rating of 'fairly good'. Therefore we have set metric targets for 85% in 2014/15 and 90% in 2015/16.
Dementia Diagnosis Rates	We have adopted dementia diagnosis rates for our local performance metric. The 2012/13 baseline was 42.9% (1,376 people diagnosed out of 3,106 calculated prevalence). In 2014 Walsall's prevalence for dementia is 3,413. 52.4% of those people are currently on GP dementia lists (CCG reported 51.4% as some GP data was missing). At the end of Q1, the diagnosis rate had risen to 52.9%, which was 48 diagnoses behind the trajectory. Projects in GP localities have begun to address this. To achieve the BCF and national target of 67% by end of 2014/15 diagnosis rate for the expected prevalence, another 448 diagnoses need to be made and any more to counteract deaths from the dementia lists. This equates to a minimum of 8 cases per Walsall GP practice over the next three quarters.

ASSURANCE PROCESS

10.1 The Government has established a comprehensive assurance process that comprises regular checks against progress in preparing the submissions within deadlines and then monitoring progress of implementation. The **National Consistent Assurance Review** and the results of the **Assurance Checkpoints** will together be used to establish whether to approve each plan.

10.2 The outcome of the review will mean that all BCF plans fall into one of four categories: *Approved; Approved with support; Approved with conditions; Not approved.*

10.3 This assessment will be determined by a judgement on two dimensions: the quality of the plan submission and the risk to the deliverability of the plan.

10.4 The plan submission date was the 19 September. The process of assurance will be completed three weeks following submission with feedback to local areas at that time.

NEXT STEPS

11.1 Next steps will be partly determined by the assurance process. The main risk to deliverability of the plan for Walsall is seen as the high level of the current rate of emergency admissions to hospital. This makes it unlikely that our plan will be approved without conditions or support. It is likely that further work will be required to provide assurance to Government Ministers that Walsall's plan is viable given the recent higher than average rise in emergency admissions.

11.2 Main areas of further work are as follows:

- The development of an operational plan that sets out the timescale for implantation with identified clinical and management leads for each element of the plan across the eight change schemes;
- Establishing a pooled fund under Section 75 of the NHS Act 2006 and aligning broader funding streams to each change scheme;
- Developing and implementing a major communications and engagement programme as described in para 8.1 above;
- Continuing with progress on the workforce development plan.

11.3 This work will continue to be supported from within the Joint Commissioning Unit.

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