Cabinet – 13 Feb 2019

Walsall Together Alliance: Integration of Health and Care Full Business Case

Portfolio: Councillor Rose Martin – Adult Social Care

Related portfolios: Councillor Tim Wilson - Health

Service: Adult Social Care

Wards: All

Forward plan: Yes

1. Summary

1.1. **Key decision:** In March 2018, Cabinet agreed the Case for Change for the Walsall Together approach, which outlined the renewed vision for improved health and care and stated the commitment to designing the preferred model for delivering integrated health and care in Walsall by early 2018/19.

1.2. The recommended next steps, were

- Establishing a Programme Team with access to dedicated resource to run the development process;
- Developing a business case for stakeholder sign-off (Including NHS Improvement) within the next six months to include the following priorities:
  - Defining appropriate governance to facilitate collective leadership in transition and end state.
  - The development of a comprehensive, Walsall wide financial model for the system.
  - Developing an Operating Model.
  - Developing an appropriate commercial model.
- The creation of a budget and resource commitments to support both internal and external inputs to the process over the next 6 months.
- To gain feedback on the proposals.
- To endorse the continuation of the direction of travel toward a “Host Provider” arrangement.

1.3 That work has now been completed, and the output is the attached Walsall Together Full Business Case.

2. Recommendations

2.1 To ask Cabinet to approve the full business case.

2.2 To approve the model of operating in principle for services as described, with more detailed plans and Cabinet approvals to be sought in due course.

2.3 To support the developments of future more specific business cases (as they emerge) and to consider those for improvements in outcomes and service delivery at the appropriate times, in accordance with the overall aims of the Walsall Together Alliance.

2.4 To endorse the establishment of the Walsall Together ICP (Integrated Care Partnership) Board and to approve that Council Senior Management roles will be working in conjunction with that Board.

2.5 To approve that Walsall Healthcare Trust will act as the "Host" which is a contractual lead to be accountable for the services in scope and the overall transformation of health and wellbeing outcomes for Walsall people. The other organisations will sub-contract with the host.

2.6 To mandate the formation of an s75 NHS Act contract during 2019/20 and for the Executive Director of Adult Social Care to bring that back to Cabinet for consideration.

2.7 To note other significant service changes during the next phases of the Walsall Together Alliance would be presented to Cabinet in accordance with the Scheme of Delegation.

2.8 To note that all other Boards will be considering this business case in the next month, and all will be required to endorse the business case to proceed.

3. Report detail

3.1 In 2016, Walsall health and care partners established the Walsall Together Board to integrate and improve health and social care to the population.

3.2 It has an independent chair and is attended by Council Officers, as in the Executive Directors of Adult Social Care, Children's and Director of Public Health.

3.3 Councillor Rose Martin is also a member of the Board.

3.4 The partners to this business case include:

- Walsall Clinical Commissioning Group
- Walsall Healthcare NHS Trust
- Dudley and Walsall Mental Health NHS Trust
- Walsall Council Adult Social Care
- Walsall Council Public Health
- Walsall Council Children's Services
- One Walsall (voluntary sector)
- GP's from each of the four localities

3.5 Cabinet members, Health and Care Overview and Scrutiny Committee and Health and Wellbeing Board have received reports in the past on the work programme of the Walsall Together Board.

3.6 In October 2016, the Executive Director of Adult Social Care and Accountable Officer of the CCG proposed that a subgroup of the Board should be established: the Walsall Together Provider Board.

3.7 This has been established to develop a vision and business case for the integration of across organisation health and care delivery centred around patient population/natural communities.

3.8 In late 2017, the Provider Board commissioned KPMG as a partner to develop an outline business case for integrated health and care delivery. Cabinet considered this in March 2018, and a full business case was requested.

3.9 This report outlines the full business case attached **Appendix 1**.

3.10 The CCG requirement is that by April 2019 there will be a new model agreed and under contract with health partners.

4. Council Corporate Plan priorities

4.1 Why Integrate Health and Care Delivery?

4.1.1 There are national policy requirements to upgrade health and social care e.g. Ten Year NHS Plan, Sustainability and Transformation Plans/Partnerships and Better Care Fund plans.

4.1.2 It is also clear that our citizens and patients require better access to health and care services; where local response is the starting position; and where care around the most complex case is coordinated and shared across the relevant agencies.

4.1.3 Financial imperatives. The high-level profile of the health and care financial gap for continuing in the current model across all organisations' projects a £172m gap by 2022/23.

4.1.4 People who work in the health and care sector know they can improve delivery to people if they join up and work closer together. The Walsall Together Board is of the view that whilst the policy and financial imperatives are key, it is the professionals' and population view that is the most compelling reason to achieve this. We can improve people's experiences of health and care which in turn could be more efficient.

4.1.5 Walsall Council's aspirations of working closer together will enable:

- The offer of a population, place based health and care system, that is person focused and based on the known needs of the population;
- The blend of different approaches of primary, secondary, community health and separate care; to one that is demand led, joint and centred on how best to respond to demand within the resources available;
- The Council to operate within the resources we have to improve the quality of care and support we offer across the whole health and care system;
- Clarity about the expectations and entitlements of access to care and support for our population;
- Empowerment of our practitioners, patients and clinicians to be the key decision makers in the design of new arrangements;
- Development of a system where prevention, early help and self-care are key, because people are well advised, confident and knowledgeable about their own health and wellbeing;

- Professionals in the health and care system to be connected, share responsibility and accountability for the health of the population;
- Care and support that is high quality, cost effective and the best value for money;
- Decisions about health and wellbeing that are evidence based and underpinned by good practice and knowledgeable staff;
- The Council can organise some of our responses to achieve the above and much more. For example, social work teams which work on a locality basis alongside GP's, voluntary sector, community and mental health staff.

4.2 **The Proposals**

4.2.1 The main aims of the Walsall Together health and care system partners are to develop new integrated ways of working to improve the health and wellbeing outcomes of the population, increase the quality of care provided and provide long-term financial sustainability for the system.

4.2.2. The model: an operating model has been developed with managers, practitioners and clinicians taking the best examples from around the world to inform our thinking. In summary, this includes a single point of access where the whole population's health is understood and the best and most effective responses are directed to them in a coordinated manner.

Resilient communities; building the capacity and understanding of what communities can do together, and for each other to keep people healthy, engaged and active. Integrated primary, long-term management and community services, where local access to support is coordinated around that community and health centres.

Specialist community outpatient and diagnostic services that are available in local health and wellbeing hubs. Intermediate and social care and unplanned care services, which step in during a crisis and prevent unnecessary access to A&E and hospital. Acute hospital services, most of which are local and some others, which are designed on a larger footprint due to their lower volumes/increased specialisms.

4.2.3. Financial Case: At present, without both efficiency savings and meaningful service change the baseline position of all these organisations show a financial gap of £174m by 2022/23. Based on the current planned efficiency savings the gap would reduce to £61m, but this is based on all plans being delivered and no other (unforeseeable) factors coming into play.

Without sustainable system wide transformation for the delivery of care, the system continues to operate in an ever-increasing deficit position for the near future. It is also known that we can use our resources better, and citizens want improved coordination and access.

The business case therefore models the activity shifts that are needed to move towards suitable financial balance. For example, an increase in access to primary, social and mental health care; and a corresponding decrease in hospital based activity. New investment in the NHS plan supports this direction of travel.

4.2.4 Governance: aims to establish an Integrated Care Partnership Board, which will be responsible for the delivery of the business plan and for achieving improvements in wellbeing and health outcomes. This is the first time such a board will have existed in Walsall, which will be able to make commissioning and service delivery recommendations in an aligned and inter-connected way.

4.2.5 The Host: the partner organisations have participated in an evaluation against established criteria to determine the best fit for the "Host" organisation to take the contractual lead for the outcome improvements sought. Walsall Healthcare Trust was evaluated as the best contender to be the host and that is recommended within the business case.

This ICP Board has senior representatives from each constituent member and will be oversee the services, which are contractually in scope and for wider system integration and transformation.

The Council's representatives are; Executive Director of Adult Social Care; Executive Director of Children's Services; Director of Public Health.

4.2.6. Contractual Arrangements: these are largely concerned with the NHS. WHT will hold two contracts with the CCG: one for "in scope" services and one for "out of scope services". During 2019/20, an "Alliance" contract will be drafted which will provide for integrated contract management of all "in scope "services under the ICP Board.

The other organisations in effect "sub-contract" with WHT. For the Council, this means developing a s75 NHS Act contract during 2019/20 which defines how the statutory duties will be executed under the contract, how the staff will be managed, and financial and performance accountability be achieved. The first component of the Council to design this s75 will be Adult Social Care, with Public Health and Children's following in later years.

4.2.7. Senior Management Team: In order to oversee a transformation of this scale, there will be various existing roles that will start to work as a virtual senior team. WHT will appoint to a Walsall Together Director role who will be responsible for delivering the transformation plans and deepening of the integrated relationships between teams and services. For Adult Social Care, the Head of Community Care and Partnerships will operate within that senior team but retain all accountability for statutory delivery, performance, staff and finances to the Director of Adult Social Care.

4.2.8. Success: will be measured success in three ways. A new Outcomes Framework has been developed by the CCG and Council to measure the quality of life improvements that for the whole population. Each of these have detailed performance indicators, and will be tracked on a regular basis.

Service quality and the experiences of citizens need to rise. These are already measured by Regulators (for example care home ratings) and data collated by each organisation but there is a requirement to join this data up and understand how a citizen may enjoy a good response from all services not just individual teams/services. Finally, there are ambitious plans for financial sustainability. WHT as the host will be fully supported by all our financial leads to ensure we are making

decisions that demonstrate value for money for all organisations in the best interests of the citizen, as opposed to decisions in isolation as now. Further development will be needed to model the assurance of the delivery between the Council and the Host, and this would be included within the s75 agreement.

5. The Option for Integrating

5.1 The Cabinet and respective Health Organisations Boards agreed in early 2018 to follow an Alliance model. This provides a flexible but contractual agreement between providers and commissioners. The Alliance contract for health partners sets out the budget, terms and risk sharing agreements, while master service agreements govern the delivery of different transformation schemes.

5.2 In addition, the Council would require an s75 NHS Act agreement to formalise its contractual arrangements. This will be produced in 2019/20.

6. Next Steps

6.1 This full business case has enabled partners to clarify the way in which they can deliver more integrated health and care services in Walsall. However, there is significantly more work to do to enable the Host Provider governance structure to become accountable, deliver transformation at a system level and truly join up care – with the full buy-in of all stakeholders.

6.2 During 2019/20 the ambitions include

1) Finalising and approving the Alliance Agreement for health partners by March 2019 to provide the contractual foundations for the ICP.
2) Establishing the Walsall Together ICP Board and new senior roles to provide the strategic oversight of the transformation detailed design.
3) To establish the Walsall Together Senior Management Team to have the operational responsibility to lead on the integration plans.
4) To identify and agree on the transformation budget requirements for April 2019 to April 2020.
5) To establish the Transformation Programme Office.
6) To consider other areas of enabling transformation such as clinical engagement, ICT transformation, estates/ asset management strategies for existing and new property requirements, and any external support for any of these functions.

7. Council Corporate Plan priorities

7.1 The integration of health and social care delivery is in line with the following Council corporate priorities:

- People: have increased independence, improved health and can positively contribute to their communities.
- Communities: are prospering and resilient with all housing needs met in safe and healthy places that build a strong sense of belonging and cohesion.

8. Risk management

8.1 There are multiple risks in a change of this scale and size. There is a requirement initially to create executive leadership team to drive the plan forward.

8.2 This will be supported by a Programme Management Team and a cross-sector transformation plan; underpinned by new governance arrangements.

8.3 Resources are needed to create a pooled fund to resource these teams (Executive and PMO) to deliver the arrangements and the Full Business Case (FBC) aims. To date these are modelled and have been funded by Adult Social Care for the Council.

8.4 The PMO will devise and run a full risk register to monitor and oversee the risks outlined.

9. Financial implications

9.1 There are no financial implications directly arising from this report, any financial commitments are subject to a separate cabinet report and S75 agreement. Financial information has been provided to the group to support the modelling carried out to date and currently articulated in the business case and its 'do nothing' scenario. Regarding next steps, for the 'do nothing' scenarios, financial information will need to be updated to take account of the Councils approved Medium Term Financial Outlook (post February 2019) as well as the final 2018/19 outturn position (post April 2019).

9.2 For the 'do something' scenarios, the financials included within the business case are high-level assumptions, subject to review, and validation via the Council as part of the 2019/20 activity.

9.3 For information, the local authority services currently included in scope are:

- All services within the Adult Social Care directorate
- Children's Social Care (both placements and support services) along with services identified as preventive (Early Help etc.) from within the Children's directorate
- To note that financial information relating to Public Health services have not been requested, and will form part of a later phase of design.

9.4 In terms of the financial information, the consultants supporting the group have been provided with the 2017/18 outturn position, the 2018/19 forecast position (as at October 2018) and the draft budget position included in the October budget consultation documents. It should be noted, the budget information provided, details the pressures and budget shortfalls for the services in scope, before any mitigating actions, new identified investment or saving proposals identified, in order to present the Councils true budget shortfall/gap.

9.5 The table below summarises that shortfall in funding for the in-scope services within Adult Social Care and Children's Services before mitigating action (savings/investments/action plans). The figures are cumulative as per the request.

Cumulative shortfall for In-scope services (prior to mitigating actions)				
	18/19	19/20	20/21	21/22
Service	**£m**	**£m**	**£m**	**£m**
Total Adult Social Care	**4.743**	**8.070**	**14.977**	**19.631**
Total Children's Services	**0.688**	**4.203**	**7.612**	**11.931**
Overall Total	**5.431**	**12.273**	**22.589**	**31.562**

9.6 For Adult Social Care, the shortfall for 2018/19 and 2019/20 is predominantly based on the level of undeliverable demand led saving proposals and pressures associated with the impact of Continuing Health care income reductions. For Children Services, the shortfall for 2018/19 and 2019/20 is predominantly based on increase in children in care costs (both placement expenditure and social care support expenditure).

9.7 For both directorates, 2020/21 and 2021/22, a proportion of the Councils required budget reductions along with assumed levels of demographic and inflationary increases for both Adults and children demand led services has been included as an estimate.

9.8 It is important to note that the financial modelling and dependencies described in the Walsall Together business case are indicative and based on a number of assumptions and financial ranges, all of which will be tested and moderated over the coming months and years as the programme develops, progresses and is finalised. It is therefore likely that the eventual financial values will be revised and tested further beyond those stated, although they will be consistent and faithful to the modelling described in the business case as submitted for approval with this report.

10. Legal implications

10.1 There will be a number of legal advice requirements during 2019/20 to produce the s75 NHS Act agreement.

i) The Host will commission legal advice to develop the collaborative position on the host and sub contractual arrangements.
ii) The Council will require individual legal advice to be fully informed about the contracts and the implications.

11. Property implications

11.1 None directly arising from this report however through transformation activity in 2019/20 any potential implications on the Council's existing property portfolio will start to be considered, as well the future estate needs of the partnership. An estate strategy focused upon delivery of services will be necessary and it will be important that this is designed in line with the Council's Proud Programme and its theme Optimising Assets' which in itself will be preparing options for how the Council's estate will need to be utilised in the future.

11.2 Over the lifetime of the Host Provider, premises will be adapted for co-location and locality access with likely shorter-term accommodation requirements arising from this new way of working. There could therefore be some short-term property implications ahead of a wider estate strategy being developed therefore any

requirements will need to be considered on a case-by-case basis and decisions relating to the Council's property assets made in accordance with local governance arrangements and the Scheme of Delegations.

12. Health and wellbeing implications

12.1 The main aim of this arrangement is to enhance the health and wellbeing of Walsall people. This is based on the partners moving to a population based management style whereby they are collectively responsible for enhancing the health and wellbeing of local residents.

13. Staffing implications

13.1 It is intended that the scope of Adult Social Care staff involved is the four locality teams, the access team, the complex and mental health team, all intermediate care and some of the business support teams. Implications may involve a redesign of services as well as redesigning the way in which we work so to increase collaboration and really put the service user at the heart of everything we do.

13.2 The commissioning resources will also be scoped within Adult Social Care.

13.3 In a later phase, some Children's and Public Health services will also be considered.

14. Reducing inequalities

14.1 The main purpose of this 'Host Provider' is to reduce the health and life opportunity inequalities of Walsall residents.

14.2 Comprehensive Equality Impact Assessments will be produced at each stage of proposed service changes to inform the impact of this development; and be further informed by the public engagement and consultation phase.

15. Consultation

15.1 The next steps identify a full citizen consultation on the plan and the Programme Office will oversee the delivery of that.

15.2 Staff (as and when clarified) will be engaged and enabled to support the improvements planned.

Background Papers

Appendix 1 – Full Business Case

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21 January 2019

Councillor Rose Martin
Portfolio Holder

21 January 2019

Walsall Together

Joining up your health and social care

Walsall Together

Moving towards an Integrated Care Partnership (ICP)

January 2019

Supported by:

Walsall Council

NHS Walsall Clinical Commissioning Group

NHS Dudley and Walsall Mental Health Partnership NHS Trust

One Walsall

Inspiring and supporting social action

Walsall Healthcare NHS Trust

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Contents

Version Control

Document Information	
Document Title	Walsall Together: Moving towards an Integrated Care Partnership
Date	January 2019
Owner	Walsall Together Programme Steering Group

Document History			
Version	**Date**	**Change made by**	**Description**
1.1	13/12/2018	Hannah Lewis	Initial draft – Financial section outstanding
1.2	20/12/2018	Hannah Lewis	Additions: Financial section and recommendations
1.3	20/12/2018	Hannah Lewis	Review by Paul Tulley
1.4	21/12/2018	Gareth Richards	Financial section
1.5	21/12/2018	Hannah Lewis	Updated exec summary
1.6	7/1/2019	Hannah Lewis	Amendments as per comments received
1.7	14/1/2019	Hannah Lewis	Amendments as per review on 9/1/2018

2.0	15/01/2019	Gareth Richards	Finance section updated
2.3	21/01/2019	Hannah Lewis	Comments from PH
3.0	18/1/2019	Hannah Lewis	TOR adjustments and others
3.1	21/01/2019	Hannah Lewis	Joshua and Sophie's User Stories adjusted
3.2	25/1/2019	Hannah Lewis	Comments from Steering Group
3.3	28/01/2019	Sarb Basi	Updated investment plan and "Do something" narrative
3.4	29/01/2019	Hannah Lewis	Final amendments, Appendix 7, watermark removed

Abbreviations

ACS	Accountable Care System
API	Application Program Interface
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme
CQC	Care Quality Commission
DWMH	Dudley and Walsall Mental Health Partnership NHS Trust
EEA	European Economic Area
FYFV	Five Year Forward View
H&W Centre	Health and Wellbeing Centre
HWBB	Health and Wellbeing Board
ICP	Integrated Care Partnership
JCC	Joint Commissioning Committee
KPI	Key Performance Indicators
MBC	Metropolitan Borough Council
MDT	Multi-disciplinary Team
MCP	Multi-speciality Care Provider
NHSI	NHS Improvement
OM	Operating Model
PAS	Patient Administration System
PBT	Place Based Team
QIPP	Quality, Innovation, Productivity and Prevention
SMT	Senior Management Team
STP	Sustainability and Transformation Partnerships
WHT	Walsall Healthcare NHS Trust
WT	Walsall Together
WTPB	Walsall Together Partnership Board
ToR	Terms of Reference

TPO	Transformation Programme Office
VCSE	Voluntary, Community and Social Enterprise

Foreword from Walsall Partners

Building on a strong history of collaboration, Walsall now has a fantastic opportunity to stand out from the crowd with a revolutionary health and care model, rivalling even the most pioneering integrated models across the country. Integrated Care is an approach aimed at recognising the diverse and increasing needs of an ageing population, and responding to the unique needs of a person to improve their health and wellbeing, rather than treating an episode of illness. (The King's Fund, 2018).

As system leaders, we understand the challenges of ensuring citizens receive the right care, in the right place and at the right time and we also recognise that this is not always happening in Walsall. Health and wellbeing outcomes vary vastly across the Borough, due in part to pockets of deprivation and affluence, and in some cases Walsall is falling behind regional peers on measures such as healthy life expectancy.

We believe by addressing the root cause of these issues - known as the wider determinants of health, such as housing, debt, education and employment- that the overall health and wellbeing of Walsall citizens can be greatly improved, alongside delivering greater value for the Walsall pound. This increased focus and associated investment in preventative and early-intervention services, forms the basis of the "Resilient Communities" offering to citizens; a place based, integrated service to connect and develop people within a community to build social capital and increase overall wellbeing.

Resilient Communities provides the foundations upon which all other health and care services are provided in the proposed model outlined here. We believe that this is the right direction for the health and care system and recognise the significant transformation that will be required to move towards a proactive system that supports residents to remain independent and away from using services which do not deliver the best outcomes.

This business case aims to accelerate this change, bringing together colleagues from across Public Health, Primary Care, Community Services, Social Care, Mental Health and Secondary Care to deliver the shared Walsall Together vision of "addressing the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams that support them and the wider health and care system." Our future plans will also include Children's Services and Public Health.

We believe that this brings the Walsall Together programme to a significant milestone in the transformation journey, with a clear plan for detailed design, implementation and continual refinement provided over the next three years supported by commissioners and partner providers. Our ambitions and plans are aligned to the recently published NHS Long Term Plan and we look forward to working with our staff, partners and citizens to bring this vision into existence for the current and future generations of Walsall residents.

Paula Furnival, Executive Director of Adult Social Care, Walsall Metropolitan Borough Council

Richard Beeken, CEO, Walsall Healthcare NHS Trust

Mark Axcell, CEO, Dudley and Walsall Mental Health Partnership NHS Trust

Simon Brake, Chief Officer, Walsall Clinical Commissioning Group

Dr Barbara Watt, Director of Public Health

Sally Rowe, Director of Children's Service, Walsall Metropolitan Borough Council

1 Introduction

The Walsall health and care system partners are developing new integrated ways of working to improve the health and wellbeing outcomes of their population, increase the quality of care provided and provide long term financial sustainability for the system. This business case outlines the way in which the "Walsall Together" partners will improve the way specialist support is delivered in the community to meet these objectives through establishing an Integrated Care Partnership (ICP) Board. This programme of work supports the wider Black Country Sustainability and Transformation Plans (STP) by enabling place-based, partnership working to improve the health and welling of a population (Kings Fund, 2018).

Overview

This business case lays out the future intentions of the Walsall provider and commissioner partners using a series of horizons, as they endeavour to deliver ever more integrated care and improved outcomes for the citizens of Walsall. This is a significant step forward in enabling formal, contractual changes that empower the Walsall Together Partnership Board (WTPB) by creating an outcome focused environment in which system partners are incentivised to deliver agreed outcomes.

It builds on the work completed to date as part of the Walsall Together programme and the Case for Change paper, further details below, and seeks to provide the clarity on the future Operating Model, commercial vehicle and governance to a level of detail required to facilitate approval by the Executive Leadership Boards of the WTPB's membership;

- Dudley and Walsall Mental Health Partnership Trust (DWMH);
- One Walsall;
- Walsall Clinical Commissioning Group (Walsall CCG), including Primary Care colleague representation;
- Walsall Metropolitan Borough Council (Walsall MBC);
- Walsall Healthcare NHS Trust (WHT).

Walsall Together and 'The Case for Change' paper

The Walsall Together programme launched in 2016, bringing together the providers and commissioners across Walsall to deliver three key aims:

- Improving health and wellbeing outcomes for the Walsall population;
- Improving care and quality standards in the provision of care;
- Meeting the statutory financial duties of all partner organisations.

The programme saw the establishment of two Boards; the Walsall Together Provider Board, consisting of all service providers in Walsall and the Walsall Together Partnership Board (WTPB) which included the local commissioning bodies; Walsall Metropolitan Borough Council (WMBC) and Walsall Clinical Commissioning Group (CCG) alongside the provider organisations.

Over the course of 2015-2016 the WTPB developed and agreed The Walsall Model of Integrated Care, which details the ambition of providers working to keep the citizen at the heart of the health and care system and ensuring they receive the right level of care, at the right time and in the right place.

The Case for Change paper delivered to the WTPB and member partners' Boards in January 2018, outlined the renewed vision and stated the commitment to agreeing the preferred model for delivering integrated care in Walsall by early 2018/19. This document was approved by the respective partner organisations' boards in February/March 2018, including the recommend next steps, which are outlined below:

1. Establishing a Programme Team with access to dedicated resource to run the development process;
2. Developing a business case for stakeholder sign-off (Including NHS Improvement) within the next six months to include the following priorities:
    - Defining appropriate governance to facilitate collective leadership in transition and end state;
    - The development of a comprehensive, Walsall wide financial model for the system;
    - Developing an Operating Model;
    - Developing an appropriate commercial model.
3. The creation of a budget and resource commitments to support both internal and external inputs to the process over the next 6 months.

This business case sets out to address point 2 above, supported by a system wide activity and cost model, and sits alongside the wider Walsall Together programme work that is currently underway. For example the Walsall Together Outcomes Framework, developed by Walsall CCG and Walsall MBC, is intended to support the move to more integrated delivery and once implemented across Walsall, will provide the framework and metrics against which all providers of health and care services will be measured.

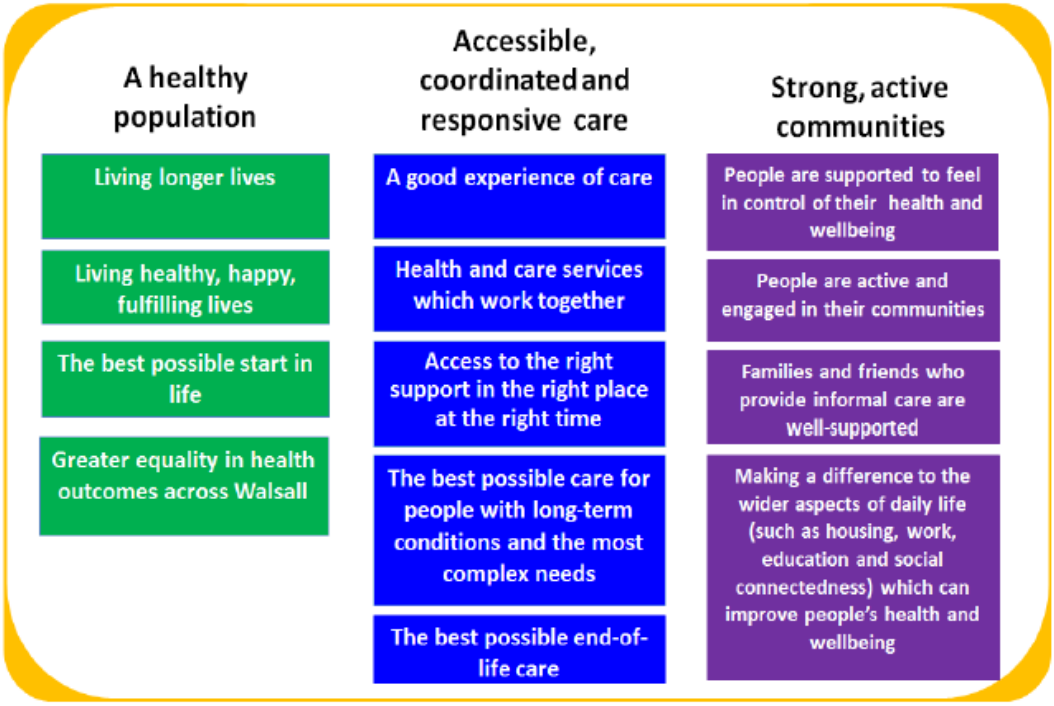


Figure 1Walsall Outcomes Framework (Under consultation)

The three themes; 'A healthy population', 'Accessible coordinated and responsive care' and 'Strong, active communities' demonstrate the shift to a more holistic approach to health and care provision, focused on addressing the wider determinants of health, designing appropriate responses and building community resilience. This new framework and the associated metrics used to measure performance demonstrates the focus of commissioners and system leaders on delivering improved outcomes for citizens and the population health as a whole, rather than units of activity delivered by local services.

Examples of these new metrics against the themes above include:

A healthy population

- Rate of five year old children free from dental decay;
- Self-reported well-being;
- Comparing outcomes achieved in the best and worst performing areas of Walsall.

Accessible, coordinated and responsive care

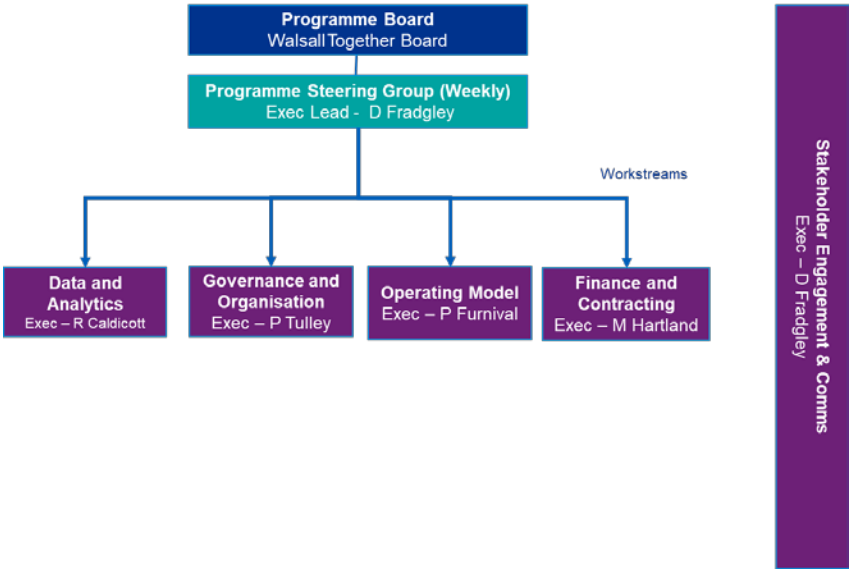
- Patients with Chronic Obstructive Pulmonary Disease (COPD) who have stopped smoking and not smoked for two years;
- Proportion of social care assessments taking place outside of a hospital setting;
- What proportion of people die in their preferred place of death.

Strong, active communities

- How many adults with a learning disability live in their own home or with their family;
- How many people in Walsall are supporting health and care services through formal volunteering;
- How many people who use services and carers report that they have as much social contact as they would like.

Process for Business Case Development

The WTPB appointed KPMG as the external advisors to support the delivery of this business case. As part of the programme mobilisation, WTPB senior leaders established the programme governance; including the creation of a Programme Steering Group, Programme Board and five individual working groups to support development of specific business case content. The programme governance structure and executive sponsor or chair of each group is outlined below, while the full membership of each group can be found in the Appendix (1):



The Programme Steering Group met weekly to review progress, risks and upcoming actions while, a highlight update was provided to the Programme Board on a 6 weekly basis, attended by a range of stakeholders from across the system, further details provided in appendix 1. Additional Board and Cabinet awareness sessions have also been held as part of the development process to allow senior stakeholders visibility and oversight of the process with appropriate opportunities to challenge direction. Following an initial draft prepared in early December 2018, the business case has undergone further review and refinement, including at Board Development sessions to ensure all parties are aligned to the outlined propositions.

Purpose of the Business Case

As detailed above as part of the business case development process, while there has been frequent and consistent engagement with a number of senior leaders and members from across the Walsall Together Partnership, this has remained a small representative group in comparison to the Walsall system. This is particularly true of the clinical and professional workforce, who have had limited involvement due to the time pressures and the largely non-clinical/professional nature of the conversations; outside of the Operating Model workstream.

As such, this business case is designed to enable system leaders to enter into Horizon 1 (April 2019/20) arrangements with the clarity required around infrastructure and governance alongside a high level view of the Operating Model, supported by data to facilitate an extensive co-design process of the Operating Model with professional colleagues. The Operating Model presented herein is intended to provide an outline of a future state health and care system in Walsall, requiring a subsequent detailed design phase to map the care pathways, patient flows and workforce requirements to deliver this. This will be an ongoing, iterative process as services and pathways are refined, in addition to new services rolling into the model over a number of years, detailed further in sections 2 and 7.

The Walsall Together partners intend to develop an Integrated Care Partnership (ICP) through which to plan, manage and deliver integrated care, which will provide the contractual environment to further develop and strengthen the role and responsibility of the Walsall Together ICP as this matures over the coming years. This will be established during the initial transition period from April 2019-

April 2020 (Horizon 1) as part of the broader detailed design phase, including developing contracting and risk sharing arrangements. Where possible, an outline of future Walsall Together objectives and arrangements between system partners are detailed, however it will be the responsibility of the ICP Board and partners to determine and agree these during Horizon 1.

Overview of the Walsall Health and Care System Partners

Dudley and Walsall Mental Health Partnership Trust (DWMH)

Dudley and Walsall Mental Health Partnership Trust (DWMH) provide a full range of integrated mental health services from 26 sites to the people of Dudley and Walsall. This includes community mental health services for children, adults and older people, in addition to inpatient facilities for adult and older people.

DWMH are currently rated as "Good" by the Care Quality Commission (CQC) following their assessment in November 2016, with improvements made in a number of areas including reducing waiting times for specialist community services for children and young people and the caring and responsive attitude staff had towards those in their care. The CQC have recently conducted a full inspection during November 2018, with results due to be published the beginning of 2019.

According to the National Community Mental Health Survey, carried out by the CQC, DWMH scores amongst the top 20% of Trusts for patients knowing who to contact in a crisis out of hours and above the national average for patients stating they got the help they needed when they contacted the team. Furthermore 66% of staff indicted they would be happy with the standard of care for a friend/relative in the 2017 Staff Survey; 3% higher than the average Mental Health Trust score. The Trust is one of the best performing providers in the country for staff engagement and culture through the annual NHS Staff survey. The Trust also achieved or exceeded 19 out of 22 Contractual Key Performance Indicators (KPI) agreed with Walsall CCG in 2017/18.

DWMH's financial performance continues to be strong, reporting a surplus for the 10th consecutive year of £3.3m. This surplus is in addition to the £3.5m of savings also delivered during the period 2017/18 as part of Cost Improvement (CIP) savings requirements. The Trust has also continued to invest in estate and IT infrastructure, with investments of £2.9m spent on capital works in 2017/18.

One Walsall

One Walsall is an independent charity which has been providing infrastructure support, representation and leadership for the Borough's voluntary, community, and social enterprise (VCSE) sector for over 30 years. Previously known as Walsall Voluntary Action, the organisation rebranded as One Walsall in 2016. Following a major organisational development programme in 2017, capacity building and volunteer support services are now delivered within the locality model described in the Clinical Strategy Section of this document. The Charity is supported financially by local statutory agencies, including Walsall Council and Walsall CCG, alongside local and national grant making trusts.

As an umbrella organisation, One Walsall represents the estimated 1500 organisations and groups that make up Walsall's VCSE sector. This diverse body of community groups, charities, faith organisations, amateur sports clubs and social enterprises deliver a broad range of early intervention and prevention activities addressing the wider, social determinants of residents' health, by building individual and community capacity and resilience. The sector spends an estimated £34million on employing 2,600 FTE staff, and is supported by over 26,000 volunteer hours given each year. Many of Walsall's VCSE organisations are already working closely with Walsall's health and care system partners to deliver health and wellbeing outcomes for residents. In the last financial year One Walsall

supported the sector to secure over £1.8million funding external to the borough to sustain these vital community services.

Walsall Clinical Commissioning Group (CCG)

Walsall CCG commissions primary care, community, hospital and mental health services across Walsall and, as a membership organisation, represents 52 GP practices covering approximately 303,000 patients. Each GP practice is mapped to one of the four localities, with each locality having at least one dedicated multidisciplinary Place Based Team (PBT) – in the larger localities, two teams are assigned to serve the population. Further detail of this model is provided in the Strategy section (3).

The CCG is currently in a positive stable financial position having been removed from Special Measures in 2017/18 following the successful implementation of the Financial Recovery Plan. This implementation, alongside the delivery of a QIPP programme of £20.7m, leaves the CCG with a cumulative surplus of £5.7m. The CCG is on target to achieve one of its key financial metrics of achieving break even in 2018/19.

Walsall Healthcare NHS Trust (WHT)

Walsall Healthcare NHS Trust is an integrated Acute and Community services provider. They deliver a full range of acute hospital services including A&E, outpatients, diagnostics, elective and non-elective admissions. In addition they provide a full range of Community services to the Borough.

WHT is currently rated as "Requires Improvement "overall following an unannounced inspection by the Care Quality Commission (CQC) in May 2017. This inspection was prompted by the placing of WHT in special measures by the Secretary of State for Health in February 2016, following significant concerns around the provision of maternity services. Following the 2017 inspection, maternity and gynaecology services retained their rating of "Inadequate", however there were improvements in ratings for all other acute services at the Manor Hospital. The community services provided by WHT have been awarded an "Outstanding" rating, and community end of life care improved from "Good" to "Outstanding" following the last inspection.

Walsall Healthcare Trust are reporting a deficit of £23m for 2017/18; £2m greater than the deficit reported in 2016/17 of £21m and therefore WHT was unable to achieve its financial duty to break even. This overspend was largely due to the high costs incurred during periods of high demand on emergency services, requiring the use of additional capacity areas and an increased reliance on temporary workforce. There has also been a significant investment in buildings and refurbishments, totalling a further £1.2m, bringing the total deficit to £24.4m.

Walsall Metropolitan Borough Council (Walsall MBC)

Walsall Metropolitan Borough Council (Walsall MBC) provide Adult Social Care and Children's Services, and Public Health in their role as health and care commissioner. This includes but is not limited to; safeguarding, supporting those with mental health needs, those with physical or learning disabilities and those acting as a carer. There are statutory responsibilities to safeguard those at risk of abuse, to look after children who cannot live within their own immediate family and to offer early help and support to children in the most need.

While Public Health and Social Care has been significantly underfunded at a national level for a number of years, despite the increasing demand for service, Walsall MBC has managed the Adult and Children and Young People's budgets well, maintaining financial balance alongside increasing savings pressures with a further £12.8m planned over the period 2018/20. For the 2017/18 period, the Adult Social Gross Income totalled £47.767, with gross expenditure of £115.500m. For Children and Young

People Services gross income totalled £181.803m, with a corresponding gross expenditure of £285.389m.

2 Strategic rationale

The momentum and alignment achieved through publication of the *Case for Change* document signifies the system's readiness for formalised processes to enable real integration and transformation. The system leaders from across the provider and commissioning bodies in Walsall have demonstrated their commitment in approving the Case for Change, with the role of this business case being to outline the Operating Model for the future sustainability of the health and care system and the commercial and governance arrangements required to support this. This will be underpinned by a clear understanding on the strategic and financial rationale for these changes.

Baseline financial position

Using 2017/18 as the baseline year, the Walsall system income is £611m, while the expenditure is £633m, leaving a current deficit of £22.1m. Using a combination of national population growth assumptions and NHS activity growth assumptions, shown in further detail in the appendices (2), the system income will rise to £675m and expenditure to £849m by 2023/24. This leaves a funding gap of £174m, taking into account all forecast changes to income and expenditure, and before any assumptions about organisations achieving efficiency targets have been applied. This substantial, but not insurmountable, financial challenge presents the Walsall partners with an opportunity to develop new operating models that provide care at a lower cost, building in long term sustainability and, most importantly, with the aim of improving quality of care.

National, Regional and Local drivers

The necessity to transform the health and care system in Walsall is far from driven purely by the current financial situation and forward forecast. There are a number of national, regional and local challenges and associated strategic plans to address these already in place, with key elements outlined below.

National Challenges

Across the UK and indeed in all developed countries across the world, system leaders are grappling with providing affordable care for an increasingly aging population with increasingly more complex needs. Coupled with ever more medical and technological advances, the range of services available to citizens is also driving up costs. A chronic underinvestment in preventative care and public health has occurred alongside an unprecedented rise in preventable or lifestyle related conditions, such as type 2 diabetes, Chronic Obstructive Pulmonary Disease (COPD) and obesity in both adults in children.

The national drive for better integration is in part a result of these factors and aims to address the fragmentation caused by the organic growth of health and care systems that are reactive to demand.

Additionally there is a national staffing shortage affecting all clinical and professional care staff. This is due to difficulties in recruitment and retention and is exacerbated by a large proportion of the workforce reaching retirement age over the next 5 years. In Q1 2018, there were 87,487 advertised vacancy full-time equivalents in England; the highest percentage of which were for Nursing and Midwifery Registered staff. The previous year had a similar level of vacancies. This is also reflected locally, with WHT and DWMH both reporting significant vacancies in this area and concerns raised over the staffing of the Maternity services at WHT in particular by the CQC in 2017, although actions have been taken since to address these.

Additionally for the UK, although the full impact of Brexit is poorly understood at this stage, there are approximately 60,000 NHS staff and 90,000 social care staff from the European Economic Area (EEA). Possible restrictions on immigration and uncertainty over the rights of EU workers living in the UK is already affecting the attractiveness of the health and care system for migrant workers and the potential impact remains to be seen.

National Strategy

The 'Five Year Forward View' (FYFV) (NHS England) published in 2014, and the follow up report 'Next Steps on the Five Year Forward View ' in 2017 describes in more detail some of the challenges above and outlines the rationale for delivering services in a more integrated way.

The recommendations set out in the FYFV include:

- Developing new models of care – based around partnership, integration and joining up organisations and funding streams. These may require the development of Accountable Care Partnerships/Organisations – now more commonly referred to as Integrated Care Partnerships (ICPs);
- A radical upgrade in prevention and public health;
- Increasing the control patients have over their care when they require access to services.

New national operational plans are in the pipeline but awaiting publication at the time of writing. These are expected to provide support for locally led models of integrated care such as these and no significant challenges to the plans outlined here are anticipated. Investment in Mental Health and Primary Care services are anticipated and will also support the Walsall Together programme.

The recently published NHS Long Term Plan sets out a clear direction of travel for system integration to deliver a new service model for the 21st century by achieving the following key objectives:

1. Boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

2. The NHS will reduce pressure on emergency hospital services

3. People will get more control over their own health and more personalised care when they need it.

4. Digitally-enabled primary and outpatient care will go mainstream across the NHS

5. Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

Regional Strategy

Black Country and West Birmingham Sustainability and Transformation Plan (STP)

The Black Country and West Birmingham (STP) was published in November 2016 and outlines the high level plans for health and care services for a population of 1.4 million The STP is a blueprint for the future development of healthcare and wellbeing services across 18 organisations in the Black Country and the West of Birmingham including primary care, community services, social care, mental health and acute and specialised services. STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by organisational boundaries. The aims are to:

- Improve the health and wellbeing of local people;
- Improve the quality of local health and care services;

- Deliver financial stability and efficiencies throughout the local health care system.

The critical recommendations of the Black Country and West Birmingham STP include the implementation of local place-based models of care, extended collaboration between service providers, actions to address the maternal and infant health challenges faced by the STP population, actions in partnership with the West Midlands Combined Authority to address the wider determinants of health and finally to develop the key enablers required to facilitate the transformation.

Walsall is identified in the STP as one of the four established place based care models and has already begun to deliver on some of the planned actions outlined in the STP, including the creation of seven integrated health and care teams assigned to localities and developing a prevention and early intervention offer to keep people well and independent in their communities.

Local Challenges

Many of the population needs in Walsall are no different than to those found across the country, such as an increasingly elderly population with the associated increase in co-morbidities and long term care needs. However there are a number of significant areas in which Walsall is an outlier. These include the inequalities of life expectancy, infant mortality rates and the number of deaths from preventable diseases. The underlying cause of these stark inequalities is undoubtedly linked to the level of deprivation and child poverty in the area, as outlined below.

Deprivation

Walsall is one of the most deprived boroughs in England; ranked 33rd out of 326 local authorities, with 36.21% of children living in poverty (Valadez-Martinez & Hirsch, 2018). This average across the borough hides stark differences between wards across the borough, with the figure for Palfrey to the South of the borough estimated to be as high as 51.7%. These high levels of deprivation are linked to a number of poor health outcomes such as high rates of infant mortality, and at 8 per 1000 births, the infant mortality rate is significantly higher in Walsall than statistical neighbours. The health inequalities that arise between the most and least deprive areas are also stark, with a difference in life expectancy of 11.3 years for males and 7.4 years for females (2014-2016).

Life expectancy

Worryingly, the latest information shows that the both the life expectancy and healthy life expectancy of males in Walsall is decreasing. Male life expectancy is significantly worse than England and has fallen from 78 years (in 2011-13) to 77.2 years (in 2014-16). Male healthy life expectancy in Walsall continues to fall, from 59.8 years (in 2011-13) to 57.7 years (in 2014-16). This is significantly worse than England, with the gap widening. Life expectancy for Walsall females at 82 years (2014-16), is considerably higher than males but significantly worse than the England average of 83.1 years. Female health life expectancy follows a similar worsening trend to males. Females' healthy life expectancy has reduced from 60.3 years (in 2011-13) to 57.2 years (in 2014-16).

This worrying trend widens the gap between Walsall and both regional and national figures, however Walsall is in line with other deprived areas.

	Male		Female	
	Life Expectancy	Healthy Life Expectancy	Life Expectancy	Healthy Life Expectancy
Walsall	77.2	57.7	82	57.2
West Midlands	78.8	62.6	82.7	63.2
England	79.5	62.9	83.1	63.4

Table 1 Life Expectancy and Healthy Life Expectancy comparison (2014-16), Source: Public Health England, Fingertips

Deaths from Preventable Diseases

The incidence of preventable diseases in Walsall is significantly higher than the national average, including; diabetes (8.7% against a national average of 6.4%), coronary heart disease (4.0% against a national average of 3.2%) and chronic kidney disease (5.2% against a national average of 4.1%). Walsall has "significantly worse than England average" scores for the percentage of physically active adults, excess weight in adults and obese children; each of which can be linked to the wider determinants of health. Also correlated is the impact on substance misuse and smoking; Walsall has a significantly higher rate of problematic drug users and the estimated prevalence for smoking 22.7% (c.45,000 adults) and smoking related deaths are significantly higher than national averages.

Diversity

Walsall is a culturally diverse borough, with almost 1 in 4 residents from a minority ethnic group, compared to the England average of 1 in 5. The largest increase has been from people with an Asian background, rising 4.75% from 2001 to 15.2% in 2011. This can impact on community cohesion if an area's ethnic composition has changed quite rapidly over a relatively short space of time, and some areas of the borough have a particularly high concentration of minority ethnic groups of up to 90%. Understanding the specific needs of a community and any barriers to access is key to ensuring equality of access to high quality care that meets the needs everyone; a founding principle of the NHS.

English language proficiency is very good in Walsall and in line with the English and Welsh averages. However 3.3% of households have no occupants that speak English as their main language, 6,200 residents cannot speak English well and 1,200 who cannot speak the language at all. This can make delivering healthcare and wellbeing information challenging and can be a barrier to accessing services. It was also raised as a factor limiting access to services in the Operating Model workshops.

Local Strategy

The Walsall Together Programme outlined in further detail in section 2 is designed to address some of these issues, but there are a number of other local policies and directives to address the wider determinants of ill health, such as the Walsall Partnership Health and Wellbeing Strategy 2017-2020. This outlines the way in which multiple agencies will work together to improve the outcomes for the people of Walsall, including Walsall Council, West Midlands Police, NHS Walsall, Walsall Probation Service, West Midlands Fire Service, Walsall Area Partnerships and representatives from the Walsall Housing Partnership, the Chamber of Commerce, Healthwatch, One Walsall and other key partner agencies.

3 The Strategy

A tiered Operating Model has been co-developed with an increased level of focus on services outside of the acute setting, to move the system towards a population management orientated model with a clear focus on prevention and early intervention. The Resilient Communities element of the Operating Model is a fundamental change in the way a population's health and wellbeing is supported and managed, with the largest volume of care and support provided in the community by Place Based Teams co-located to ensure integrated and joined-up delivery of care.

Overview

The term Operating Model is used to describe at a high level how the health and care providers will work together to deliver health and wellbeing services in Walsall. This includes non-clinical wellbeing and professional services also, such as those provided by the CCG, Local Authority and voluntary sector. The significance of language that is both inclusive and representative of the diverse parties involved was a theme throughout many of the Operating Model workshop sessions and discussions, with colleagues from across the system working side by side on the development of the model and sharing different approaches to the same issues.

To this end, the workstream was led by the Executive Director of Adult Social Care and had membership from all provider and commissioner organisations, including One Walsall and Public Health. The focus of this group was to develop a set of agreed design principles to guide the development of an outline Operating Model. The outputs of this workstream are detailed in the following section.

Development of the Operating Model for Walsall

As outlined in section 1, the Walsall Together programme has been in place since 2016, bringing together providers and commissioners across Walsall to plan, develop and deliver more integrated care. As part of this early work the Walsall Together Partnership Board developed an initial model of integrated care, with the citizen at the heart, as shown on the next page.

Walsall Model of Integrated Health & Social Care

Resilient Communities

Early intervention and prevention to support people and communities to live independently and to have active, prosperous and healthy lives.

General Practice and Integrated Health and Care Teams

People registered with GPs in Walsall will be supported by a team that is made up of GPs, community nursing, social care, mental health and the voluntary sector, providing accessible, high quality co-ordinated care in people's homes and communities.

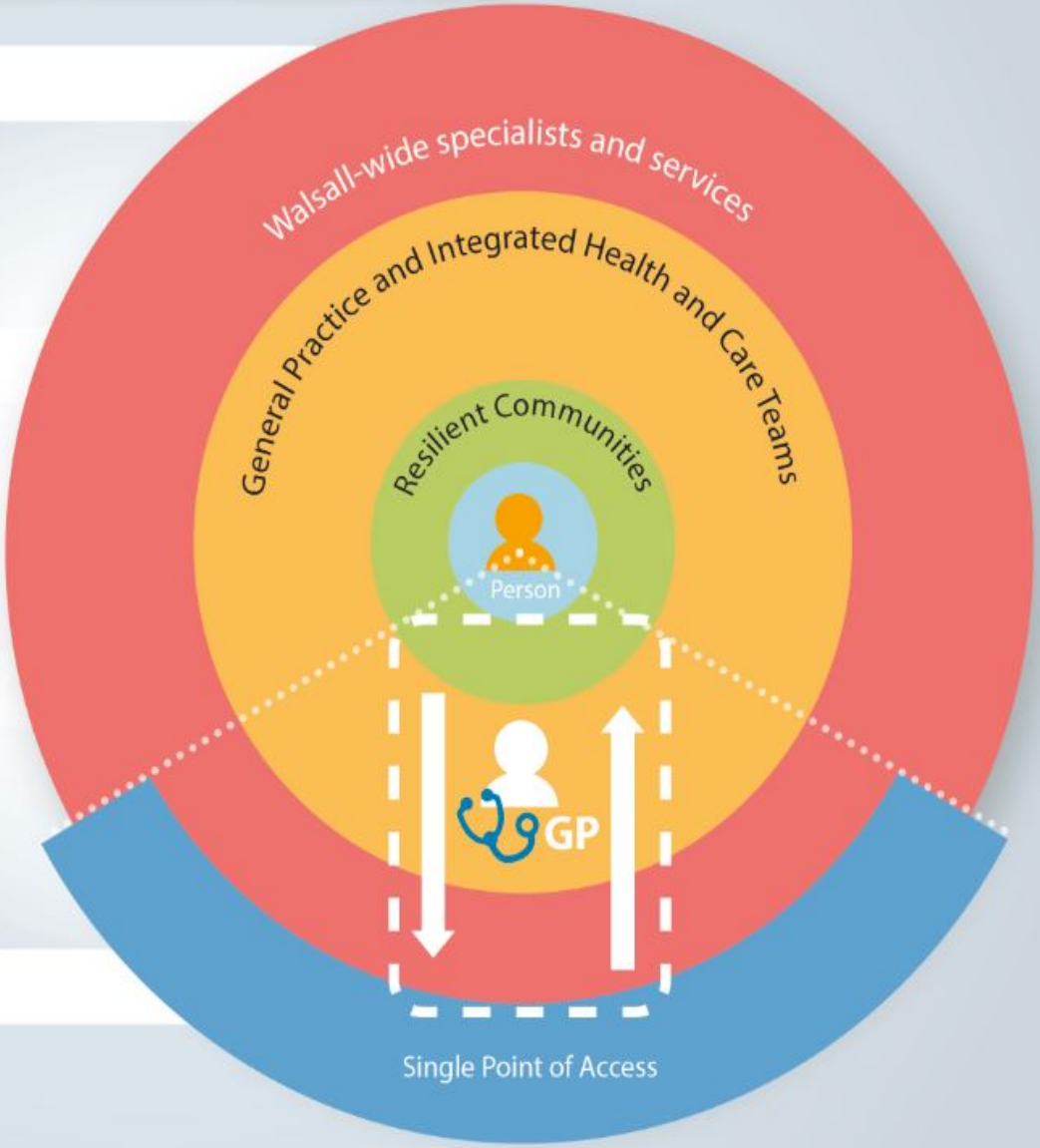
Walsall-wide specialists and service

Accessible, high quality care with local hospital teams working as part of a network of specialist care.

Supporting people with health needs to prevent unnecessary hospital admission and receive care in the most appropriate setting.

Single point of access

A single point of access for care coordination and navigation for all health, care and prevention services. To help ensure rapid and timely access and effective co-ordination for professionals and patients.



Despite this work not being underpinned by contractual obligations, the WTPB have innovated and worked collaboratively as a Partnership to deliver the changes required for the betterment of the Walsall population, including developing a high level timeline for implementation that has been developed and socialised across the health and care system since 2018 (Appendix 3), however this has since been further refined.

This forward-thinking and collaborative attitude has enabled Walsall to progress further than many other neighbouring boroughs and equivalents across the country, including the established Place Based Teams, a coherent and joined up VCSE approach and a well-articulated Resilient Communities offer to address the wider determinants of health. This partnership mentality and drive to deliver on the ground changes continues to permeate discussions and planning currently and moving forward. Further details are provided in sections 6 and 7.

One such on the ground change includes the identified and agreed locality model, based on GP practice location, with Primary Care, Social Care and Community colleagues assigned to these areas to deliver care to a registered population. Furthermore since mid-2017, the WT partners have begun to create multi-disciplinary Place Based Teams (PBT) working in these localities.

The current challenges to locality working include the lack of appropriate working space to facilitate the co-location of these PBT, with clinicians reporting that many current spaces are “make-shift” or too small to allow for meaningful communication collaboration with the full team. Additionally the administrative effort required to facilitate meetings is not available universally to all teams, impacting on the opportunity for and outcome of meetings.

The Operating Model outlined below builds on this locality model and extends the scope of integrated working beyond primary, community and social care and into specialist services and beyond. These plans build on best practice and the experience of other integrated health and care systems, which identify five key areas to inform planning, shown overleaf:

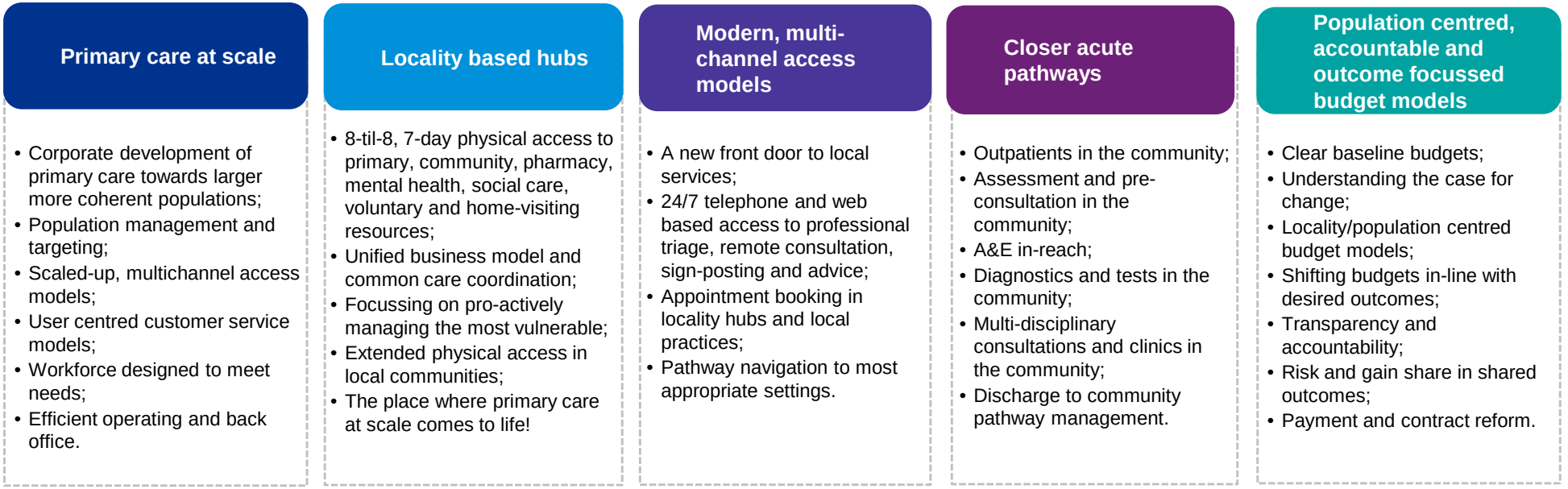


Figure 4 Elements of an Integrated Health and Care System

In order to shape the design of the Operating Model, the Operating Model workstream members identified six design principles aligned to the current local challenges, outcomes framework and vision for the future:

Design Principle	Citizen statement – What does it mean for me?
Collaborative working	My health and wellbeing will be planned holistically, looking at me as a whole person, not a condition.
Care Closer to Home	Wherever possible, I am able to access services or care close to my home.
Prevention and Early Intervention	My health and wellbeing is proactively monitored to ensure issues are identified and managed at the earliest opportunity. I know how to access support to prevent reduced independence.
Reducing Inequalities	If I am at risk of poor outcomes, I will be proactively supported to reduce the likelihood and impact of these factors. I will be supported to be as independent as possible regardless of my personal circumstances.
Resilient Communities	My community is an empowered and active asset in the management of my health and wellbeing and I am supported to take control of my own care.
Admission Avoidance	I am supported to avoid unnecessary admission to hospital or premature admission to long term care and my stays are as brief as possible.

These design principles were then used to guide a process of identifying key features of the desired Operating Model, at both a whole system and locality level, as shown in the figure below. The three green elements in the diagram; payment incentives reform, an integrated workforce plan and population management software and shared records were identified as key enablers of the desire future state.

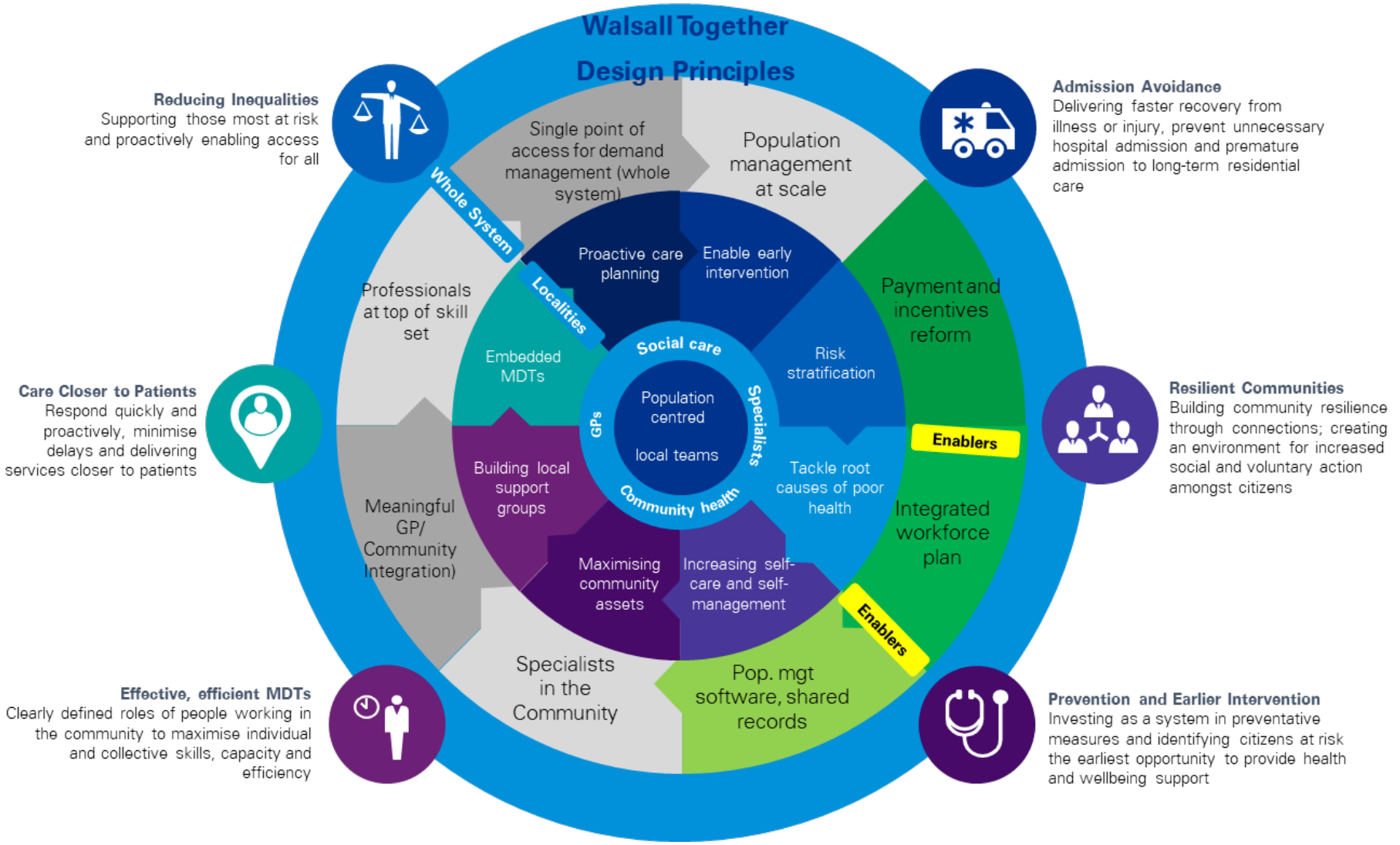


Figure 5 Designing the Walsall Together Operating Model

User Personae were developed in partnership with clinicians and professionals from across Walsall to represent a broad selection of users in Walsall that are currently not receiving the best possible care and/or where there are numerous organisations involved in their health and care. These were used to test the design principles and design a future state Operating Model through the lens of a citizen.

Figure 6 Walsall User Personae

Outline Operating Model

The *Next Steps of the NHS Five Year Forward View* paper published in March 2017 and the recent NHS Long Term Plan outlines the continued focus of NHS England on integration as part of the STPs and more broadly, while also providing an outline of the technology and innovation plans moving forward. While there are a number of formal models emerging such as Multi-speciality Community Providers (MCP) (of which DWMH is part of the Dudley MCP) and the recently identified Accountable Care Systems (ACS), including nearby Nottinghamshire, national policy for integrated care is still in its infancy, with the consultation on the Integrated Care Provider Contract ongoing at the time of print. It is for this reason systems such as Walsall have an opportunity to outline their own intentions for integrated working in a manner that works for their population; breaking down organisational barriers and silo working to deliver the greatest value for the local pound.

Globally health and care systems are reconfiguring services to capitalise on technology and the self-activated, empowered citizen to unlock new possibilities including remote monitoring, self-assessment and virtual consultations, which not only improve user satisfaction and outcome but allow services to be delivered at a lower cost. This aspect is missing in the Walsall Model of Care as shown in figure 3, while other elements do not go far enough to re-envision the delivery model. As such, a new tiered model of care has been developed, Figure 8, with citizens accessing services through a Single Point of Access (SPA). It is from this starting point that all other services can be accessed, with the SPA also acting as a two-way mechanism for the Resilient Communities offering.


Tier 1 – Integrated Primary, Long term condition management, Social and Community Services
Primary Care at scale and integrated health and care teams, working through a hub and spoke model across each locality
Tiers of Care
1
2
3
4
Tier 2 – Specialist Community Services
Outpatients and Diagnostics services delivered from locality based Health & Wellbeing Centres or the home
Walsall Together
Tier 0 – Resilient Communities
An Integrated prevention and early intervention offer to all Walsall citizens
Single Point of Access (SPA)
Care access, navigation and co-ordination including clinical triage
Tier 3 – Intermediate, Unplanned and Crisis Services
Network of specialist care delivered from Health & Wellbeing Centres, preventing unnecessary hospital admissions and facilitating timely discharge from hospital.
Tier 4 – Acute Hospital Services
Access to high quality acute hospital services for patients when they need specialist intervention, provided a) locally and b) at a Black Country, Regional or National level where necessary/

The Tier 0 "Resilient Communities" offering at the centre of the model reflects the substantial shift in thinking in the way this model will operate, with a significant investment in these services required to support it in this role. It is expected that this service will continue to grow from its current incarnation into a clearly defined and well connected infrastructure of VCSE Services, empowering localities to access, shape and deliver a range of health and wellbeing initiatives to improve outcomes for their localities.

Each tier is explained in further detail below:

Tiers	Description
Tier 0	**Resilient Communities** Prevention, identification, early intervention and pro-active self-care, health and wellbeing services.
Tier 1	**Integrated Primary, Long term condition management, Social and Community Services** Integrated health and care, delivering primary, social and community care at scale, with teams working through a hub and spoke model across each locality
Tier 2	**Specialist Community Services** Accessible, high quality care with local hospital teams working in a locality to deliver specialist care, outpatient, and diagnostic services, delivered from "Health and Wellbeing Centres" – repurposed estate used as a hub for MDTs
Tier 3	**Intermediate, Unplanned and Crisis Services** Network of specialist care delivered from a selection of Health and Wellbeing Centres, preventing unnecessary hospital admissions
Tier 4	**Acute and Emergency Services** Access to high quality acute hospital services for patients when they need specialist intervention, provided both in-borough and through a wider network

Single point of Access

Health and Wellbeing Care access, navigation and co-ordination; including triage to clinical and non-clinical services

The Walsall health and care system will develop a Single Point of Access to care and services that is co-ordinated and organised to ensure citizens are able to get to the right part of the system, to the right service and to the right professional in an efficient and timely manner. This service will allow citizens access to services via mobile app, web, phone or face to face at one of the Health and Wellbeing Centres; repurposed current estate offering access to health, care and third sector professionals. In order for this to be an effective service, the digital infrastructure, such as shared patient records and directories of services must be in place. This is described further in Section 7 - Enablers.

Tier 0 – Resilient Communities
Prevention, identification, early intervention and pro-active self-care, health and wellbeing services.

The traditional approach to health and social care has always tended to be reactive, responding when a patient or service user experiences a crisis, in order to return them back to health and provide limited support during the periods between crises. These health and social care approaches have tended to foster a culture of dependency and passivity and an over reliance on interventions, drugs,

clinics and hospitals – even though there is good evidence that the management of long term conditions, for example, usually requires high levels of patient motivation, self-care and behaviour change to be effective.

The Resilient Communities offering to citizens aims to rectify this over dependence and equip communities with the necessary tools and resources to improve the health and wellbeing of their population, by addressing the wider determinants of health such as housing, education and employment and embedding a prevention approach.

Work to date in this area has seen the introduction of "Making Connections Walsall" (MCW), a service targeted at the over 55s to address social isolation and loneliness – supporting over 500 clients since its launch in September 2017. This programme commissioned by Public Health, involves the West Midlands Fire Service acting as a central point of contact and providing "Safe and Well" visits to all vulnerable people accessing the service focusing on three key areas; Home, Community and Care.

Home	Community	Care
• Join up housing related advice and support across sectors and embed in localities; • Provide greater access to Aids/adaptations; • Domestic house & garden support.	• Provide local points of support to build capacity and resilience within communities, through increased social and voluntary action; • Connecting people within communities, developing and sharing skills and capabilities; • Increase support for carers; • Increase coordination and access to information and advice.	• Providing people with Long term conditions with more options to self-care by supporting creation and growth of community-led peer support groups; • Increase access to social prescribing services, wellbeing assessments and plans; • Encourage and support across partnership delivery of evidence based interventions to prevent deterioration and / or escalation.

One Walsall's core activity provides infrastructure support, development and capacity building of the borough's voluntary and community sector. As such, One Walsall will continue to build capability within the VCSE sector to resource the ambitious vision for the wider Resilient Communities approach, in collaboration with MCW's programme.

Resilient Communities will be underpinned by digital tools and technology; enabling access to work, leisure and training for people alongside organisations such as VCSE groups seeking resources or advice. This focus on preventative action is recognised as fundamental to delivering long term improvements in health and wellbeing outcomes for people, and it is anticipated that services delivered at Tier 0 will be evaluated and recognised alongside interventions delivered at other Tiers.

Services delivered through Tier 0 Resilient Communities may include;

- Social Prescribing, delivered consistently and in a co-ordinated manner by One Walsall and health and care professionals, from within the Place Based Teams and Integrated Intermediate Care Service. A current pilot embedding VSC Community Link Officers is underway, with plans to expand this to cover the whole borough if successful.
- Making Connections Walsall Social Connectors;

- Direct access to community assets including VCSE providers and opportunities, housing, education and training information and advice, through an up to date directory of services and point of contact;
- Expert Patient programme;
- Care Navigation and co-ordination;
- Carer support;
- Citizen education for specific clinical pathways e.g. diabetes, respiratory problems;
- Volunteering groups, programmes and opportunities. Currently there is a lack of diverse volunteering opportunities in the borough and great potential to develop volunteer supported projects for areas of varying deprivation, need and demographics. High quality experiences are the key to attracting and retaining volunteers as detailed in the National Council Voluntary Organisations Time Well Spent Survey (2019). Therefore opportunities and investment targeted at VCSE organisations to increase the number of high quality volunteering opportunities is key to unlocking the potential of the Resilient Communities approach.

Citizens will be able to access the services listed here by phone, online or in person, by visiting one of the "Health and Wellbeing Centres" in their locality. For the volume of contacts to be dealt with at this Tier, it is essential that there is 24/7 online access to these services, with a physical presence also provided on an extended hours basis. There needs to be increasing emphasis on assisting citizens to actively engage in education, prevention and wellbeing services using the voluntary sector as a first point of contact and access. However the ongoing and desired increasing contribution of the VCSE outlined here cannot be assumed without acknowledging the capacity limitations of these services.

Tier 1 - Integrated Primary (physical and mental health), Long term condition management, Social and Community Services
Integrated health and care Place Based Teams working through a hub and spoke model

The tier is based on the joined up delivery of wellbeing services, primary care, social care and community services in each locality through Primary Care Networks (PCN). PCNs represent the most local, neighborhood level of care systems and form the foundations of Place Based Care as outlined in the FYFV (NHS England, 2014), Next Steps on the FYFV (NHS England, 2017) and NHS Long Term Plan published in January 2019. They provide the community level mechanism for coordinating Primary Care services for a given population at scale. PCN will interface with the Place Based Teams based at Health and Wellbeing Centres in each of the four localities. These Health and Wellbeing Centres – remodeled and repurposed facilities from the current local estate, as well as other primary care centers and GP surgeries will operate routine, booked, walk-in type facilities with flexibility for unplanned walk-in facilities covering essential and enhanced services. It is proposed that services would be available between 8.00am and 6.30pm Monday to Friday, with extended access from the wider Health and Wellbeing Centres that are part of the Walsall locality network. This will include the integration of place based community, social care and primary mental health professional teams wrapped around locality populations. These professional teams will include but not be limited to:

- Adults Social Care Services;
- Adult Community Health Services;
- Adult Primary Mental Health Services;
- Proactive virtual monitoring.

Tier 2 - Specialist Community Services

Accessible, high quality care with local hospital teams working in a locality to deliver specialist care, outpatient, and diagnostic services, delivered from Health and Wellbeing Centres

The traditional model of specialist care involves a patient attending a Primary Care appointment in order to get a referral for more specialist assessment and care, usually provided by a consultant at the acute hospital. The patient has to travel to the hospital for one or more outpatient appointments with the consultant and for associated diagnostic tests. If a patient requires surgery, some patients may need to stay in hospital for a few days before being discharged home, with one or more subsequent outpatient appointments, again at the hospital with the consultant to confirm progress.

Under the proposed model of care, a Tier 1 or 2 professional (this could be an Advanced Nurse Practitioner, GP or a similarly qualified professional) would refer all but the most complex or low volume cases to a specialist within the community who would undertake a first 'outpatient' consultation at a clinic run in one of four Health and Wellbeing Centres for Specialist services across the Walsall area. Where further investigation by a consultant is required with only the most complex or low-volume cases being seen in an acute hospital setting.

During the first phase of delivery it is proposed the following specialties will be seen in the Health and Wellbeing Centres:

- Respiratory;
- Cardiology;
- Rheumatology;
- Neurology;
- Palliative Care;
- Pain Management;
- Diabetes;
- Urology;
- Gynecology;
- Ear, Nose and Throat;
- Musculoskeletal.

It is envisaged that these will be seen by General Practitioners with a Special Interest (GPwSI), Community Consultants, and out-reach hospital staff by managing care differently and implementing new care pathways.

Tier 3 – Intermediate, Unplanned and Crisis Services

Network of specialist care delivered from Health and Wellbeing Centres, preventing unnecessary hospital admissions.

The aim will be to provide the appropriate level of intermediate care to prevent unnecessary hospital admissions. These services will be time limited, enable better assessment and care planning for

individual patients which is multidisciplinary and focused on active rehabilitation working out of the locality integrated Health and Wellbeing Centres.

Services delivered at this tier are not "in-scope" for Horizon 1, however the future state services may include:

- Integrated Rapid Response Service
- Paramedics in the community

The core aims of these integrated community based services at tiers 0-3 Care:

- To help people achieve their full potential for independence.
- To reduce the need for long term hospital based care.
- To prevent physical and mental deterioration and dependency as a result of hospital admission and long stays in hospital.
- To respond flexibly to the multiple, overlapping and changing needs of vulnerable individuals and the frail elderly.

Unplanned/Urgent Care Services

It is nationally recognised that a significant number of A&E attendances across the country are inappropriate and could be treated or routed through different settings. It is well within the capability of primary care clinicians in a multi-disciplinary setting to be able to deal with a significant proportion of this attendances providing they have access to routine diagnostics and community services.

All major trauma and life-threatening conditions would be treated at the most appropriate acute hospital across the borough and the majority of blue-light ambulance calls would be taken to acute facilities, which would also be open to walk-in patients.

Therefore the new model of unplanned care would see the WHT A&E department being supported by the existing unplanned care facilities led by primary care clinicians, including Out of Hours services in one or more of the Health and Wellbeing Centres.

Tier 4 - Acute and Emergency Services
Access to high quality acute hospital services for patients when they need specialist intervention, provided both in-borough and through a wider network

When patients require acute or emergency care they will be able to access high quality appropriately resourced services delivered from their local hospital. Despite the increased provision and capacity in primary and community services from tier 0-3 patients and professionals still need to know they can get access to high quality acute and emergency services when they require surgery, deteriorate from a current condition or need immediate intervention.

Estate Requirements

It is envisioned these services be provided using the existing estate, however this may require a significant repurposing and reconfiguration in order to deliver the four proposed Health and Wellbeing Centres. Further details of this can be found in the Mobilisation and Implementation section, along with initial investment cost requirements. A representative outline of the estates configuration is provided below.

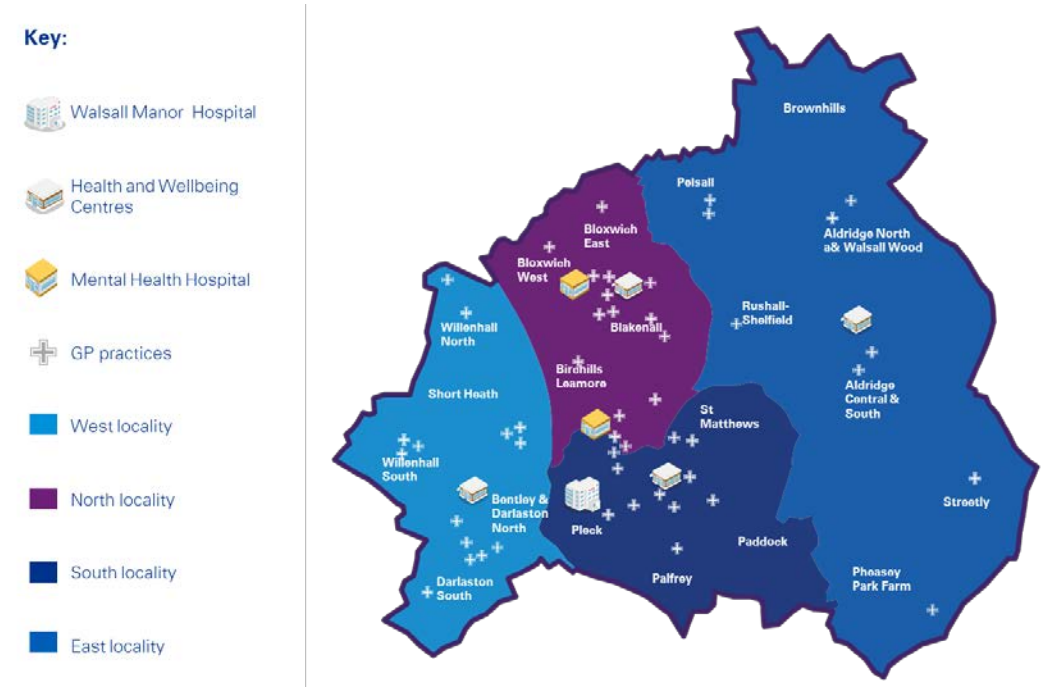


Figure 8 Representative Future Estates Configuration

This locality based model outlines the designation of four Health and Wellbeing Centres based across the four localities, from which citizens can access services (i.e. the SPA and Tier 0, 1, 2 and 3 services subject to the detailed design phase). These Health and Wellbeing Centres will form a hub for the Integrated MDTs working in the community and will be repurposed from existing estate, with the redeployment of resources into these locations. The Manor Hospital is illustrated here, however Tier 4 services also covers those specialist acute services provided outside of Walsall. In the case of the large East, South and West localities these are split into two, with a single multi-disciplinary, Place Based Team (PBT) serving a population of approximately 40,000 registered patients.

- North PBT– covering 58,115 citizens.
- East 1 PBT– covering 32,930 citizens.
- East 2 PBT – covering 42,530 citizens.
- South 1 PBT– covering 41,068 citizens.
- South 2 PBT – covering 49,060 citizens.
- West 1 PBT– covering 39,817 citizens.
- West 2 PBT – covering 39,131 citizens.

This helicopter view of the Walsall system is intended to provide a framework for delivering not only integrated services but shifting care away from the expensive acute environment and delivering a far greater volume of care in the community; alongside increasing citizen activation and community resilience. Each tier increases in the level of acuity and as such, the volume of care delivered at each tier should decrease. The benefits to this model are outlined in further detail below.

What will this mean for patients in the future?

A series of user stories have been generated to illustrate what the new operating model might be like for each of the users, mapped to the relevant tier of care, with a selection of these illustrated below

and further examples in the appendix (3). Note, these have not undergone detailed design with clinicians or professionals and are for illustrative purposes only.

Single Point of Access

Citizens will access all health and wellbeing services, from GP appointments to support for carers' through a single entry point; whether that is via a mobile app, phone number, website or by visiting their local Health and Wellbeing Centre based in their community. The SPA will be supported by an up to date digital directory of services available to be accessed across all the tiers.

Tier 0 - Resilient Communities
Citizens will be able to contribute towards and access locality based services to improve the health and wellbeing of themselves and their community throughout their lives. Preventative services focused on strengthening social networks to prevent isolation and volunteer health 'champions' to tackle issues such as obesity, workplace absence and unemployment will provide the bedrock of the community health and wellbeing services. Place Based Teams of health and care professionals from Primary, Community and Social Care will work alongside VSC colleagues to ensure citizens are provided with the right advice, opportunities and support to enable them to live healthy, fulfilled lives with maximum independence. VCSE Community Link Officers will operate from each of the Health and Wellbeing Services, providing a visible and accessible direct contact for Social Prescribing for citizens and health and care professionals (in addition to the phone, web and mobile access channels provided via the SPA).

Tier 1 - Integrated Primary (physical and mental health), Long Term Condition Management, Social and Community Services
Through the SPA, citizens will be able to arrange the most appropriate appointment for their health and care need from their Place Based Team, whether that is a telephone appointment with their GP regarding a mental health issue, a home visit from a social worker regarding their accessibility requirements or a group learning session held at the local Health and Wellbeing Centre for those newly diagnosed with diabetes. The organisational divisions will be less obvious, with the Place Based Teams co-located in many cases and working collaboratively to ensure citizens receive the right care, at the right time and in the right place. The use of regular, focused Multi-disciplinary team (MDT) meetings will be key to ensuring a holistic approach, allowing professionals to raise concerns or recommendations regarding their cohort of citizens. In line with the NHS Long Term Plan digital technology will be introduced to enhance primary are access and delivery across each locality.

Tier 2 – Specialist Community Services
This tier builds on the development of a network of Specialists providing care across Walsall. In the future state, this will allow citizens to access specialist services without visiting the acute hospital through the use of virtual clinics and digital tools such as remote monitoring devices and sensors. Data will be shared across providers and between citizens and their care providers, allowing real time reactions and informed decision making. This is in line with the NHS Long Term Plan which sets out a key objective that Outpatient services will be fundamentally redesigned in the future.

Tier 3 – Intermediate, Unplanned and Crisis Services

When a citizen requires immediate or urgent care that does not necessitate an acute emergency attendance, they will be able to access services 24 hours a day through the SPA. Through a triage process, citizens will be able to access the most appropriate professional for their needs. This will include mental health nurses and social workers who are able to respond to a crisis and provide the best level of care and support.

Tier 4 – Acute and Emergency Services

At this Tier, the services accessed by citizens will remain largely the same at they are at present, with 24 hour A&E services available at the Manor Hospital for those requiring emergency medical treatment and secondary care and specialist services provided by Walsall Healthcare NHS Trust and other secondary care providers in the region and nationally where necessary. Shared digital records across Walsall will allow clinicians and professionals' real time access to a citizen's engagement with health and care services, allowing for informed and improved decision making and better outcomes. Once a patient is at the hospital, either due to a referral or independently, they can expect to be assessed by a clinical team to ensure acute/emergency treatment is the best course of action, potentially utilising the clinical referral pathways into the SPA, to refer citizens to a service at a lower tier if necessary. If admittance is the most appropriate route, the PBTs will work collaboratively to ensure the citizen is discharged to a setting closer to home as soon as possible, improving outcomes and reducing the number of bed days.

What it could look like for Sophie...

Sophie

Age: 26

Job title: Unemployed

Sophie is an independent but isolated young mother, who's son Joshua has recently started school. She has had difficulty managing her alcohol intake since Joshua was born and has been abusing prescription drugs and cannabis to cope with the violent relationship she has with his father. Sophie has attended A&E on six occasions due to domestic violence but is extremely fearful of losing custody of her son.

Tier of Care:

0 1 2 3 4

1

The social worker at the MDT highlights the risk of domestic violence in the home, while her GP flags that she has struggled with drug and alcohol since Joshua's birth. They agree a Care Plan, to led by her GP and supported by the local family support VCS group.

Following a review from MASH, Sophie meets with a member of the Early Help Team at the Children's Centre, where they discuss how they can support Sophie in caring for Joshua and develop an Early Help Plan. Her Care-coordinator from the PBT also refers Sophie to the Beacon for Drug & Alcohol support.

2

Following the Early Help Plan, Sophie attends a Targeted Parenting programme at her local Children's Centre and receives support from specialist teams to ensure she and Joshua are not at risk from violence. The PBT also guide Sophie to access support for her substance dependencies.

2

With increased confidence and control over her dependencies, Matt works with Sophie and her Social Worker to enrol her on a parenting support programme. Sophie is able to engage better with Joshua and is looking at adult education to improve her employment opportunities.

0

At their monthly review, Sophie confides in Matt that she has not met with the councillor or domestic abuse support as she is fearful her partner will find out. Matt takes this information back to the MDT, who review her Care Plan.

4

Following an attendance at A&E for broken ribs, the consultant flags Sophie as at risk of domestic violence and refers to the PBT and the Multi Agency Safeguarding Hub (MASH) as she has a young child at home.

What it could look like for Karanjit...

Karanjit

Age: 85

Job title: Retired teacher

Karanjit is an intelligent and sociable woman, who enjoys visiting and writing letters to her friends. She is very independent and lives alone in the house she shared with her late husband, despite her family's wishes that she move in with them. She has had a number of falls in the last 5 years, with increasing frequency and also been treated for multiple, recurring UTIs.

Tier of Care:

0 1 2 3 4

Karanjit and her family work with the Care Coordinator to evaluate her home environment. With some small modifications and the installation of monitoring devices, everyone is satisfied Karanjit can continue to live at home safely.

1

By utilising a wide range of digital monitoring devices and software, Karanjit and her family can be assured that she is safe and well at all times. In the event of an emergency or fall, the staff at the Hub can act immediately with the appropriate course of action 24 hours a day, with full shared access to her care record.

3

2

Karanjit is able to attend her local community centre to meet her friends and speak to her Care Coordinator in her mother tongue, who arranges for her to be picked up to reduce her fall risk. She is also able to attend her outpatient appointments at the community centre and her family are pleased she is supported to remain independent.

What it could look like for Muhammad...

Muhammad

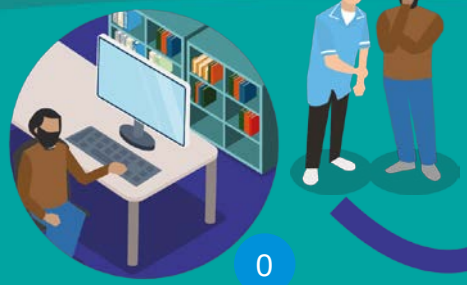
Age: 34

Job title: Unemployed

Muhammad has a passion for fantasy football and would love to spend more time socialising He has moderate learning disabilities and currently lives at home with his parents. Muhammad has little social interaction outside of the family home and is currently overweight and at risk of developing diabetes due to a poor diet.

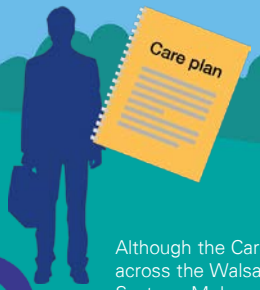
Tier of Care:

0 1 2 3 4



0

Muhammad is able to access information in his local library about a sports team for adults with learning difficulties and meets with a Care Coordinator who supports him to build a Care Plan, including attending weekly healthy living group.



Although the Care Plan is shared digitally across the Walsall Health and Care System, Muhammad's Care Coordinator ensures this is developed into a format and language that Muhammad is able to access easily and amend.

2

1

Muhammad's Care Coordinator arranges with Muhammed and his family an assessment of his needs at the local community centre. Muhammad is found to be eligible for an individual budget, and a package of care is put in place to support him and his parents.

0

Muhammad and his family lead their own support with the help from the Care Coordinator. Muhammad uses his budget to employ a personal assistant, who accompanies him to the job centre where the DWP run a weekly coaching session.

With renewed confidence and support from the learning disabilities employment scheme, Muhammad begins part time work in a shop – squeezing in fantasy football when he can.

Developing the "Do something" scenario

Using the tiered model of care outlined above along with the future state user journeys and clinical/professional input, the following elements have been identified as featuring in the desired future state.

Tier	Scheme/Service/Initiative
SPA	• Single citizen portal for accessing advice, appointments and support • Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • 24/7 Clinical/Professional triage • Citizen access to health records • Referrals management
0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing information and advice • Aids/adaptations and housing related support to keep people safe at home
1	• Multidisciplinary Place Based Teams of Mental Health, Community, Primary and Social Care professionals • Remote monitoring of citizens with some long term conditions • Telemedicine • Risk stratification and targeted intervention • Shared patient record • Care Planning • Care Home and at home In reach service • Greater Community/Specialist Nursing • Consultants in the community • Condition Specific Rehabilitation
2	• Outpatients in the community • Virtual Outpatient Clinics
3	• Integrated Rapid Response Service • Paramedics in the community
4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear routes to discharge, including Estimated Date of Discharge (EDD)

Evidence base for change scenarios

The table below provides an analysis of evidence based change initiatives that have been developed and implemented in different parts of the U.K. and internationally. These provide an evaluated reference point to the potential impact of these different change initiatives at both a base case and

best case level. This outlines the potential transformation opportunity and impact these initiatives could deliver depending on to what extent they are implemented across a local system:

Tier	Contributing Change Scenarios/initiatives	Impact	Base Case	Best Case	Rationale (sample)
SPA	• Single citizen portal for accessing advice, appointments and support • Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • 24/7 Clinical/Professional triage • Citizen access to health records	Increase in VCSE and Social Care contacts	20%	35%	Increasing citizen awareness of VCSE alongside promotion of these as alternatives to primary/community appointments will result in increased demand. Improved triage will also direct inappropriate primary care appointments to the correct service, as it is estimated 1 in 4 GP appointments could be avoided with more coordinated working, improved technology and access to MDTs. Furthermore, it is estimated a fifth a GPs time is spent dealing with social issues including debt, social isolation, housing, work, relationships and unemployment. (Making Time in General Practice, 2015).
		Reduction in Primary Care Appointments	15%	30%	Clinical triage and advice has been shown to reduce the requirement for face to face primary care appointments by up to 50% (Bunn, Bryne, & Kendall, 2004).
Tier 0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing information and advice • Aids/adaptations and housing related support to keep people safe at home	Reduction in ambulatory sensitive condition admissions	10%	20%	The Compassionate Frome project reported a reduction in emergency hospital admissions of 30% following the introduction of "community connections" (Abel & Clarke, 2018).
		Reduction in A&E attendances	10%	20%	The Nuffield Trust report published in 2017 outlines that self-care in long term conditions has been shown to reduce A&E attendances, in particular for adults with COPD, asthma and heart failure (Imison, et al., 2017).
		Increase in population self-care and self-management	5%	10%	It can be expected that through providing clear and easy access to self-care advice and guidance that the management of self-limiting illnesses will be improved (Rosen, 2014) , with citizens also likely to seek advice and treatment from their local pharmacists.

Tier 1	• Multidisciplinary Place Based Teams of Mental Health, Community, Primary and Social Care professionals • Remote monitoring of citizens with some long term conditions • Telemedicine • Risk stratification and targeted intervention • Shared digital citizen/patient record • Care Planning • Care Home and at home In reach service • Greater Community/Specialist Nursing • Consultants in the community • Condition Specific Rehabilitation • Referrals management	Reduction in ambulatory sensitive condition admissions	10%	20%	This Dutch model empowers teams of nurses to deliver all the care needs of their patient cohort. This has resulted in a 50% reduction in overall hours of care, with a 40% reduction in costs per patient. (Buurtzorg, n.d.)
		Reduction in ambulatory sensitive condition admissions	10%	30%	The Hull tele-monitoring service for heart failure patients reduced admissions in this cohort by 10%, with a return on investment of 48% (Cruickshank & Paxman, 2013). A 2015 Cochrane review revealed a 30% reduction of heart failure related hospitalisations when using remote monitoring (Inglis, Clark, Dierckx, Prieto-Merino, & Cleland, 2015).
		Reduction in A&E attendances	10%	30%	A Unified Care Plan programme in Birmingham found citizens that followed their care plan had a 50% reduction in A&E attendance, and a 25% reduction in non-elective admissions.
		Reduction in outpatient referrals	10%	35%	Electronic referrals, particularly when embedded within a shared electronic record have been shown to reduce inappropriate referrals and improve the quality of diagnosis (Blank, et al., 2014). Communications between GPs and consultants following an e-referral resulted in a 25% reduction of outpatient appointments (Scheibe, et al., 2015). The Torfaen referral evaluation project reduced referral rates in orthopaedics and emergency admissions reduced by up to 50% (Evans, 2009).
		Increase in Community and Social Care Contacts	10%	30%	The use of remote monitoring, remote consultation and telemedicine will enable citizens, their carers and professionals access to clinical advice and guidance without admission or attendance at an acute facility. This will result in more episodes dealt with remotely or by carers or nursing staff directly in the community. An increase in social care contacts will not assume a like for like increase in social care expenditure and will be modelled on marginal cost basis.

		Increase of Community contacts	20%	35%	The expansion of community nursing and shift of appointments from secondary to community services will increase the number of community contacts.
Tier 2	• Outpatients in the community • Virtual Outpatient Clinics • Condition Specific Rehabilitation • Referrals Management	Reduction in outpatient appointments	20%	50%	Renal e-clinics in Tower Hamlets allowed GPs to refer patients to a virtual clinic, resulting in 50% of referrals managed without the need for an outpatient appointment. (NHS England, 2016)
		Reduction in DNAs and length of outpatient appointments	25%	50%	A virtual outpatient scheme called 'Diabetes Appointments via Webcam in Newham (DAWN)' showed an increase in patient satisfaction and a reduction in DNAs by 50% (Vijayaraghavan, et al., 2015).
Tier 3	• Integrated Rapid Response Service • Paramedics in the community	Reduction in ambulatory sensitive condition admissions	40%	50%	NHS England (2013) states that 50% of all emergency call needing an ambulance could be managed at the scene or in the community, preventing unnecessary admissions. The Kings Fund paper (2014) also estimates that up to 30% of emergency admissions could have been avoided if appropriate alternative forms of care are available at the point crisis or if care had been managed better in the period leading up to the admission.
Tier 4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear Routes to discharge/ discharge planning	Reduction in ambulatory sensitive condition admissions	5%	10%	Front end streaming service pilots found a reduction in A&E attendance of 3.5% and non-elective admissions were reduced by an average of 5%.
		Reduced Length of Stay	10%	20%	Monitoring of a patients vital signs when in ICU has shown to reduce length of stay in this unit by 20%.
		Increase in Social Care and Community contacts	25%	30%	The impact of discharging patients from acute beds into the community will increase the demand on Social and Community Care to provide the necessary care for these patients.

Creating Realistic Targets for Walsall's Integrated Care System

While the evidence base for many new models of care both in the UK and globally is still in its infancy (very few studies apply the impact of individual initiatives at the system level overall), with many studies failing to provide high quality evaluations of the impacts (Imison, et al., 2017), a review by the Nuffield Trust in 2017 outlines that by delivering a combination of these initiatives, many of the projected impacts illustrated by The Nuffield Trust for improved patient care are promising, with the following changes to activity projections for 2020/21:

- 15.5 per cent fewer outpatient attendances (range 7–30 per cent).
- 9.6 per cent less elective inpatient activity (range 1.4–16 per cent).
- 17 per cent fewer A&E attendances (range 6–30 per cent).
- 15.6 per cent fewer non-elective inpatient admissions (range 3–30 per cent).

Taking these projections, the evidence base above and by applying a degree of local system knowledge, we are able to estimate the potential impact of change for the existing components of the Walsall system through a set of realistic system targets:

Area of Impact	Average of Base	Average of Best	Walsall Target Assumptions	Walsall Target
Increase in Community Contacts	12%	22%	Grow towards the full target increase in community health contacts	21%
Increase in population self-care and self-management	8%	15%	Deliver this through an integrated SPA and resilient communities offer to a full target of 15% over time. See below.	No impact on existing services
Increase in Social Care contacts	7%	13%	13% increase in social care contacts by year 3 feels realistic	13%
Increase in VCS contacts	10%	20%	Assumed that whilst this takes place it doesn't impact existing services - i.e. it is a consequence rather than a change in itself.	Not modelled no target
Increase of outpatient appointments in the community	10%	20%	Assumed that this is part of the increase in community contacts above and that it isn't additional to that. This recognises the challenges in Walsall around delivering true outpatients appointments in the community.	Not additionally modelled, no additional target

Reduced Length of Stay	10%	20%	Assumed that Walsall over time achieves an average position versus external evidence	15%
Reduction in A&E attendances	10%	25%	Assumed that Walsall grows towards the best case scenario with an up to 25% reduction in A&E attendances, supported by the relative increases in community contacts.	25%
Reduction in ambulatory sensitive condition admissions	15%	26%	Assumed that Walsall grows towards the best case scenario with an up to 26% reduction in ambulatory care sensitive admissions, supported by the relative increases in community contacts.	26%
Reduction in DNAs and length of outpatient appointments	25%	50%	Whilst this makes an efficiency from a usage of workforce time perspective it doesn't change the relative capacity and demand issues in the system and therefore hasn't been put forwards as a modelled scenario.	Not modelled no target
Reduction in outpatient appointments	20%	50%	Assumed that this achieves a level of circa 28% by year 3, recognising that there have been challenges in Walsall around delivering these at scale in the community.	28%
Reduction in outpatient referrals	10%	35%	Included in outpatient appointment changes	Not modelled no target

Reduction in Primary Care Appointments	30%	50%	We would expect to see a reduction in existing primary care contacts of circa 30% in Walsall (as large parts of what GPs currently do will be provided by the SPA, resilient communities and community contacts), albeit GPs will be asked to see more acute patients/manage the care of patients for longer and therefore we envisage no net impact on the capacity required in GP settings (albeit that capacity will need to change what it does).	Not modelled no target

These targets for the existing parts of the system are complemented by the addition of new system components, The SPA and the Tier 0 Resilient Communities offer. We've set a target of these new components growing to 678000 contacts with the people of Walsall per annum, once at full scale.

Note: at this stage we have not included a "big shift" associated with a shift from secondary to primary mental health services. Whilst this is a clear aspiration in Walsall, at this stage there is little evidence for this being possible within the current primary care infrastructure. Additional work would be required in the detail to assess the requirement for the development of primary mental health resources, as a component of enhanced integrated teams. We believe that a more detailed design exercise will inform this.

4 Financial and activity data analysis

The analysis within this business case provides a clear direction for the future model of care in Walsall and the aim of Walsall partners is to move to a position of financial balance alongside an investment into services to improve health outcomes for Walsall citizens. At present, without both efficiency savings and meaningful change to service delivery the baseline position will rise to a very significant gap of £174m by 2023/24. If existing efficiency savings plans are delivered and sustained (year on year), this gap reduces by £113m by 2023/24. Whilst positive this still leaves an additional gap by 2023/24 of £61m.

Without sustainable, system wide transformation in the delivery of care, the system in Walsall will continue to operate in an ever increase deficit yearly position for the foreseeable future. This is the challenge that must be overcome through genuine transformation of services. Achieving the efficiency saving expectations e.g. CIP and QIPP bridges a significant amount of the financial gap as described above and the total impact of delivering the change scenarios as part of the new operating model closes this further to £10.7million by the end of Horizon 3.

Current state – Affordability and capacity

The outputs of the model provide the extent to which the system is likely to be challenged by changes to activity and the impact of inflation on both income and expenditure. This includes forecast changes to the funding allocation received by the CCG as well as budgetary pressures on Local Authority funding.

We have taken a view of the income to the system at the top level – this includes commissioner funding allocation, local authority budget allocation for both Social Care departments and defined programmes delivered by WHT, and defined income to the local authority such as grants and contributions from the population, and income for specialised commissioning. This is compared to system expenditure at the point of delivery, which is a combination of CCG expenditure (where provider level data is unavailable e.g. GP data), and provider expenditure (where the data is available from providers like WHT and DWMHT that tells us the actual cost of treating people from Walsall).

This presents a true system view, without consideration of how the individual providers or commissioners might reconcile their own particular financial situation, and in that sense supports the integrated care system direction.

Proportion of spend by type of service

Analysis of commissioning data gives the following split of system cost, indicating which sectors are currently the biggest cost to the system. As expected, it is the acute sector that costs the most, and therefore in driving savings for the system as a whole, moving activity from a high cost to a low cost area like the Community will be beneficial from both a financial perspective, and the experience of the population.

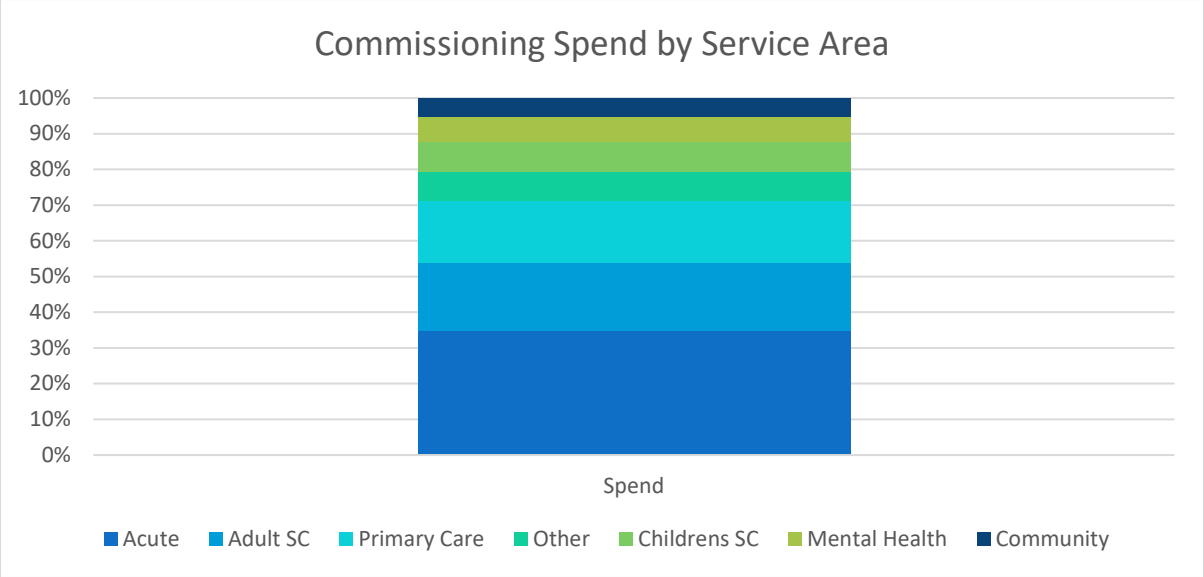


Figure 12 17/18 Base Case relative spend on of health and care services (without overhead allocation)

Income forecast based on the change in profile of the age population and wage and cost inflation

In considering the outputs of the data modelling process, a high level income (projected funding) forecast versus the projected expenditure forecast required to meet growth in activity/population and inflation is shown below.

The forecast system income as defined above for the health and care system is estimated at £675 million by 2023/24 which is an increase of £64 million. This is compared to a total system expenditure at the point of delivery, of £849 million, which is an increase of £216 million over the same period.

That increase is a combination of the inflationary impact of current costs, and the additional cost of treating increased demand (also adjusted for inflation). In the acute setting, this activity growth by the 2023/24 equates to 6,200 more A&E attendances, 16,000 more Inpatient spells, and 113,000 more outpatient appointments/procedures.

The 'do nothing' scenario not only increases running costs significantly but the forecast increased demand would also mean the need for a significantly enhanced and increased hospital facility in Walsall to accommodate the rise in inpatients (24 additional hospital inpatient beds at the Manor by 2021/22), provide more hospital outpatient appointments and undertake more day case procedures.

Horizon	Income	Expenditure	Difference
1 – 2019/20	629,850	679,284	(49,434)
2 – 2020/21	639,604	717,849	(78,246)
3 – 2023/24	675,568	849,999	(174,432)

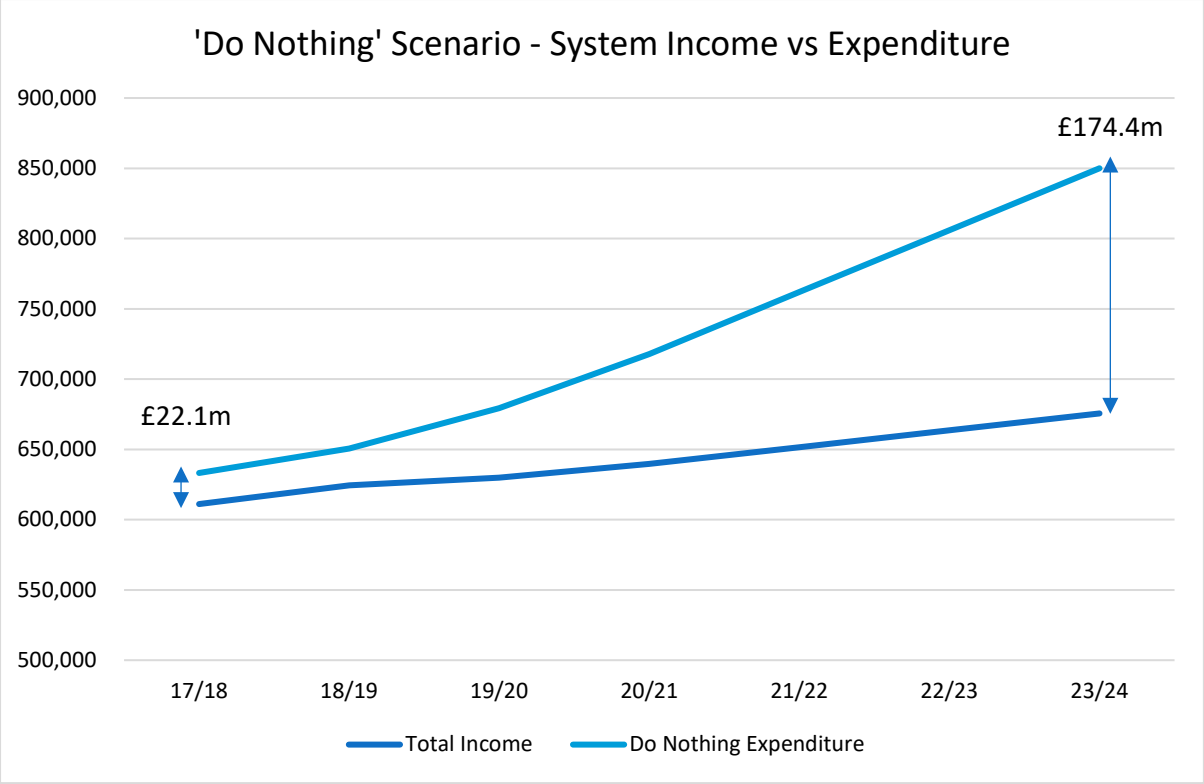


Figure 13 "Do nothing" Forecast

The above graph shows the impact within the 'Do Nothing' Scenario of the combined changes in activity forecast, and monetary inflation based on the assumption set out in Appendix 2.

From a provider perspective, in every case a proportion of costs are fixed but there is an assumption that income is variable in line with activity changes. Therefore any increase in activity results in an improvement in their individual financial position over time. What this does not take into account is the possible increase in fixed costs required to facilitate an increase in activity within certain departments. The greater the increase in activity, the greater the risk that fixed costs would also have to increase, which would worsen the financial position further. Additionally, the above does not include any planned Cost Improvement Programmes or other efficiencies that might reduce expenditure.

The most significant drivers of the worsening financial position are the increased system spend to serve the projected increase in activity, as well as almost £30million of funding pressures within the Local Authority from Adult Social Care and Children's Services alone. In simple terms, the expectation is that the system needs to do more, with less funding.

Current state Summary

In summary, the 'do-nothing' scenario results in a serious financial challenge which could not be addressed without a considerable increase in funding to compensate. As the rest of the developed world is realising, only major transformational change to our health and care systems will address the financial, capacity and staffing gaps which are being driven by increasing demand from the aging population.

Future state – Summary the 'Do-Something change scenario

The objective of the Walsall Together programme has been to deliver a much more integrated care system to improve the health and wellbeing of local people, thereby improving the quality of local health and care services, and delivering financial stability and efficiencies throughout the local health and care system.

As summarised above the 'do-nothing' scenario results in a serious financial challenge across the Walsall system. This approximately level of financial gap has been modelled as £174.4m by 2024. In order for the system to close this gap over time and achieve better quality of care requires a transformation plan to deliver a range of scenarios outlined in section 3 earlier. These are summarised below along with the financial impact of delivering these schemes over a period of time.

Developing the "Do something" scenario

Using the tiered model of care outlined in section 3 along with the future state user journeys and clinical/professional input, the following elements have been identified as featuring in the desired future state:

Tier	Contributing Change Scenarios/initiatives	Impact	Base Case	Best Case
SPA	• Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • Single citizen portal for accessing advice, appointments and support • 24/7 Clinical/Professional triage • Citizen access to health records	Reduction in Primary Care Appointments	15%	30%
		Increase in population self-care and self-management	5%	10%
		Increase in VCSE and Social Care contacts	20%	35%
		Reduction in ambulatory sensitive condition admissions	10%	30%
Tier 0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing	Reduction in A&E attendances	10%	20%
		Reduction in ambulatory sensitive condition admissions	10%	20%
		Reduction in A&E attendances	10%	20%

	information and advice • Aids/adaptations and housing related support to keep people safe at home			
Tier 1	• Multidisciplinary Place Based Teams • Greater Community/Specialist Nursing ("Buurtzorg" model) • Consultants in the community • Condition Specific Rehabilitation • Referrals Management	Reduction in ambulatory sensitive condition admissions	10%	20%
		Reduction in A&E attendances	10%	30%
		Increase of WHT outpatient appointments in the community	10%	20%
		Reduction in outpatient referrals	10%	35%
		Increase in Community and Social Care Contacts	10%	30%
		Increase of Community contacts	20%	35%
Tier 2	• Outpatients in the community • Virtual Outpatient Clinics	Reduction in WHT outpatient appointments	20%	50%
		Reduction in DNAs and length of WHT outpatient appointments	25%	50%
Tier 3	• Integrated Rapid Response Service • Paramedics in the community	Reduction in ambulatory sensitive condition admissions	40%	50%
Tier 4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear Routes to discharge/discharge planning	Reduction in ambulatory sensitive condition admissions	5%	10%
		Reduced Length of Stay	10%	20%
		Increase in Social Care and Community contacts	25%	30%

The above is shown on a scheme by scheme basis. We have taken a consolidated view of the shifts in activity to model through the system in the 'Do Something' scenario, representing the combined impact of the system wide changes set out above. Those shifts are as follows:

	Activity Shifts		
Description	2019/20	2020/21	2021/22
Shift Primary Care to Single Point of Access	15%	29%	43%
Increase Activity in Community Services	11%	16%	21%
Increase Activity in Social Care	7%	10%	13%
Reduction in A&E Activity	-10%	-18%	-25%
Reduction in WHT Inpatient Day Case & Non Elective Admissions	-15%	-21%	-26%

Reduction in WHT Outpatient Activity	-8%	-18%	-28%
Reduction in Length of Stay for Elective and Non Elective Inpatients	-15%	-15%	-15%

In section 3 The Strategy, the evidence base around some of the potential big shifts were outlined these highlighted the increased volume of care that is required to be delivered, or accessed individually, in the community, while the reduction in volume at the acute end of the systems reflects the "left shift" required in the new model; with the vast majority of care delivered in a lower acuity. The hypothesis shows:

- Reduced elective inpatient activity;
- Fewer A&E attendances;
- Fewer outpatient attendances;
- Fewer non-elective inpatient admissions.

As a result we would expect to see an increase in activity in primary and community settings in particular over a 5 year period:

- 15% rising to 43% shift of primary care appointments to the SPA;
- 21.25% increase in Community contacts;
- 13.3% increase in Social Care contacts, resulting in:
  - 13.3% increase in assessments completed;
  - 10% increase in Social Care Community Activity;
  - 3% increase in higher level Social Care interventions (e.g. Residential/Nursing Care)
- 25% reduction in A&E attendances;
- 26% reduction in Ambulatory Sensitive Condition Admissions;
- 28% reduction in outpatient appointments delivered in an acute setting.

"Do something" forecast

The 'Do Something' forecast is a combination of the shifts outlined above that occur as a result of the change in operating model, combined with some expected changes that are already scheduled to occur as a result of local changes and efficiency schemes. Due to the way efficiency savings at the Local Authority are calculated, these are included in the model outputs and not in the explicit savings assumptions outlined below.

Assumption	Description
CIP and QIPP (note, efficiency savings from the LA are also reflected in the model)	Through the data and finance work stream the impact of Cost Improvement Programmes (CIP) at a provider level, and Quality, Innovation, Productivity and Prevention Programmes (QIPP) at the Commissioner level were discussed. For the purposes of the high level business case, the inter-relation between CIP and QIPP schemes was not explored in significant detail although it is recognised that there may be some crossover between the two. Without exploring this in detail, we have applied a 2% CIP for NHS providers, and 1% QIPP to the end point system expenditure within the model outputs as a total 3% reduction in expenditure across the system. Future detailed design would consider these elements in greater detail and potentially account for crossover between the two schemes.

	The CIP and QIPP adjustment is applied cumulatively on the assumption that cost savings will be carried forward to the next year and then additional savings would be found.
Midland Met	The impact of the Midland Metropolitan hospital project which is expected to result in an increase in activity in the Manor in the order of: • 9,000 additional A&E attendances from outside Walsall • 2,694 additional Emergency Admissions resulting from the above There is an existing business case being carried forward for enhancements to the A&E department to facilitate this within the Manor Hospital. This carries with it an assumption of increased fixed costs of £5.4million per year. All of the above has been applied in the 'Do Something' model from 2021/22 onwards, however as this business case is focused on Walsall registered patients, this does not impact on the system position set out above.
Stroke Services Transfer	There are two other known adjustments in the model related to Stroke services which are no longer offered in the Manor Hospital. Firstly, 95% of this activity is transferred out to Wolverhampton from 18/19 onwards. Secondly, amendments to the delivery of Rehabilitation activity are projected to result in a 96% increase from 18/19 onwards.
WHT Non Recurrent Finances	Compared to the 17/18 baseline position there are elements of cost and income that were non recurrent and therefore in the 'Do Something' these are taken out. These are: • £800k reduction in income • £3.6million reduction in expenditure Both are applied from 18/19 onwards
Provider Sustainability Fund	From 19/20 onwards, an assumption that Walsall Healthcare Trust will receive £5million of PSF is applied. The impact on the scenario of this is limited as it effectively reduces the gap for WHT only which is not represented in the summarised figures for the system.
Big Shifts	As per the table above, the activity shifts in line with the change in operating model have been actioned to arrive at the 'Do Something' scenario output.
Activity Shifts – Fixed Costs	As discussed above in relation to activity increases in the 'Do Nothing' scenario, the model is designed to flex income and variable elements of cost only. Therefore, when making big shifts and moving associated costs,

	consideration would need to be given to stranded or stepped up fixed costs to manage that change in activity.
Length of Stay – Financial Impact	Whilst the model output is able to identify the potential reduction in bed usage as a result of big shifts in activity, it does not apply a financial impact. This is because there is no defined income or expenditure for a single bed day. Therefore, when exploring this in the detailed design phase it will be important to explore the reduction in beds and bed days at a detailed specialty level to consider where physical beds could be reduced in the hospital, and the associated reduction in fixed costs.
Primary care appointments transferring to the SPA	The model assumes a shift in primary care activity to be delivered by the SPA in future and that the SPA will be funded from the current and future primary care allocation. This will have the impact of primary care being able to deliver more focussed activity on patients who would normally have be seen in either the community or acute settings. The absolute number of primary care appointments is an approximation per the assumptions listed in Appendix 2.

Change scenarios - Outputs from the change scenarios £ and activity

The total impact of the above is shown in the graph below, whereby the combination of efficiency savings is applied to the 'Do Nothing' expenditure, and then the additional impact of the change scenarios in the 'Do Something' is shown separately.

Achieving the efficiency saving expectations e.g. CIP and QIPP , bridges a significant amount of the financial gap, and the change in operating model closes this further to £10.7million by the end of Horizon 3.

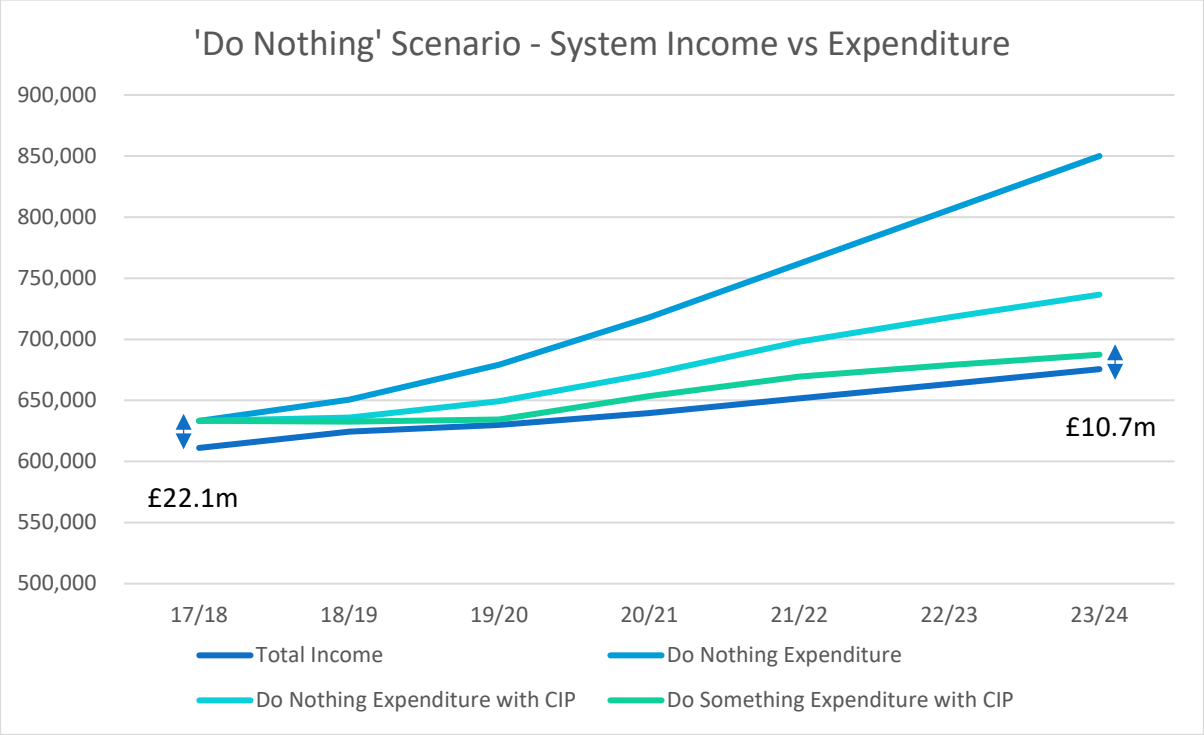


Figure 14 "Do Nothing" Forecast

	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Do Nothing Total Income	611m	624m	629m	639m	651m	663m	675m

Do Nothing Expenditure	633m	650m	679m	717m	761m	805m	849m
Difference	(22m)	(26m)	(50m)	(78m)	(110m)	(142m)	(174m)
Do Nothing Expenditure with CIP & QIPP	633m	635m	649m	671m	698m	718m	736m
Difference	(22m)	(11m)	(20m)	(32m)	(47m)	(55m)	(61m)
Do Something Total Income	611m	624m	630m	640m	652m	664m	676m
Do Something Expenditure	633m	647m	663m	698m	730m	763m	795m
Do Something Expenditure with CIP & QIPP	633m	632m	634m	653m	669m	678m	687m
Difference	(22m)	(8m)	(4m)	(13m)	(17m)	(14m)	(11m)

Table 2 "Do nothing" and "Do something" financial forecast

The above is achieved by moving activity into lower cost areas in line with the details set out in Section 3. This results in the following change in activity profile across key areas:

		Baseline 17-18	Horizon 3 - Do Nothing	Horizon 3 - Do something	Difference
Primary Care	GP Setting	1,595,199	1,595,199	917,239	-677,959
	SPA	0	0	677,959	677,959
Community Contacts		384,292	439,811	573,060	133,249
Social Care Contacts		12,484	13,584	16,263	2,678
Social Care - Short Term Residential/Nursing		744	800	840	39
Social Care - Long Term Residential/Nursing		1,096	1,227	1,287	60
A&E Attendances		91,800	97,993	59,266	-38,728
Inpatient Admissions		80,761	96,729	63,964	-32,764
Outpatient Appointments & Procedures		357,191	470,323	262,896	-207,427

Table 3 "Do something" activity impact

Financial impacts of the Walsall Targets

The system starting point of a £22.1million deficit in 17/18 for Walsall is made up of a number of elements and does not necessarily equate to the combined surplus deficit position of each organisation. At best it represents the true cost of care against the income to the system. Therefore, whilst the individual deficit positions of each organisation add up to approximately £30million, this highlights inherent inefficiency that would be addressed by a move to an integrated care system.

This gives a net change to expenditure as a result of the Big Shifts, as follows:

£000s	Horizon 1	Horizon 2	Horizon 3
Community Setting	2,903.27	4,414.477	9,410.341

Social Care	1,966.165	4,196.714	10,032.14
Accident & Emergency	-707.487	-1,288.02	-6,453.36
Inpatients	-9,436.62	-13,631.5	-44,745.6
Outpatients	-1,504.76	-4,034.3	-12,847.8

Table 4 Net "Do something" expenditure impacts by setting

Financial impacts of the big shifts by organisation

The financial impact of these big shifts and change in income and expenditure by CCG and each of the WT providers is shown in the table below;

Financial Impact in £000s					
			Horizon 1	Horizon 2	Horizon 3
1		Community Setting	2,903.27	4,414.48	9,410.34
1a		WHT - Expenditure*	2,903.27	4,414.48	9,410.34
1b		WHT - Income (CCG Spend)*	3,383.76	5,145.07	10,967.74
2		Social Care	1,966.17	4,196.71	10,032.14
2a		ASC - Expenditure	1,966.17	4,196.71	10,032.14
2b		ASC - Income	197.94	452.46	1,135.22
3		Accident & Emergency	-707.487	-1,288.02	-6,453.36
3a		WHT - Expenditure	-328.83	-598.66	-4,757.05
3b		WHT - Income (CCG Spend)	-918.49	-1,672.16	-4,114.68
3c		Other Provider - Income (CCG Spend)	-378.66	-689.36	-1,696.30
4		Inpatients	-9,436.62	-13,631.50	-44,745.60
4a		WHT - Expenditure	-5,246.74	-7,567.58	-32,426.14
4b		WHT - Income (CCG Spend)	-13,756.17	-19,191.29	-37,248.37
4c		Other Provider - Income (CCG Spend)	-4,189.88	-6,063.95	-12,319.45

5	Outpatients		-1,529.69	-4,061.55	-12,882.71
5a		WHT - Expenditure	-686.56	-1,692.66	-5,198.60
5b		WHT - Income (CCG Spend)	-2,122.29	-5,142.87	-15,677.14
5c		Other Provider - Income (CCG Spend)	-843.14	-2,368.89	-7,684.11

Table 5 Financial Impact of the "Do Something" by setting

Financial risks and mitigations

A full set of the assumptions used in the development of this model is provided in the appendices (2), however it is worth highlighting here that the Finance and Contracting group have acknowledged that the NHS activity growth assumptions are higher than anticipated and therefore add up to a significant increase in activity. The impact of this, should this increased growth not materialise in the future years, means the expenditure will be less than forecast. This will have a knock on effect on the level of impact achieved from the change scenarios.

A second assumption worthy of note is that all CIP and QIPP s for all organisations, apart from the Local Authority where there are not applicable, are assumed to have been fully delivered over a five year period. The consequence of these not being fully realised, the year on year decrease would not be achieved.

Investment requirements

Delivering the transformation required to implement the new Operating Model will require additional investment as a cost of change to the system to deliver the benefits of moving to a move integrated health and care model. These have been included in the model based on an international evidence base for transformation of this scale.

We have carried out a bottom-up costing of the leadership and governance requirements, additional capacity and transformation costs required over each horizons, which is summarised below. These equate to a larger 1.53% of system spend during horizon 1, decreasing to 1.50% in horizon 2 and an average of 0.69% annually across horizon 3. This also includes a budget of 5% of Primary and Community Care spend for dual running and additional Primary and Community Services capacity.

The next stage of detailed design will utilise this as an investment budget which will sit with the CCG and will be triangulated on a tiered programme basis against a bottom up analysis of the tiered Operating Model changes described in section 8, Mobilisation and Implementation, which also includes estimated costs of key enablers such as estates reconfiguration, workforce development and technology transformation.

			Horizon 1	Horizon 2	Horizon 3		
£000s	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Investment	-	-	9,240	9,240	4,364	4,364	4,364
Saving (assuming CIP and QIPP is achieved)	-	-	15,021	18,131	28,701	39,104	49,157

Cumulative Total Investment	-	-	9,240	18,480	22,844	27,208	31,572
Cumulative Total Saving	-	-	15,021	33,151	61,852	100,956	150,113

Table 6 Summary of Investment Requirements

Over a 5 year investment profile we would expect a budget of £31.6m will act as a key catalyst to fund a year on year saving to the system of £150m in total to close the finance gap described above. A detailed breakdown of these figures is provided in Appendix 5.

5 Governance Arrangements

The ICP Board will be established as a sub-committee of Walsall Healthcare NHS Trust's Board as the nominated Host Provider. The ICP Board will be responsible for the delivery of the business plan and chaired by a newly appointed Non-Executive from WHT, whose appointment will be made by the partner organisations. A newly appointed Director of the Walsall Together ICP will be responsible for executing the ICP Board strategy and objectives with support from a Walsall Together ICP Senior Management Team.

This structure supports implementation of the dual responsibility of the ICP Board; for the oversight of services contractually in scope and for the wider system integration and

Overview

An essential enabler for the proposed Operating Model and commercial arrangements is a robust and clearly defined governance structure in which to operate and provide sufficient assurances to Boards and Cabinet, both in the initial year from April 2019 (Horizon 1) and beyond (Horizons 2 & 3).

At the commencement of the business case development, the Programme Steering Group established a Governance and Organisation working group tasked with the responsibility of developing the approach to governance. The details outlined below are therefore the agreed outputs of this workstream.

The Host Provider Model

Host Provider arrangements were identified as the most appropriate model to move forward the Walsall Together programme as part of the Phase 1 Case for Change. The intention is that the Host organisation will provide a vehicle for governance of the ICP by establishing an ICP Board and management structure within the framework of its existing corporate structure. The ICP partners would work to initially align the objectives and agree the processes before delegating authorities to their representatives on the ICP Board through an Alliance Agreement and a Section 75 agreement. A Section 75 is a legal requirement to allow for partnership working between local authorities and NHS bodies in relation to certain functions. It allows for the pooling of local authority and NHS budgets in order to deliver these services or functions more effectively.

In this way the Alliance Agreement would be the mechanism for defining the membership and terms of reference for the ICP Board, with the additional Section 75 supporting the legal requirements for Walsall MBC. The Alliance Agreement would also be the mechanism for defining the final agreed membership and terms of reference for the ICP Senior Management Team and for providing resources to enable the management team to carry out its functions.

This is a specific variation on the more familiar Lead Provider model and distinctly so, due to the delegation of decision making authority to a Board with representation from partner organisations rather than the Board of the host/lead provider. Decisions to delegate authority to the Board will be made as and when this this required and agreed by the Boards of the partner organisations.

It is proposed the ICP Board will therefore be established as a sub-committee of the Host Provider's Board. While the structures outlined below are intended to support governance arrangements from April 2019 onwards, the WT partner organisations anticipate that these are subject to change with the emerging objectives and direction of the ICP as it moves into Horizon 2 and 3. Where possible, the

arrangements beyond 2019/20 are outlined on the basis that these are agreed in principle only at this stage. Any further changes would be subject to agreement by all partner organisation's boards and governing bodies.

Options Appraisal

The Walsall Together Partnership Board agreed that the role of the Host Provider could have been potentially filled by one of three organisations in the area; Walsall Metropolitan Borough Council; Walsall Healthcare Trust, or Dudley and Walsall Mental Health Foundation Trust. This is documented in the *Case for Change* agreed by WTPB in January 2018:

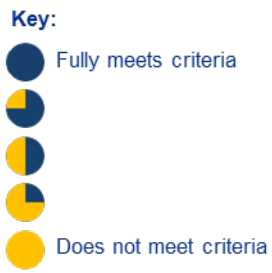
'*In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale.'*

During this second phase of planning, the Governance group identified seven key factors to be considered in selecting the host organisation.

Key factors	Rationale
Credibility	The host organisation should have a credible track record in corporate governance, quality of service and financial management
Vires	The host organisation should have the legal powers and relevant regulatory accreditation(s) or approvals to perform the host functions
Corporate structure	The host organisation should have a corporate structure within which an integrated care Board and management structure may operate
Conflicts	The host organisation should not be conflicted out or perceived to be conflicted out of performing the host functions
Scope of services	The host organisation should provide a significant scope of the services to be integrated through the Walsall Together programme
Strategic fit	The strategic priorities of the host organisation should be aligned to the strategic aims and direction of the Walsall Together programme
Management capacity	The host organisation should be able to invest sufficient management capacity to developing the host functions

Table 7 Considerations for a Host Provider

Each organisation was evaluated by the group against each of these factors, with a summary of this process provided in appendix 5. A summary of this appraisal is provided below.



Key factors	Walsall Council		Dudley and Walsall Mental Health Partnership Trust		Walsall Healthcare Trust	
Credibility	Credible candidate.		Credible candidate, good CQC rating.		Credible candidate due its role as the main provider of hospital and community health services and its location in Walsall – however rated as overall "Inadequate" by the CQC.	
Vires	Not licenced as provider of NHS healthcare services.		Licenced provider of NHS healthcare services.		Licenced provider of NHS healthcare services.	
Corporate structure	Corporate structure with powers to provide health related services.		Corporate structure within which an integrated care Board and management structure could be developed.		Corporate structure within which an integrated care Board and management structure could be developed.	
Conflicts	Could be perceived conflict between host provider functions and local authority commissioning functions.		None identified.		None identified.	
Scope of services	Responsible for commissioning/provision of significant scope of services within Walsall Together.		Responsible for providing community mental health services within the scope of the Walsall Together programme, as well as inpatient mental health services for Walsall outside of this programme, and services across a wider geographical footprint.		Responsible for providing a significant scope of the services to be integrated over the next phase of the Walsall Together programme, including community health services and acute hospital services at the Manor Hospital.	

Strategic fit	The strategic priorities of the Council are aligned to the aims of the Walsall Together programme although its focus is on developing its role as a strategic commissioner. Has not set out an ambition to extend its role in providing NHS services.		Strategic aims are aligned to the aims of the Walsall Together programme although will have other key priorities due to position in the Dudley ICS and across the wider STP footprint.		Strategic priorities are aligned to the aims of the Walsall Together programme although other key priorities include acute hospital integration and potential chain arrangements across the Black Country.	
Management capacity	To take on the role of the host organisation would require diversion of management resources.		Wider footprint may put pressure on senior management capacity to fulfil role of Host Provider.		Most able to prioritise senior management resources to fulfil the role of the host and to engage with partners in developing its functions.	

Table 8 Host Provider Appraisal Summary

Operation of the ICP Board

As a result of the options appraisal outlined above, the Governance working group, led by the Director of Commissioning for Walsall CCG and the WTPB recommends that WHT fulfil the role of host organisation. While the areas in which WHT does not fully meet the criteria is recognised by the Steering Group and the WTPB, partner organisation are supportive of the provider that currently delivers the largest volume of services e.g. Secondary and Community Services fulfilling the role of Host Provider.

WHT is closely embedded within the Walsall community and also provides the bulk of hospital and community services to be integrated during Horizon 1 of the Walsall Together programme. The strategic priorities of WHT and its medium term quality and financial improvement objectives are also closely aligned to the strategic aims of Walsall Together programme.

The alternative options are also credible, but are not recommended at this time. For the Council to fulfil the role of the host provider would risk creating public misconceptions that developing the Host Provider model in Walsall could lead to services and staff being transferred out of NHS bodies. This could appear at odds with the recommendations of the Parliamentary Health Select Committee that integrated care partnerships should be established as NHS Bodies and would be a distraction from the Council developing its role as a strategic commissioner, whilst DWMH provides a smaller scope of services in Walsall compared to WHT.

Risks

The main risks to be managed in selecting WHT as the host organisation are to balance the investment of senior management attention in developing the host functions against the need to maintain focus on delivering its own statutory quality and financial improvement plans. This will also be a risk to manage in building public confidence in the Walsall Together programme given the need to address issues identified by the CQC rating of WHT as 'Requires Improvement', in addition to the failure to achieve key financial metrics.

WHT will need to be able to assure NHSI that these risks are being managed adequately and that it has the support of its commissioners and provider partners in developing its role as the host organisation. This will be addressed as a primary objective for the ICP Board upon its formal appointment in April 2019, with further details outlined in Mobilisation and Implementation.

A proactive communications strategy will also be required to set out the aims and benefits of the Walsall Together programme and to explain the role of the Host Provider as a vehicle for delivering integrated care. In addition to setting out key messages, communications will also need to address potential misconceptions about potential major service reconfigurations, privatisation, takeovers or staff transfers.

Establishment of the ICP Board

The formal establishment of the ICP Board for April 2019 is a primary recommendation of this paper, to provide the governance for the ongoing and continual development and delivery of the Walsall Together Programme. It is expected that the below details be formalised through an Alliance Agreement that will establish Terms of Reference including the delegated authorities for the ICP Board from April 2019.

As Walsall Healthcare Trust has been identified as the recommended Host Provider for the Walsall system, for clarity, the Board of the ICP will exist as a sub-committee of Walsall Healthcare NHS Trust's Board, with the ICP Director having full voting rights on WHT's Board. An additional Non-Executive Director appointment will be made to the WHT Board, the appointment to be made by all partner organisations. This individual will chair the ICP Board.

While the establishment of an ICP Board will provide the forum for decision making and strategic direction, in order to formalise the arrangement, the WT partners intend to enter into an Alliance Agreement. Further detail is provided in the Alliance Agreement section below.

Roles and Responsibilities

The primary responsibility of the ICP Board will be the integration and transformation of services deemed to be "in scope" and not for the delivery of those services.

The functions of the ICP Board would be to:

- Provide strategic leadership and oversight of service delivery for in-scope services and for ICP programme work streams;
- Oversee the development of, and transition to, new models of care in priority areas/in scope services;
- Make decisions in the context of the shared vision for the Walsall Together Partnership, and as detailed in the Alliance Agreement;
- Consider investment and any disinvestment decisions across the partnership;
- Collectively hold ICP partners to account for upholding the commitments made in the Business case, and the Alliance contract.

Partner organisations, through membership of the ICP Board will not be expected to delegate responsibility for service provision but to be a partner to the integration and transformation of services. The legal responsibility for the delivery of services will remain with each of the current providers, alongside the responsibility for the quality of those services and the assessment of these by regulatory bodies such as the CQC.

As a sub-committee of WHT, the ICP Board will report to WHT's Board, alongside each of the parties to the Alliance Agreement. It is also anticipated that as the ICP Board will effectively replace the Walsall Together Provider Board, this will be formally closed as a forum for the Walsall Together Providers to plan integrated care.

Delegated Authority

During Horizon 1 there will be no delegated authority to the ICP Board from the partner organisations. At such a time that this is required, this will first be referred to the respective Partner's governing bodies for approval. It is anticipated that during Horizon 1, the full scope of services and any necessary delegation of authority will be reviewed and refined by the partners, with iterations anticipated throughout the Horizon 1 period and beyond. The full Terms of Reference (ToR) for the ICP Board will be established through the Alliance Agreement and while in draft currently for finalising in the period prior to April 2019, a summary is provided below, with the current draft ToR provided in Appendix 7:

Extracts from the ICP Board Terms of Reference (Appendix 7)

Constitution

1.1 The Integrated Care Partnership Board is established by the Participants, who remain sovereign organisations. It is established as a Board Committee of the host provider to provide a governance framework for the delivery of the Walsall Together Plan.

1.2 The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

1.3 Each Partner shall delegate to its representative to the ICP Board, such authority as is agreed to be necessary in order for the ICP Board to function effectively in discharging the duties within these Terms of Reference. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation or similar.

1.4 The ICP Board is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

Purpose

2.1 The ICP Board has been established to provide strategic direction to the partnership and has responsibility for the delivery of the Walsall Together Plan.

2.2 Thus the ICP Board will have responsibility for the oversight of services contractually in scope and for the wider system integration and transformation

Membership

It is proposed that the ICP Board should have a mix of executive, professional and non-executive membership which reflects the nature and scope of the partnership, the purpose and duties of the Board and is not too large to risk its ability to operate effectively. An outline of the proposed membership is provided below:

- The ICP Board to be chaired by a newly appointed non-executive of the host provider.
- Representation from partner organisations:
  - Chief Executive, Walsall Healthcare Trust.
  - Chief Executive, Dudley and Walsall Mental Health Partnership Trust
  - Director of Adult Social Care, Walsall MBC
  - Director of Public Health, Walsall MBC.
  - Director of Children's Services, Walsall MBC
  - Chief Officer, Walsall CCG
  - Chief Executive, One Walsall.

- GP representation.[1]
- Director of Walsall Together.

- Professional Representation:
  - Consultant, professional lead for in-scope hospital services.
  - Consultant, professional lead for mental health.
  - Professional lead for nursing and AHPs.
  - Professional lead for Adult Social Care
  - Professional lead for Children's Services.

- In attendance functions (by invitation):
  - Finance Director.
  - HR Director.
  - Strategy Director.
  - Governance Director.

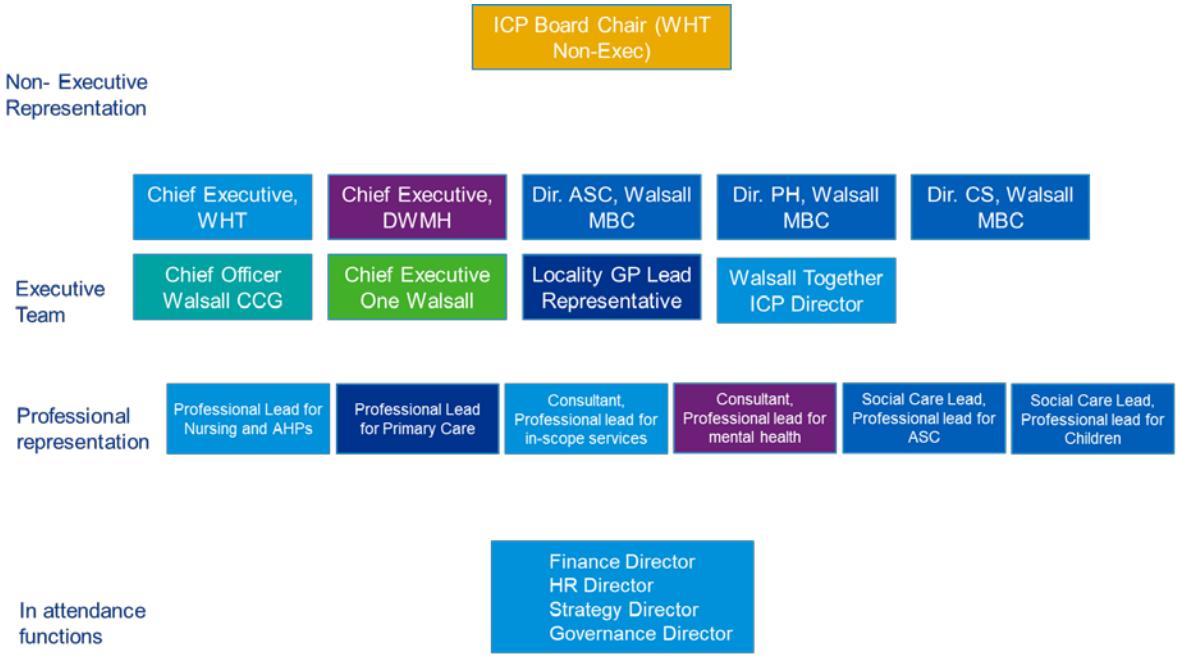


Figure 15 Walsall Together ICP Board

Wider Governance and Relationships

The governing arrangements illustrated in this business case are focused exclusively on the Walsall Together partners, however the Walsall Together ICP Board will interface with existing health and care governing bodies in Walsall, such as the Joint Commissioning Committee (JCC) and the Health and Wellbeing Board (HWBB). Ultimately, the ICP Board is accountable to the WHT Trust Board and WHT is now an active member of the HWBB.

[1] While there are a number of options for GP representation, at this stage it is proposed this position be rotated/shared between the currently appointed four GP Locality Representatives. Each GP Locality Representative will constitute a member, with a single representative vote.

This place-based programme must also ensure it continues to align with and support regional plans, including the Black Country STP/ICS. These relationships ensure the ICP operates in line with the regional health and care objectives and support the NHS Long Term Plan and STP plans.

Formal Powers

The formal powers of the ICP Board will be established through the Alliance Agreement, to be in place for April 2019.

ICP Senior Management and Delivering the Transformation

The strategic direction and plans from ICP Board will be effected through the newly created ICP Senior Management Team, under the leadership of the Walsall Together ICP Director. This structure ensures alignment between strategic and management of integration of services and provides a direct line of communication.

The ICP Senior Management team will be responsible for delivering the ICP Board's purpose and priorities and support the Board as a formal operating group. It will be required to interface with each of the WT partner organisation's Senior Management Teams to ensure the delivery of ICP "in-scope" services are meeting the ICP Board's objectives.

The diagram below outlines the proposed structure of the ICP Senior Management Team to be established during 2019/20:

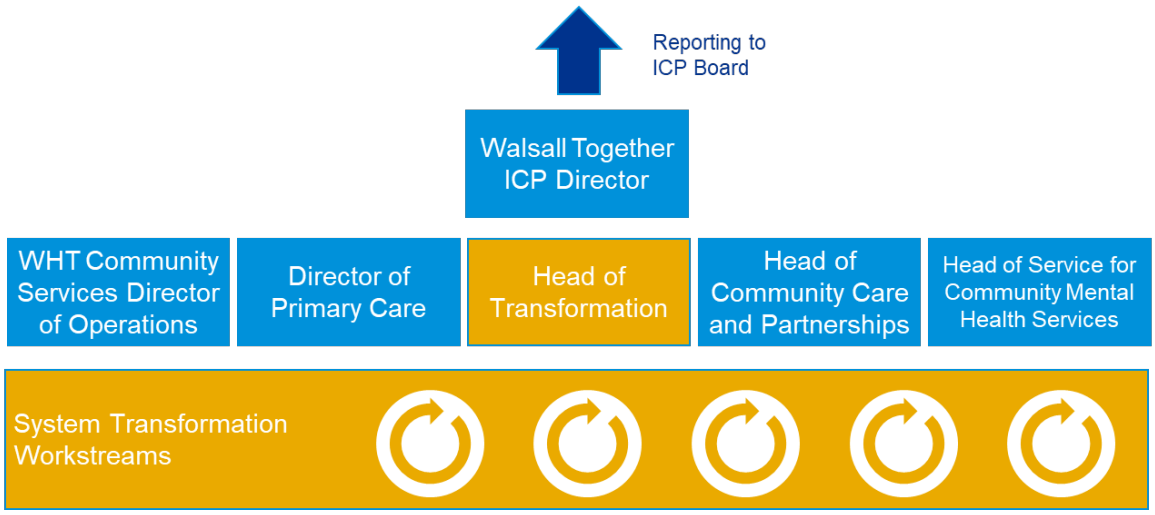


Figure 16 Walsall Together ICP Senior Management Team 2019/20

The Walsall Together Director will have 5 senior leadership colleagues from across the system, including some new roles, each with the following responsibilities:

- Walsall Together ICP Director – Oversee transformation and integration for the initial proposed 3 year timescale with 5 senior colleagues in Year 1;
- Community Services Director of Operations – This existing role from WHT will be responsible for the operational management of the in-scope community and acute services;
- Director of Primary Care – This existing role will be responsible for supporting the development of Integrated Primary Care;
- Head of Community Care and Partnerships – A current Adult Social Care post from the Council will assume responsibility for the management of in-scope care services;

- Head of Service Community Mental Health Services – Will be drawn from the Senior Management Team at DWMH, this role will be responsible for the management of in-scope mental health services;
- Head of Transformation – responsible for transforming the health and care delivery model overall and managing the transformation programme office.

This group is ultimately charged with two tasks; delivery of "in scope" services and transformation of the wider system as per the desired operating model. To achieve this, there are two capability and capacity gaps to be filled:

- The establishment of a robust Transformation Programme Office (TPO) that drives the programme forwards and manages stakeholder relationships through to delivery
- The establishment of a clear and repeatable process for co-designing the detailed service change required and actually implementing it through front line staff.

The TPO will include workstream leads who will be held to account for workstream delivery through the Head of Transformation and TPO. The SMT will also invite representatives of Public Health and Children's Services to develop their future involvement in the Alliance. This reflects the way in which the role and structure of the SMT will mature over time, with the initial expected requirements for each horizon outlined below:

Horizon 1 – A mix of existing roles representing the current line management of the "in-scope" services. Full representation of all current organisations is required. During this initial year the SMT will be supported by additional management, including a "Lead Professional Group" and two new management roles; a "Lead Commissioner for Resilient Communities" and the "Single Point of Access Lead."

Horizon 2 – It is anticipated that some senior and operational roles will become joint appointments as the ICP gains traction;

Horizon 3 – A truly integrated line management structure will be designed and implemented in accordance with the WT Alliance objectives; some roles will blend accountability across professions, organisations and statutory duties (including regulations) others will not as appropriate.

The TPO office should adopt a rapid cycle implementation approach that takes strategic objectives and engages frontline staff in real world change to deliver it on the ground. Interdisciplinary action teams should be participating in high intensity workshops where they design and implement new care pathways for patients. Solutions are developed using existing resources and infrastructure. In a relatively short period of time, new ways of working – can be launched, embraced by staff, and real impact in terms of process and outcome change delivered.

Alliance Agreement

The WT Partners have identified an Alliance Agreement as the preferred vehicle for formalising the governance arrangements from April 2019, with an initial duration of two years, with an option to extend. The Alliance Agreement is still in development and will be subject to all partner organisation Board and governing body sign off prior to planned implementation in April 2019, as shown in the implementation timeline (figure 22).

This time frame provides enough space for the planning and initial implementation and evaluation that will take place during this period, without requiring further contractual amendments before April 2021. This also correlates with the model forecasts, allowing for a degree of validation of progress against a basepoint.

The Alliance Agreement will not be an NHS contract as outlined in Section 9 of the National Health Service Act 2006, but supplements and operates in conjunction with existing Service Contracts. All members remain separate sovereign Partners, and will work together over the period of this agreement positively and in good faith, in accordance with the ICP Principles, to achieve the ICP Objectives.

The Objectives as agreed by partner organisations are to deliver sustainable, effective and efficient Services with significant improvements over the term of the agreement. Members of the ICP have agreed the following:

To work collaboratively to:

- Improve the health and wellbeing outcomes for the Walsall population;
- Improve care delivery and quality standards in the provision of care;
- Meet the statutory financial duties of all partner Partners.

The Alliance agreement enables a formal mechanism in which the ICP Partners will work together to perform the obligations set out in the Alliance Agreement and, in particular, achieve the Alliance Objectives.

In order to achieve the objectives we will work to the following principles:

- work towards a shared vision of integrated service provision, acknowledging the phasing required in the journey to an Integrated Care System;
- commit to delivery of system outcomes in terms of clinical and professional matters, Service User experience and financial matters;
- commit to common processes, protocols and other system inputs for those in-scope services, as defined within this case;
- take responsibility to make unanimous decisions on a Best for Service basis;
- always demonstrate the Service User' best interests are at the heart of Our activities;
- adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;
- establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law compliance;
- adopt collective ownership of risk and reward, including identifying, managing and mitigating all risks in performing our respective obligations in this Agreement; and
- co-produce with others, especially service users, families and carers, in designing and delivering the Service,

To achieve the ICP Objectives, the Partners of the ICP will operate from the principle of professionally led, collaborative working between the Partners, in order to ensure the services meet the health and care needs of the local population.

The ICP Board will be accountable to the boards and governing bodies of all participants, to enable recommendations to be made between the ICP Partners. This approach does not require formal decision making delegations from statutory boards and is founded on a number of Governance Principles, namely that we will,

- Strive to reach joint consensus prior to any further decisions which may be required at an organisation level;
- Maintain strong clinical/professional leadership through a clinically/professionally led process to ensure that decision makers can be confident that changes are being made in the best interests of patients;
- Provide oversight to the operation of the alliance agreement;
- Use business as usual / standard governance procedures as widely as possible to take decisions;
- Commit to wider integration with Local Government and other strategic partnerships which add value for the taxpayer;
- Remain transparent and open to scrutiny from patients and the public; and
- Provide assurance in a coherent manners to Our regulators.

Through the Alliance Agreement the partners will define the membership and Terms of Reference for the ICP Board, which will be the team responsible for leading the Alliance. The ICP Board will hold to account the Senior Management Team.

6 Commercial arrangements

The contractual structure of the ICP will be virtually integrated from 2019/20 under an Alliance Agreement that will provide for integrated contract management of in-scope services under oversight of the ICP Board. Contractual accountability lines will continue to be bilateral between commissioners and providers as in 2018/19. Contract variations will be implemented to define where the integrated contract management processes would apply. Any future commissioning decisions to consolidate in-scope services within a single contract, would be subject to procurement rules. In the interim, providers may agree, subject to commissioner approval, to subcontract services to the Host as the ICP governance matures and as they can be assured in delegating contractual responsibilities.

Overview

Key terms of the commercial model

As recognised above, the commercial model from April 2019-March 2021 is 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. It is also intended to support the necessary investment decisions to be made by Walsall system partners to support the other enablers of the Operating Model, such as technology, workforce and estates reconfiguration.

Contractual structure

During Horizon 1, contractual accountability lines will continue to be bilateral between commissioners and providers as in 2018/19. The addition of an Alliance Agreement will provide a mechanism for integrated contract management of in-scope services under oversight of the ICP Board (i.e. integrated contract management will be a hosted function). Contract management reviews and variations will distinguish between in-scope and out-of-scope services under separate clauses and schedules to define for which services the 'hosted' contract management processes would apply. There will be no separate bilateral contract management processes for in-scope services to avoid duplication.

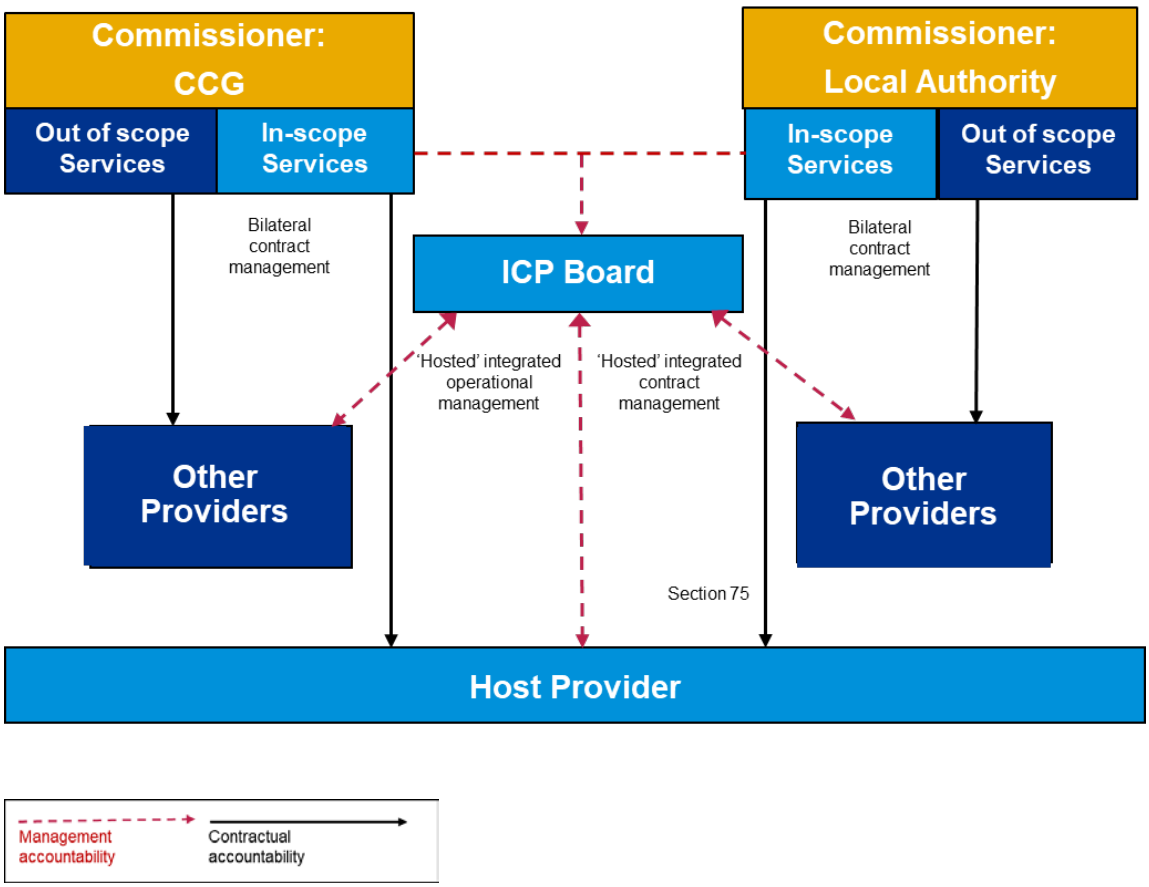


Figure 18 Contractual arrangements for April 2019/20

Objectives

The effect of this arrangement will be to create a virtually integrated contractual structure. This virtual integration, as described by NHS England, uses an Alliance agreement as a "wrapper" around existing contracts, allowing existing commissioning contracts to remain in place but providing an environment in which the management of services can be integrated. This will enable an integrated approach to contract management under oversight of the ICP Board (i.e. integrated contract management will be a hosted function).

The primary objective of this approach is intended to strengthen collective accountability for integration of in-scope services to deliver the ICP aims and objectives for improving outcomes and value. A secondary objective is to avoid duplication in parallel contract management processes, which should improve the efficiency of these processes and may potentially reduce transaction costs. The ICP Board's ability to influence decisions, such as wider commissioning within Walsall and regionally, is expected to evolve over time and with ongoing guidance and support from regulators, such as NHS England.

This virtual integration arrangement can be established within the existing bilateral contractual structure as a transitional measure without delay. Any potential future commissioning decisions to consolidate services under a single contract for integrated service delivery would be subject to procurement rules and NHS regulatory oversight. In the interim providers may decide, subject to commissioner approval, to subcontract services to the Host as and when the ICP governance matures and they can be sufficiently assured in delegating contractual responsibilities that they will remain accountable for.

Risk sharing

For 2019/20 the default assumption is that any risk sharing is expected to be bilateral between commissioners and providers. However, the Alliance Agreement will provide a framework within which a multilateral risk sharing mechanism could be developed for Horizon 2 and beyond.

7 Enablers

The Operating Model outlined above will require a drastic transformation of the way services are currently accessed and delivered, impacting on citizens, professionals and organisations. It will be the responsibility of the ICP Board to ensure the necessary enablers are provided at the relevant touch points to facilitate this; including workforce, estates and technology. Current assumptions on the requirements of these three aspects are outlined below. In their role as Host Provider, in addition to the Community Services provider, WHT has an integral role in shaping and delivering these enablers, alongside partners, to achieve the desired future state.

Digital and Technology

As the Host Provider for the ICP, WHT will be responsible for ensuring the resources, investment needs and digital tools and infrastructure are in place to enable the ICP to be effective. To this end, in parallel to the development of this business case, WHT have developed a complimentary IT strategy that serve the needs of the acute Trust alongside the wider ICP objectives within the currently disjointed system of multiple partners. The WTPB recognise the need to review the below in light of the ICP plans, and agreeing a suitable system IT strategy will be a primary focus of the ICP Board once established in April 2019.

The draft strategy below supports the technology and digital enablers outlined as part of the tiered Operating Model outlined above, including the Single Point of Access, Population Management capabilities and development of a shared digital record.

This approach takes into account the current fragmentation across providers, with multiple record systems in place that are poorly integrated and with limited mobile capabilities e.g. relying upon Wi-Fi to download files, upload edits and a lack of real time updates. Consequently the technology architecture is not a “one size fits all” approach and allows for integration without forcing assimilation of software and processes.

A layered structure, with level 1 being citizen facing and level 4 encompassing all of the current Patient Administration Systems (PAS) has been proposed, with the middle levels providing the integration and interoperability capabilities. This system IT architecture is outlined below, with further detail provided in Appendix 7:

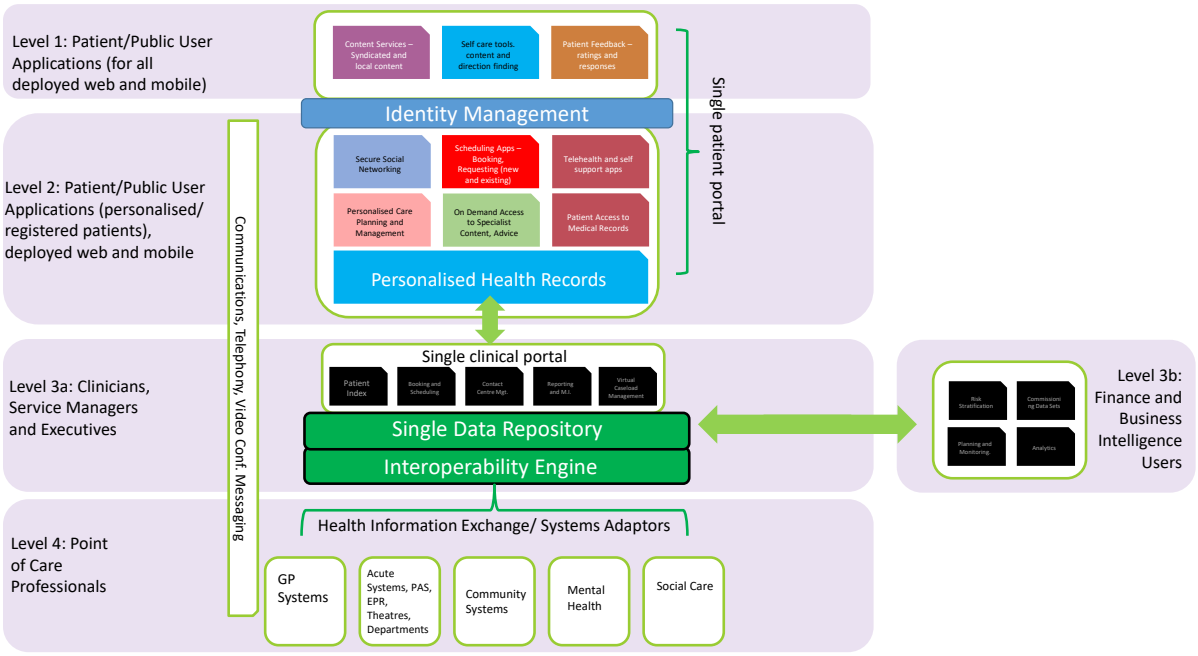


Figure 19 Walsall Together IT Architecture

The Level 1 here fulfils many of the requirements of the SPA by providing a patient/public portal through which citizens can access content, non-personalised self-care tools, advice and service finding (including those provided by One Walsall and/or those part of the Resilient Communities offer) and access to personalised services provided at the other Tiers e.g. appointment booking. This level will also provide the ability to leave feedback – giving transparency in terms of service feedback and response and creating a 'customer service' culture from the outset.

Level 2 provides citizens with a personalised service response and therefore requires the sharing of data within a secure environment. It requires a secure identity management layer, which services can be added to gradually over time, providing a "one-stop-shop" to access any health and wellbeing service, including the Resilient Communities offer. This will require a common identity standard and consent framework for citizens wishing to access health and care services on-line. This will also facilitate the integration of further on-line services such as telehealth, appointment booking and sharing of data amongst providers (with consent) and third parties, such as fitness trackers and monitoring devices via Application Program Interfaces (API).

Level 3 is split between functions for Service Management (3a) for use by Clinicians, Service Managers and Executives and a Finance and Business Intelligence Function (3b) for corporate users. 3a provides the Population Management and Care Coordination required for Tier 1 of the Operating Model, by allowing data exchange and interoperability. In order to facilitate interoperability, a single data repository will be required to scrape data from the separate clinical record systems, in addition to a common user interface for clinicians and professionals.

The Finance and Business Intelligence function at 3b is built upon the functionality provided at 3a, however for the purpose of enabling risk stratification, population identification and predictive analytics. This provides the data for forward planning, informed commissioning, budgeting and monitoring. This is vital to empower the prevention and early intervention agenda of the new Operating Model, supporting the proactive approach to reducing inequalities; a key design principle of the model.

The final Level 4 accommodates the individual PAS of the current providers, without requiring any change in software. This approach facilitates the integration and capabilities required at a system level, without requiring investment or changes at an individual provider level. It is assumed that the changes outlined above would be jointly funded by the ICP investments that is required along with some cost covered by WHT.

In order to deliver this digital and technology transformation it will require the WT partners to investment around £6m over a five year period as part of the implementation of the operating model. This is outlined in the investment plan shown in appendix 5 as part of the transformation section of the overall investment required.

Estates

Delivering high quality facilities - a facilities model for health and social care

Taking all of the tiers of services outlined in section 3 into account, the resulting configuration of facilities across the Walsall area under the proposed model of care is shown below:

As for the IT strategy, this high level outline of the estates plan will require review, refinement and agreement by the ICP Board during horizon 1 to ensure it meets the objectives of the ICP and is fit for purpose.

SPA Hub

A Single Point of Access hub will sit within one of the four locality Health and Wellbeing Centres serving the whole of the Walsall area delivering care access, navigation and co-ordination services including clinical triage to ensure patients can navigate across the system efficiently.

Tier 0 – Resilient Communities

In addition to a strong online presence, this offering will be available to access physically at each of the of the four locality Health and Wellbeing Centres, providing citizens the opportunity to speak face to face with VSC Community Link Officers, access the Directory of Health and Wellbeing Services or receive health and care advice and support from Care Coordinators, clinicians and professionals.

Tier 1 – Integrated Primary, Long term condition management, Social and Community Services

These units will operate from a number of facilities across the borough and will ensure that integrated primary, social and community care services are delivered from purpose-built premises that offer easy access and provide the facilities required for primary care clinicians and care professionals to make the best use of their skills. This will include active care remote care management of citizens with long-term conditions and those at risk of hospital admission.

By delivering primary care at scale GP practices can share a single larger building, while retaining their individual identities. This will make it possible to provide a wider range of facilities and services than before, as practices can jointly generate enough activity to justify specialist staff, treatment rooms, and additional equipment that would otherwise be beyond the ability of any one practice alone. These centres would also offer the facilities for group teaching to be carried out, enabling patients to take a more proactive role in self-care.

Tier 2 - Specialist Community Facilities

These facilities will provide managed care models for pre-booked or rapid access specialist primary care services for further intervention, treatment or therapy services. The facilities will also provide a single point of access for demand management services for in scope services. It is anticipated that these facilities would also provide services to people with more complex long-term conditions.

Tier 3 – Intermediate, Unplanned and Crisis Services

This will be co-located within one of the four locality based Health and Wellbeing Centres providing access to intermediate, unplanned and crisis management services for patients to prevent avoidable and unnecessary hospital visits to A&E or admission to an acute physical or mental health bed. The service and facilities will increase the level of integration of work across integrated primary, social and community care and walk-in type services. The additional capacity provided by walk-in facilities should support both A&E and primary care in the delivery of access for patients.

Tier 4 – Acute Hospital Services

Access to high quality acute hospital services, including A&E, from Walsall Manor Hospital. Specialist acute services will continue to be provided through the wider regional and national acute network.

In order to deliver estates reconfiguration required to deliver the new operating model and specifically the four health and wellbeing centres in each locality the WT partners will need to investment around £2m over a two year period. This is outlined in the investment plan shown in appendix 5 as part of the transformation section of the overall investment required.

Workforce

Development of a high quality workforce - a workforce model for each tier of care

Taking all of the tiers of services outlined in section 3 into account, the development of locality based integrated Place Based Teams to deliver patient focussed services across the Walsall area under the proposed model of care is shown below:

SPA Hub

A single point of access team will be developed serving the whole of the Walsall area delivering care access, navigation and co-ordination services including clinical triage to ensure patients can navigate across the system efficiently.

Tier 0 – Resilient Communities

A dedicated team of integrated care workers, including a Community Link Officer, will provide access to proactive population health and care management services for patients as part of the Resilient Communities offer. This will include social prescribing, active care, remote care management of patients with long-term conditions and those at risk of hospital admission.

Tier 1 – Integrated Primary, Long term condition management, Social and Community Services

Place Based Teams will be expanded to deliver joined up primary, social and community services for citizens, including the following:

- General practice;
- Community nursing and therapy services;
- Primary care mental health;
- Social care and enablement services.

Tier 2 – Specialist Community Services

Teams of specialists will work alongside primary, social and community care professionals from the Health and Wellbeing centres delivering a range of specialist, outpatient and diagnostic services providing more local access for citizens.

Tier 3 – Intermediate, Unplanned and Crisis Services

A network of specialist care professionals and workers will work in an integrated way to deliver a range of intermediate, unplanned and crisis services from a locality Health and Wellbeing Centre to prevent unnecessary hospital admissions.

A detailed workforce development model will be developed alongside the transitional transformation and implementation plan as the Walsall Together model of integrated care evolves over time.

Tier 4 – Acute and Emergency Services

Workforce planning for Tier 4 is anticipated to take place during the next phase of detailed design.

In order to implement new ways of working within the new tiered operating model will require some element of dual running of teams and training and development of existing staff. Therefore a workforce development and training and development budget of £1m over a five year period has been included in the investment plan shown in appendix 5. In addition an investment for dual running (which has been calculated on the basis of 5% of total primary and community services spend) has also been included which equates to a budget of £12m over a five year period.

8 Mobilisation and Implementation

The WT partners are tasked with agreeing, designing and implementing significant transformation of their individual operating models in order to deliver their shared vision for the future over the next five years; detailed here across three Horizons. A detailed design phase during Horizon 1 will inform the scope, objectives and requirements for the subsequent Horizons. To drive forward this programme, a significant investment outlined in the previous sections will be required to enable the scale of transformation.

Overview

This section outlines the overall transformation plan to be established from April 2019 (Horizon 1) and the anticipated timeline for implementation across 2 subsequent Horizons.

Transformation plans and timeline

In order to deliver the significant programme of transformation outlined in this business case, the Walsall Together partners require the following key elements:

- The resource, capacity and process for co-designing and implementing the detailed service changes required;
- The establishment of a robust and experienced Transformation Programme Office (TPO) that drives the programme forwards and manages stakeholder relationships through to delivery;
- A commitment from each partner organisation to the delivery of all the key milestones over the next five years.

The first 6 months of Horizon 1, beginning April 2019, will be focused on the detailed design of the service pathways and contracting to support this, alongside establishing the governance and management structures outlined above. It is expected the first phase of service implementation will take place from late October 2019.

Horizon 2 will see the first application of any new contracts to support the ICP objectives and delivery of additional integrated services as part of the Alliance Agreement. Ongoing evaluation of progress and success against agreed KPIs will inform the services and scope of the ICP in Horizon 3. The WT partners will also need to engage with the regulatory bodies, including but not limited to NHS England, to ensure parties are meeting their statutory requirements and that the plans outlined in this business case are fit for purpose. For Walsall CCG, additional assurances may need to be provided to NHS England with regards the "four tests" following the detailed design phase of services. A high level analysis of the programme's progress against these four tests is outlined below, however it is noted that these are clinically focused and more appropriate criteria for an integrated care programme will need to be developed in due course:

- **Strong public and patient engagement** – At this stage, as outlined in section 3, there has been limited clinical involvement outside of the Operating Model working group, and no public or patient engagement has been completed at this stage. A Stakeholder engagement and communications group has developed a plan for subsequent engagement post April 2019.
- **Consistency with current and prospective need for patient choice** – This element will be addressed during the detailed design phase post April 2019.
- **Clear, clinical evidence base –** Once a clear scope of services has been defined, the WT partners will seek guidance from local, national and international examples of clinical best practice to inform the detailed design of pathways.

- Support for proposals from clinical commissioners – The proposals within this business case have the support of Walsall CCG, who have played an active and central role throughout. The four Locality GP Representatives have also been involved, however the wider clinical network will be engaged fully at the point of detailed design. In addition, the local authority have been involved throughout as a clear partner from both a commissioning and delivery perspective.

If during the detailed design phase there was an intention to reduce the number of beds, Walsall CCG would also need to ensure this is justified according to the Proposed Bed Closures test. However at present there is no plan to do this.

The diagram below outlines the implementation steps envisioned across each of the 3 Horizons.

Do Something Initiative Implementation

While the detailed design phase required during Horizon 1 will identify and refine the service pathways to be delivered, an approximate timeline for implementation of these has been provided below.

Tier	Initiative	Horizon 1 – 2019/20	Horizon 2 – 2020/21	Horizon 3 – 2021/22 – 2023/24
0	Single citizen portal for accessing advice, appointments and support, including Resilient Communities offerings	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	Multi-channel Contact Centre (SPA)	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups (Resilient Communities)	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	24/7 Clinical/Professional triage			
	Citizen access to health records			
	Remote monitoring of citizens with some long term conditions			
	Telemedicine			
	Risk stratification and targeted intervention			
	Shared patient record			
	Social Prescribing (Resilient Communities0			
	Care Planning			

	Care Home and at home In reach service			
1	Multidisciplinary Place Based Teams			
	Referrals management			
	Greater Community/Specialist Nursing			
	Consultants in the community			
	Condition Specific Rehabilitation			
2	Outpatients in the community			
	Virtual Outpatient Clinics			
3	Integrated Rapid Response Service			
	Paramedics in the community			
4	Assess to Admit/Front end streaming			
	Remote 24/7 monitoring of inpatients			
	Clear routes to discharge, including Estimated Date of Discharge (EDD)			

Table 9 Draft Initiative Implementation Timeline

Overall Programme Timeline

The Gantt chart below outlines the key elements of the transformation programme between December 2018 and April 2021. These milestones are subject to change as the programme transitions from the detailed design phase and into implementation during Horizon 1, and will be dependent on the resource commitments and agreements made during this period.

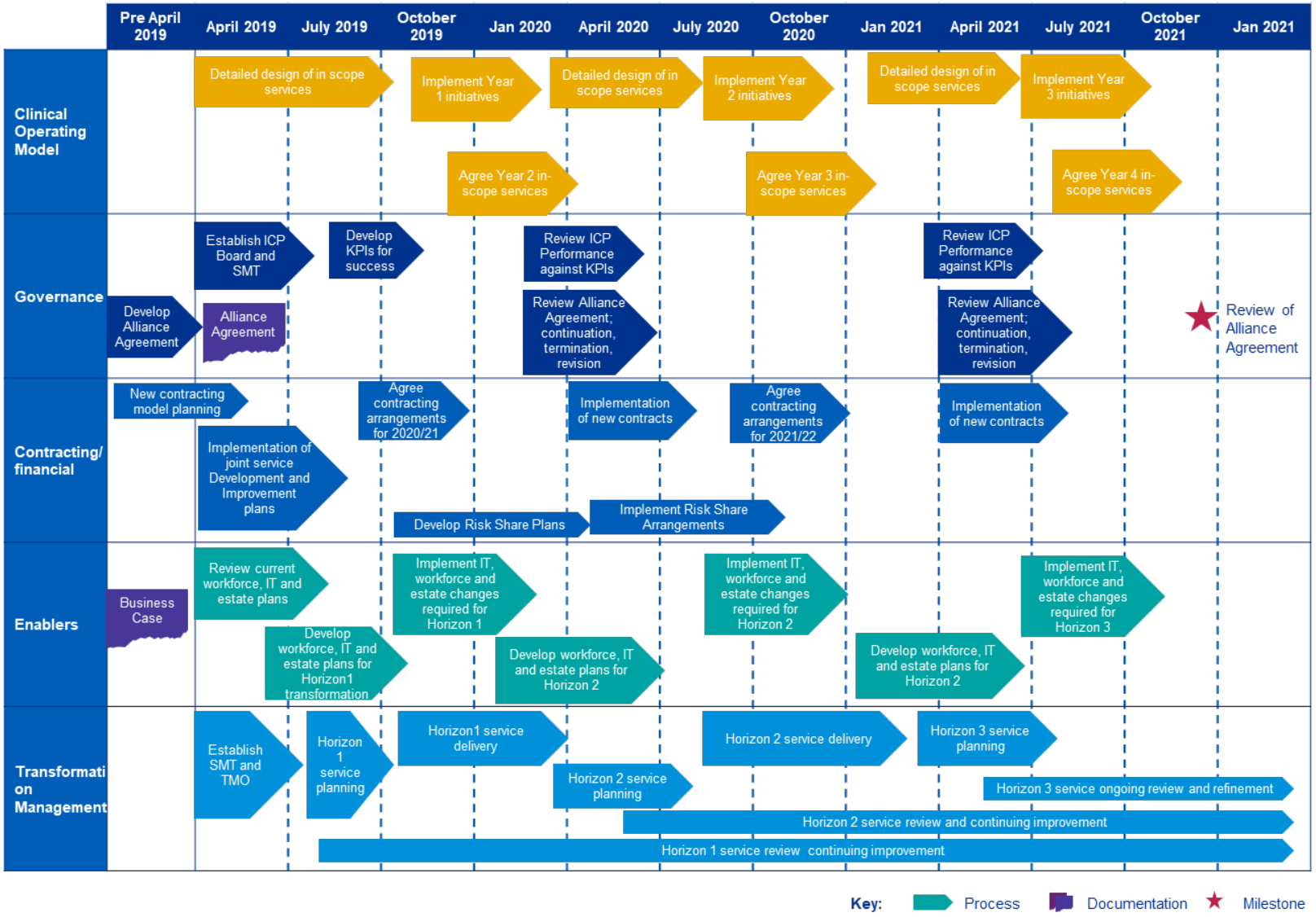


Figure 21 Timeline for Implementation

9 Glossary

Alliance Agreement	A contractual agreement that sits alongside existing NHS and LA contracts, providing a single line of communication between the commissioner and the Alliance Leadership Team (ICP Board) for the services.
Host Provider	The provider organisation hosting the ICP Board, as a sub-committee of the Executive Board.
ICP Board	A sub-committee of the Host's Board, with representation from all providers bound by the Alliance Agreement.
Section 75	A legal agreement made under section 75 of the National Health Services Act 2006 between the Local Authority and NHS organisations. A Section 75 allows for the pooling of resources and the delegation of certain functions to the other partner(s).

10 Appendices

Appendix 1: Group membership

Operating Model Workstream		
Paula Furnival - Lead	Exec Director of ASC	Walsall Council
Mark Axcell	CEO	Dudley and Walsall Mental Health Partnership NHS Trust
Marsha Foster	Director of Operations	Dudley and Walsall Mental Health Partnership NHS Trust
Daren Fradgley	Director of Strategy and Transformation	Walsall Healthcare NHS Trust
Richard Beeken	CEO	Walsall Healthcare NHS Trust
Matthew Lewis	Medical Director	Walsall Healthcare NHS Trust
Kerrie Allward	Head of Integrated Commissioning, Adult Social Care	Walsall Council
Simon Brake	Chief Officer	Walsall CCG
Paul Tulley	Director of Commissioning,	Walsall CCG
Martin Thom	Head of Community Care, Adult Social Care	Walsall Council
Dr Barbara Watt	Director of Public Health	Public Health
Sarah Shingler	Chief Nurse	Walsall CCG
Simon Harlin	GP	Walsall CCG
Anand Rischie	Walsall CCG Chair and GP	Walsall CCG
Shadia Abdalla	GP Commissioning	Walsall CCG
Carsten Lesshaft	GP	Walsall CCG
Narindar Sahota	GP Lead for engagement - WEST	Walsall CCG
Hammad Lodhi	GP Lead for engagement - SOUTH	Walsall CCG
Bhupinder Sarai	GP Lead for engagement - EAST	Walsall CCG
Israr Ahmed	GP Lead for engagement - NORTH	Walsall CCG
Andy Griggs	Programme Manager	Walsall Healthcare NHS Trust
Alex Boys	CEO	One Walsall
Mark Weaver	Joint Medical Director	Dudley and Walsall Mental Health Partnership NHS Trust

Rosie Musson	Acting Director of Nursing	Dudley and Walsall Mental Health Partnership NHS Trust
Iftikhar Ahmad	Joint Medical Director	Dudley and Walsall Mental Health Partnership NHS Trust
Donna Chaloner	Director of Community Adult Nursing	Walsall Healthcare NHS Trust
Kelly Geffen	Care Group Manager/Professional led-Adult Community Nursing	Walsall Healthcare NHS Trust
Becky Temple-Purcell	Associate Director of Nursing	Dudley and Walsall Mental Health Partnership NHS Trust
Jacky O'Sullivan	Clinical Service Director	Dudley and Walsall Mental Health Partnership NHS Trust
Sarah Taylor	Development Officer	One Walsall
Uzoma Ibechukwu	Deputy Director of Pharmacy	Walsall Healthcare NHS Trust
Robin Vickers	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Assistant Manager	KPMG

Data and Analytics Workstream		
Russel Caldicott - Lead	Director of Finance	Walsall Healthcare Trust
Kevin Slater	Performance and Systems Manager	Walsall Council, Adult Social Care
Jill Brittle	Performance & Systems Development Officer	Walsall Council, Adult Social Care
Helena Kucharczyk	Head of Performance Improvement and Quality	Walsall Council, Children's Social Care
Michelle Gordon	Deputy Director of Finance	Walsall CCG
Kevin McGovern	Head of Finance - Information	Walsall CCG
Dylan Morris	Head of Contracting and Income	Walsall Healthcare Trust
Tony Kettle	Assistant Director of Finance	Walsall Healthcare Trust
Tracy Simmonds	Costing & Income Accountant	Dudley and Walsall Mental Health Trust
Paul Chamberlain	Head of Financial Planning	Dudley and Walsall Mental Health Trust

Finance and Contracting Workstream		
Matthew Hartland - Lead	Director of finance	Walsall CCG
Rob Pickup	Director of Finance	Dudley and Walsall Mental Health Partnership NHS Trust
James Parker	Commissioning Liaison and Contracting Manager	Dudley and Walsall Mental Health Partnership NHS Trust
Daren Fradgley	Director of Strategy	Walsall Healthcare Trust
Russell Caldicott	Director of Finance	Walsall Healthcare Trust
Tony Gallagher	Director of Finance	Walsall CCG
Paul Tulley	Director of Commissioning	Walsall CCG
Ross Hutchinson	Finance Business Partner, Adult Social Care	Walsall Council
Tracey Simcox	Lead Commissioner Adult Social Care	Walsall Council
Suzanne Letts	Interim Lead Accountant, Adult Social Care	Walsall Council
Mark Banks	Deputy Director of Finance	Dudley and Walsall Mental Health Partnership NHS Trust
Seb Habibi - KPMG Lead	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Manager	KPMG
Andy Griggs	WHT - Programme Manager	Walsall Healthcare Trust
Kerrie Allward	Head of Integrated Commissioning, Adult Social Care	Walsall Council
Michelle Gordon	Deputy Director of Finance	Walsall CCG
Kevin McGovern	Head of Finance & Information	Walsall CCG
Kevin Slater	Performance and Systems Manager	Walsall Council
Tony Kettle	Assistant Director of Finance WHT	Walsall Healthcare Trust
Jane Sillitoe	WHT - Programme Support	Walsall Healthcare Trust
Roseanne Crossey	WHT - Head of Business Development and Planning	Walsall Healthcare Trust
Dylan Morris	WHT - Head of Contracting	Walsall Healthcare Trust
Paul Steventon	WHT - Head of Financial Management	Walsall Healthcare Trust
Helena Jucharczyk	Head of Performance Improvement & Quality	Walsall Council

Paul Clarke	Manager	Walsall Council
Jill Brittle	Performance & Systems Development Officer	Walsall Council
Paul Chamberlain	Head of Financial Planning, DWMHT	Dudley and Walsall Mental Health Partnership NHS Trust
Imran Hussain - KPMG Lead	Senior Manager	KPMG
Gareth Richards	Manager	KPMG

Governance and Organisation workstream		
Paul Tulley - Lead	Director of Commissioning	Walsall CCG
Daren Fradgley	Director of Strategy	Walsall Healthcare Trust
Jenna Davies	Director of Governance	Walsall Healthcare Trust
Marsha Foster	Director of Operations	Dudley and Walsall Mental Health Partnership NHS Trust
Paul Lewis Grundy	Company Secretary	Dudley and Walsall Mental Health Partnership NHS Trust
Kerrie Allward	Head of Integrated Commissioning	Walsall Council
Mark Axcell	CEO	Dudley and Walsall Mental Health Partnership NHS Trust
Sebastian Habibi - KPMG Lead	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Assistant Manager	KPMG
Robin Vickers	Director	KPMG
Andy Griggs	Programme Manager	Walsall Healthcare Trust
Jane Sillitoe	Programme Support	Walsall Healthcare Trust
Paul Clarke	Manager	Walsall Council

Appendix 2: Data Analysis, process and assumptions

In order to support the Walsall Together Programme, a data and analytics work stream was set up in order to pull together the data requirements to support the programme. Data was obtained from each of the organisations in the partnership to enable the creation of an activity linked financial model. The purpose of the model was to establish a 'Do Nothing' scenario that showed how the system is likely to develop through to the end of the 2021/2022 financial year, with an additional trend analysis to carry that through to the end of Horizon 3. This was followed by the development of 'Do Something' scenarios that show how significant changes to the operating model across Walsall could impact on the activity and finances for the overall health and care system and each partner organisation.

Initial Data Request Meeting

An initial meeting with key data leads from the partner organisations was convened at the beginning of the project to facilitate a discussion around the modelling exercise and identify the source data each organisation holds that would be relevant to this project. The timelines, data requirements, and individual organisation challenges were discussed and addressed, to inform the model inputs for the 'Do Nothing' baseline year.

Data Request Submission

With data sharing agreements in place, data was requested from each organisation in line with the initial specification of the financial and activity model. This consisted of the following key elements data specification;

Data Item	Explanation
Provider/Organisation Name	The main provider of the treatment / care.
Specialty / Service Line Code	To identify the Specialty / Service Line under which treatment or care is being delivered.
Specialty / Service Line Name	
POD Code	To identify the Point of Delivery (if applicable) - e.g. inpatient care, community, outpatient
POD Name	
GP Code	To identify the locality of the patient without requiring patient identifiable data. GP has been translated into Locality (North, East 1, South 2 etc.)
Age Band	To identify population group without requiring patient identifiable data. Age bands are set out in the table below
Activity Count	For baseline setting and to model activity over time as population changes
Length of Stay (in days)	For baseline setting and to look at bed requirements over time and in 'Do Something' scenarios

Age band profiles:

Age Bands		
0-4	30-34	65-69

5-9	35-39	70-74
10-14	40-44	75-79
15-17	45-49	80-84
18-19	50-54	85-89
20-24	55-59	90+
25-29	60-64	

Income and expenditure data requests;

Data Item	Example
I&E Category (Income, Expenditure)	Income
Provider	Provider X
Specialty / Service Line	e.g. Cardiology
POD	Non Elective
Year Total	£xxx,xxx
Total Income	£xxx,xxx
Total Expenditure	£xxx,xxx
Of which	
Expenditure - Fixed	£xxx,xxx
Expenditure - Semi Variable	£xxx,xxx
Expenditure - Variable	£xxx,xxx

Receipt of Baseline Data

Each organisation prepared data in accordance with the data requests discussed with them individually and submitted this to the data analytics team. The following table outlines the status of data received from each organisation;

Organisation	Activity Data	Finance Data
Walsall CCG	• Data falling outside the scope of the other Walsall providers, particularly where Walsall patients receive treatment or care outside the Walsall area	Detailed financial information linked to the activity taking place at providers outside the Walsall area Full CCG financial information including yearly funding allocation and current expenditure
Walsall Healthcare Trust	• SLAM data providing full details of acute activity in A&E, Inpatients and Outpatients • Additional activity datasets for other service lines outside the above	• Detailed financial information linked to the activity being delivered by WHT • Additional income received on block or for which activity detail is not available

	• Activity data by service line within the Community services, by CCG	• Detailed expenditure by Point of Delivery and Service Line
Dudley and Walsall Mental Health Trust	• Line item data for all activity delivered on behalf of Walsall CCG	• Detailed financial information linked to the activity being delivered on behalf of Walsall CCG, including Income and Expenditure
Walsall Council – Adult Social Care	• Line item data for all activity	• Detailed financial information for the Adult Social Care department of the council including income and expenditure
Walsall Council – Children's Social Care	• Summary data for activity relating to Early Help and Social Care referrals, Child Protection, Looked After Children and Children with Special Educational Needs	• Detailed financial information for the Children's Social Care department of the council including income and expenditure

Data Processing

On receipt of the above data for the baseline year 2018/19, we processed that data to consolidate the various service lines and other parameters into a manageable list for the model. If we were to use the data in its raw format we would expect to see several hundred different service lines and points of delivery, as well as data from the Local Authority of a very different nature to NHS data. The processing stage of the project was to bring this data into a single coherent model that would align the data for all organisations, whilst still being able to recognise the inputs individually from partner organisations and split by commissioners and providers.

In addition to this mapping and consolidation exercise it was also necessary to, in some cases, complete additional data processing to align the finance data with the activity data, and to 'fill gaps' where the data provided did not go down to the same level of detail and granularity as the model would expect.

Finally, in order to establish the future state of the system, we used projections for activity changes across Walsall. For Local Authority activity this meant using population changes to prepare age weighted projections of activity change. For health organisations we have used the NHS projections for activity growth as per the below:

GP Referrals	0.8%
Other Referrals	4.6%
TOTAL REFERRALS	2.2%
Consultant led 1st OP attendances	6.4%
Consultant led follow-up OP attendances	4.1%
TOTAL OUTPATIENT ATTENDANCES	4.9%
Elective admissions: Day Cases	4.2%
Elective admissions: Ordinary	0.3%
TOTAL ELECTIVE ADMISSIONS	3.6%
Non-Elective: Zero day LoS Spells	5.6%
Non-Elective: 1+ LoS Spells	0.9%
TOTAL NON-ELECTIVE ADMISSIONS	2.3%
All A&E Attendances	1.1%
A&E Attendances - Type 1	1.1%

Initial Data Validation

Once the above processing had been undertaken, packs were prepared for each individual organisation in order to view a summary of the data, mapping and consolidation that had taken place to align their information with the model structure. This included an outline of the data for the baseline year as well as the forecasting projections being used to predict activity changes until 2021/2022.

Group Data Validation

Following on from the initial validation, the outputs of the 'Do Nothing' scenario modelling have been brought to a series of workshops that join the Operating Model and Finance and Contracting elements of the project supported by the Data Analytics work stream. This group, consisting of data and finance leads from each organisation, has considered the outputs and raised points for clarification and validation.

Baseline 'Do Nothing' Assumptions

The following assumptions were made in order to build and populate the baseline model;

Baseline Year – 2017/18

The base year for the 'Do Nothing' scenario was the 2017/2018 financial year.

Activity Forecast – ONS Population Projections

The detailed activity forecast for the Local Authority was populated using ONS Population Projections for Walsall as set out in the following table. These projections were applied to the baseline activity resulting in either growth or reduction in activity based on the increase or decrease in population size.

AGE GROUP	2017	2018	2019	2020	2021
0-4	19.2	19.1	19.0	19.0	18.9
5-9	19.5	19.7	19.9	20.1	20.1
10-14	17.8	18.4	18.8	19.3	19.6
15-17	10.1	10.0	10.0	10.0	10.3
18-19	6.7	6.6	6.6	6.7	6.8
20-24	16.7	16.6	16.4	16.2	16.1
25-29	19.3	19.2	19.2	19.0	18.7
30-34	18.9	19.2	19.5	19.6	19.9
35-39	17.2	18.0	18.3	18.6	18.8
40-44	16.1	15.7	15.9	16.4	16.8
45-49	19.3	19.0	18.4	17.7	16.9
50-54	18.8	18.9	18.9	19.1	19.1
55-59	16.9	17.3	17.9	18.3	18.5
60-64	14.2	14.4	14.6	15.0	15.5
65-69	13.6	13.3	13.2	13.1	13.2
70-74	12.5	12.7	12.7	12.8	12.8
75-79	9.9	10.0	10.2	10.3	10.5
80-84	7.3	7.6	7.8	7.8	7.8
85-89	4.3	4.4	4.4	4.5	4.6
90+	2.2	2.3	2.3	2.4	2.5
All ages	280.5	282.3	284.0	285.7	287.4

Activity Forecast – NHS Growth Projections

The detailed activity forecast for NHS organisation was populated using NHS Growth Projections as set out in the following table. These projections were applied to the baseline activity resulting in growth of activity in line with national assumptions.

GP Referrals	0.8%
Other Referrals	4.6%
TOTAL REFERRALS	2.2%
Consultant led 1st OP attendances	6.4%
Consultant led follow-up OP attendances	4.1%
TOTAL OUTPATIENT ATTENDANCES	4.9%
Elective admissions: Day Cases	4.2%
Elective admissions: Ordinary	0.3%
TOTAL ELECTIVE ADMISSIONS	3.6%
Non-Elective: Zero day LoS Spells	5.6%
Non-Elective: 1+ LoS Spells	0.9%
TOTAL NON-ELECTIVE ADMISSIONS	2.3%
All A&E Attendances	1.1%
A&E Attendances - Type 1	1.1%

Activity – Bed Usage

The model assumes that beds are used for 92% of the time, on the basis that there will be some turnaround in bed usage for cleaning, restocking equipment etc.

Finances – Income

From a provider perspective, where activity data was provided and linked to income, any changes to activity will result in a direct change to income. The model does not fix elements of block contracts if the activity and finance data for those contracts has been provided. This means that the forecast changes to activity based on the population forecasting do impact on the provider income and subsequently the projected commissioner cost.

The CCG provided funding allocation information up to 2020/2021, and for the purposes of the model it was assumed that 2021/2022 would see the same percentage increase in allocation as 2020/2021. That has then been carried forward in the trend analysis.

The Local Authority has some income linked to activity in the same way as the other NHS provider income, but this is significantly less than expenditure. The remaining funding that provides the balance is allocated from a central budget from the Council's overall income.

Finances – Income Forecast

In addition to the changes to income resulting from activity shifts, the income is forecast to change in line with inflation.

For NHS organisations, NHSE inflation projections are used. The latest NHS figures go to the end of the 2020/21 financial year and therefore 2021/22 has been populated with the combined forecast inflation rate from RPI and CPI projections. This gives the following projection:

	2018/19	2019/20	2020/21	2021/22
Yearly	2.00%	2.00%	2.90%	2.95%
Cumulative	2.00%	4.04%	7.06%	10.22%

For non NHS organisations, specifically the Social Care departments of the Local Authority, the NHS projections were not considered appropriate and therefore the Consumer Price Index inflation rate was used, as follows;

	2018/19	2019/20	2020/21	2021/22
Yearly	2.30%	1.90%	2.00%	2.10%
Cumulative	2.30%	4.24%	6.33%	8.56%

Finances – Expenditure

All organisations provided expenditure data split into Fixed, Semi Fixed and Variable. Similar to income, where activity data was provided and linked to expenditure, any changes to activity will result in a direct change to Variable Expenditure, as well as a proportion of the Semi Fixed expenditure. The proportional changes are different for each organisation per the following table:

Organisation	Semi Fixed Sensitivity
Walsall Healthcare Trust - Acute	70% Fixed, 30% Variable
Walsall Healthcare Trust - Community	14.6% Fixed, 85.4% Variable
Dudley and Walsall Mental Health Trust	80% Fixed, 20% Variable
Walsall Council – ASC and CSC	50% Fixed, 50% Variable

Regarding the Fixed costs, and the fixed element of Semi Fixed Costs, the model will not increase these at any given thresholds, these are deemed to be entirely fixed. Therefore, when considering the baseline position in terms of increase activity over time, as well as the impact of change scenarios, it is important to interpret the outcomes in that context. A significant increase in activity may require an investment in fixed costs, and consequently a decrease in activity might require a reduction in fixed costs left stranded by those shifts.

Finances – Expenditure Forecast

The same inflation rates were applied to Expenditure as they were for Income for each organisation.

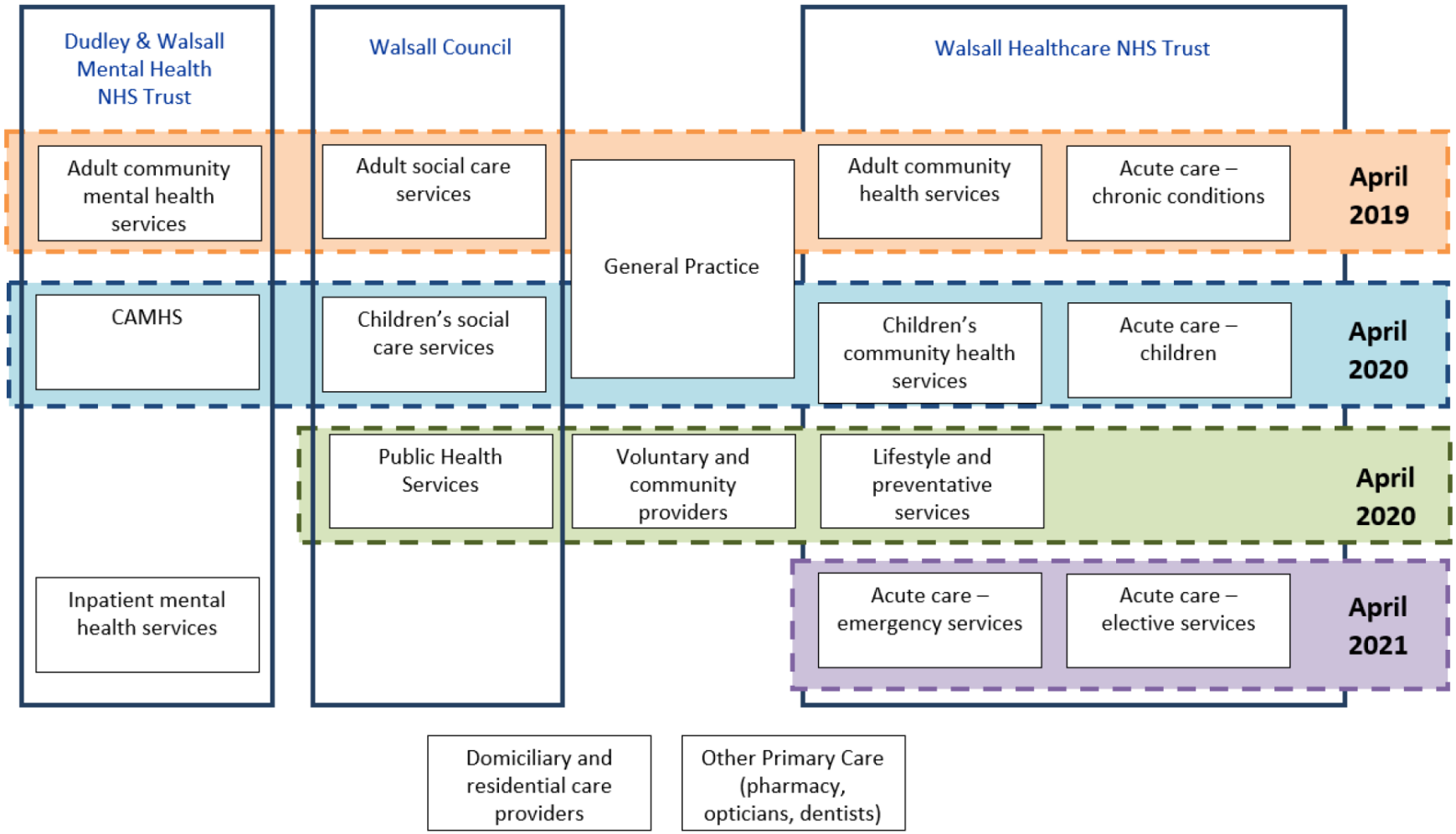
Organisation Assumptions

The following assumptions were also agreed and made for each individual organisation:

Organisation	Assumption
Walsall Healthcare Trust - Acute	Day Case bed usage is assumed to be 1 day when calculating bed requirements
Walsall Healthcare Trust - Community	The service is assumed to 'break even' in that the same data has been used for expenditure and income
Dudley and Walsall Mental Health Trust	The data within the model is for activity undertaken on behalf of Walsall CCG only, therefore the model is not representative of the activity or financial position of the Trust overall.

	Any data which is showing for a GP that does not come under Walsall CCG has been put under the category of 'Other – Walsall' (0.1% of activity)
Walsall Council – ASC and CSC	Only Adult Social Care department activity has been included. Additional activity within the council such as public health initiatives were not within the scope of the modelling project. Only Children's Social Care department activity has been included. Additional activity within the council such as public health initiatives were not within the scope of the modelling project.
Walsall CCG	GP activity data could not be provided. Data obtained from NHS Digital has been used however this only covered November 2017 to October 2018. The total appointments for Walsall has been calculated from this, plus an extra 10% as only 90% of GP's data was included in the dataset. Similarly, there are costs for the CCG to commission specific services for which there is no activity data. As a result, we have adjusted the financial inflation to account for the forecast increase in demand. Individual organisation inputs have been reconciled against headline data for the CCG, with 'balancing lines' entered into the model to account for variation between the contract value in the CCG data versus additional items of income for providers.

Appendix 3: Initial High Level Timeline for Integration Implementation



Appendix 4: Future State Citizen Stories

What it could look like for Joshua...

Joshua

Age: 7

Job title: Student

Joshua is a quiet boy who lives with his mother, Sophie. He sees his father infrequently due to the violent arguments that can sometimes break out between his parents. At home, he looks after himself most of the time, as his mother is frequently incapacitated. His school is unaware of the situation at home and Joshua's recent decline in performance has been largely overlooked by his teachers.

Tier of Care:

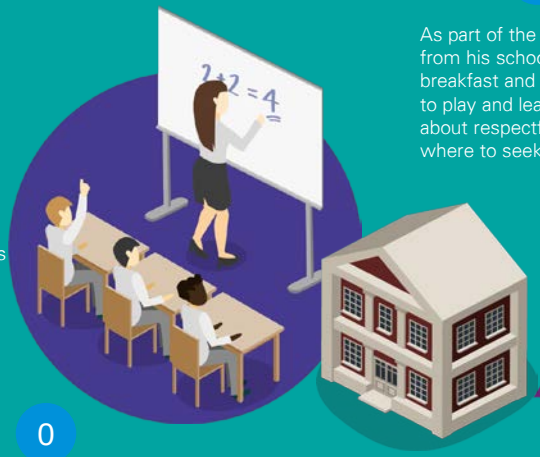
0 1 **2** 3 4

2

Following a referral to MASH, Joshua's mum visits the local Children's Centre, where a domestic abuse worker discusses their disruptive home life and ways the family can be supported, developing an Early Help Plan.

0

As part of the Early Help Plan and with support from his school, Joshua begins attending breakfast and after school clubs, where he is able to play and learn from other children. He is taught about respectful adult relationships and knows where to seek support if needed.



0

The Targeted Parenting programme attended by Joshua's mum is having a huge impact on Joshua and their relationship. Joshua feels safer at home and having clear routines and boundaries means he is more alert at school; and his grades are improving. The Early Help Team are in regular contact with the family and have noticed the growth in his confidence.

What it could look like for Cassie...

Cassie

Age: 32

Job title: Manager

Cassie is an outgoing and confident young woman who works as a Manager. She has Lupus, but is otherwise healthy and she manages her condition well. She is 3 months pregnant with her first child and her Lupus means that it is considered high risk. She is anxious the pregnancy and becoming a mother. She has a busy full time job which can make attending medical appointments difficult.

Tier of Care:

0 1 2 3 4

Cassie is allocated a case loading midwife who will manage her pregnancy, including her birth and after care. Cassie will continue updating her record digitally for the pregnancy, as she does for her Lupus, allowing clinicians to monitor throughout.

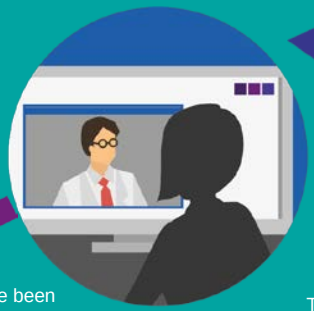
2

0

Cassie is able to search for local pre-natal exercise classes through the and joins a pregnancy yoga class and meets other new mums to be.

1

The use of digital records means that Cassie can have her bloods taken at her local GP surgery with the results being made available within 24 hours to her hospital based consultant. Her consultant is able to offer Cassie a virtual clinic, assessing her blood results alongside her daily monitor of disease activity.



Cassie and her midwife have been able to put in place a postnatal lupus care plan, including visits from her midwife in the evening when her husband is at home and able to offer support. She feels very supported and is enjoying motherhood.

1

What it could look like for John...

John

Age: 41

Job title: Builder

John is a family-orientated hardworking man from the travelling community. His lifestyle means accessing consistent care has been difficult in the past, however he is very self-sufficient and has kept himself well throughout his life, more or less. He does enjoy and drink and is a heavy smoker. He is highly influential in his community and wants to support grass roots initiatives close to his heart.

Tier of Care:

0 1 2 3 4

John is able to view a directory of local services on his smartphone and can complete a questionnaire to direct him to the most appropriate service, without requiring registration.

0

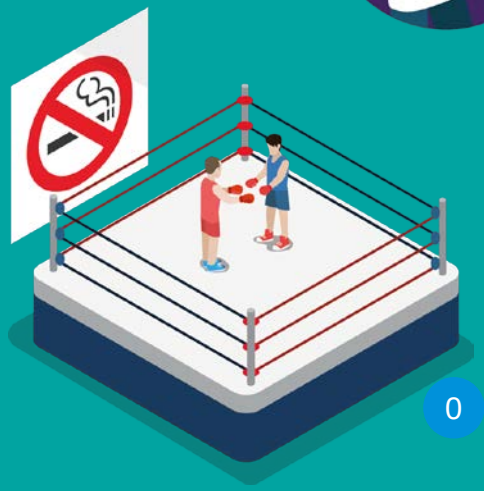
By having full access to his digital care record on his phone, John is able to share this with the health and care professionals he engages with, regardless of their location.

John finds the drop in sessions at the Health and Wellbeing centre are the most convenient for him and he develops a good relationship with the Care coordinators, who put him in touch with a local boxing club.

2

With support from the local community, John sets up a local boxing club at the Community Centre. The centre also offers Stop Smoking drop in sessions and John begins a smoking cessation programme.

0



What it could look like for Maria...

Maria McBride

Age: 14

Job title: Student

Maria is a quiet, anxious teenager with undiagnosed depression. Her family are concerned that she is being bullied at school, however Maria is unwilling to disclose information and asked her parents not to tell school. She has been experiencing suicidal thoughts and has begun self-harming. She has a very small group of friends but does not feel able to share her feelings and is convinced she will fail her upcoming exams.

Tier of Care:

0 1 2 3 4

0

Maria attends an assembly at her school organised by CAMHS and a local mental health charity, in which people talk openly about their challenges with mental health. She downloads the recommended app and recognises that she needs support.

Maria speaks to an advisor, who arranges a face to face counselling session at her school, as well as directing her to self-monitoring tools and mindfulness techniques. She discusses her progress with the councillor, who is able to message Maria via the app in between their sessions.

1

Maria is encouraged to broaden her social network by joining an after-school art class, where she can nurture her talent for art alongside building her confidence. Following the early intervention, Maria's depression is prevented from escalating and she is better equipped to manage her mental health challenges in the future.

0

What it could look like for Clara...

Clara

Age: 84

Job title: Retired bookkeeper

Clara is a softly spoken woman with 12 grandchildren and 3 great-grandchildren; of whom she is very proud. Following the death of her husband 3 years ago and a diagnosis of dementia the following year, Clara's condition has steadily deteriorated. Her family have been able to support her to date, however she is at risk of admission to institutional care if not properly supported.

Tier of Care:

0 1 2 3 4

Clara's family want her to be supported to live at home for as long as possible and so work with her GP and the local community teams to develop a comprehensive care package. 1

Clara's care package includes regular appointments with a Consultant Geriatrician at the local Community Centre. The Health and Wellbeing Centre is also open 24/7, allowing social care and health workers access to advice and support at any time. 2

Using proactive care planning, Clara is able to live at home for longer with access to local, integrated teams of specialists and professionals. 0

What it could look like for David...

David

Age: 68

Job title: Retired carpenter

David is a considered and contemplative man who enjoys spending time at home with his wife. They have no children or other family nearby, but have always enjoyed gardening and visiting museums. He was diagnosed with bowel cancer 3 years ago and has been placed on palliative care. Since this diagnosis, he has struggled to communicate his wishes directly and is feeling isolated for the first time in addition to worrying about his wife when he passes.

Tier of Care:

0 1 2 3 4

David and his wife are able to visit his Care coordinator at the local Health and Wellbeing Centre to discuss and review his care at any time, which they prefer over the telephone number that is available 24/7.

2

David's records are shared amongst all the providers involved in his care and the ambulance service, should their be an emergency, ensuring his EoL plan is followed and he remains at home where possible.

1

0

The Care coordinator refers David to Macmillan services, allowing him a safe space to speak openly about his cancer. They also find a local boules club that David and his wife are able to join and have made new friends together. David feels relieved that his wife has a wider network than before.

The palliative nurse works closely with David and his wife to minimise the number of appointments and wherever possible sees him at home, providing as much time as possible for David and his wife to be together.

1

What it could look like for Marvin...

Marvin

Age: 52

Job title: Warehouse Night Manager

Marvin is a night shift worker in a warehouse, who values the time outside of work he can spend with his family. He doesn't prioritise his health and has poorly managed Type 2 diabetes and has been recently been diagnosed with COPD. He is distrusting of health professionals and avoids visiting his GP, as they always seem to find something to lecture him about – like his diet.

Tier of Care:

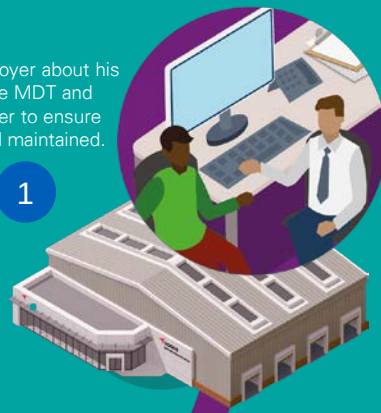
0 1 2 3 4

Marvin is able to access the Health and Wellbeing centre out of hours to suit his shifts. He is encourage to self-monitor his diabetes to reduce the need for appointments. The Care Coordinator also suggested he speaks to his employer.

2

Marvin speaks to his employer about his Care Plan developed by the MDT and how they can work together to ensure his health is prioritised and maintained.

1



Marvin is now able to better control his diabetes through self monitoring and diet. This has enabled him to stay well and out of the hospital. He is able to access a local gym out of hours and has much more time to spend with his family.

0

Appendix 5: Investment Requirements Breakdown

Walsall Together - Investment Profile								
	Revenue	Capital	total		Horizon 1	Horizon 2	Horizon 3	Total
Leadership and Governance	£ 497,730	£ -	£ 497,730		£ 497,730	£ 497,730	£ 1,493,189	£ 2,488,648
Capacity	£ 3,998,162		£ 3,998,162		£ 3,998,162	£ 3,998,162	£ 7,032,394	£15,028,718
Transformation	£ 7,411,000	£ 3,000,000	£ 10,411,000		£ 4,744,333	£ 4,744,333	£ 4,566,333	£14,055,000
Total	£ 11,906,892	£ 3,000,000	£ 14,906,892		£ 9,240,225	£ 9,240,225	£ 13,091,916	£31,572,366
Percentgae of total system spend								
	Year	investment @ 1%	investment costs	%	ROI	total saving	ratio	
Horizon 1	19/20	£ 6,056,000	£ 9,240,225	1.53%	system saving	£150,000,000	4.75	
Horizon 2	20/21	£ 6,151,000	£ 9,240,225	1.50%				
Horizon 3	21/22	£ 6,268,000	£ 4,363,972	0.70%				
	22/23	£ 6,352,000	£ 4,363,972	0.69%				
	23/24	£ 6,447,000	£ 4,363,972	0.68%				
total		£ 31,274,000	£ 31,572,366					

Capacity																				
								Annual								Horizon 1		Horizon 2		Horizon 3
Capacity Building and Development			Resource	Number of sessions pw				Budget												
				Medic	Nurse / AHP	SC rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Clinical backfill	Detailed design Clinical patient cohorts	LTC	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Frailty	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Primary Mental Health	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		OP & Diagnostics	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Urgent Care	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Intermediate and Care management	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
				Operations manager	Service Devleopment lead	SC operations rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
	Detailed design Operational Service development	Tier Development - Tier 0	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 1	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 2	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 3	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
Total			30.00	10.00	10.00	10.00		£ 3,000	30.00	1,380.00	£ 414,000	£ 111,780	£ 525,780			£ 525,780		£ 525,780		£ 525,780
				Finance	Gvoernance/ HR	Operstions		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Professional backfill	Detailed design Clinical patient cohorts	LTC	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Frailty	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Primary Mental Health	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		OP & Diagnostics	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Urgent Care	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Intermediate and Care management	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
				Operations manager	Service Devleopment lead	SC operations rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
	Detailed design Operational Service development	Tier Development - Tier 0	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 1	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 2	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 3	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
Total			30.00	10.00	10.00	10.00		£ 2,500	30.00	1,380.00	£ 345,000	£ 93,150	£ 438,150			£ 438,150		£ 438,150		£ 438,150

Additonal Capacity in Community Services																				
Dual running costs and transformation	Costed at 5% Primary Care and Community Services												£ 3,034,232			£3,034,232		£3,034,232		£ 6,068,464.10
Total Capacity Costs			Resource	Number of sessions pw				Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Total	Clinical backfill	Detailed design Clinical patient cohorts	18.00	6.00	6.00	6.00		£ 1,800	18.00	828.00	£ 248,400	£ 67,068	£ 315,468			£ 315,468		£ 315,468		£ 315,468
		Detailed design Operational Service development	12.00	4.00	4.00	4.00		£ 1,200	12.00	552.00	£ 165,600	£ 44,712	£ 210,312			£ 210,312		£ 210,312		£ 210,312
	Professional backfill	Detailed design Clinical patient cohorts	18.00	6.00	6.00	6.00		£ 1,500	18.00	828.00	£ 207,000	£ 55,890	£ 262,890			£ 262,890		£ 262,890		£ 262,890
		Detailed design Operational Service development	12.00	4.00	4.00	4.00		£ 1,000	12.00	552.00	£ 138,000	£ 37,260	£ 175,260			£ 175,260		£ 175,260		£ 175,260
	Dual running costs and transformation	Costed at 5% Primary Care and Community Services											£ 3,034,232			£3,034,232		£3,034,232		£ 6,068,464
Total			60.00	20.00	20.00	20.00		5,500.00	60.00	2,760.00	759,000.00	204,930.00	3,998,162			£3,998,162		£3,998,162		£ 7,032,394

PMO	Position	Resource			Budget				Horizon 1	Horizon 2	Horizon 3
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Senior Programme Manager	1.00			£ 80,000	£ 80,000	£ 21,600	£ 101,600	£ 101,600	£ 101,600	£ 304,800
	Programme Manager	1.00			£ 40,000	£ 40,000	£ 10,800	£ 50,800	£ 50,800	£ 50,800	£ 152,400
	Programme Support officers	2.00			£ 30,000	£ 60,000	£ 8,100	£ 68,100	£ 68,100	£ 68,100	£ 204,300
Total		4.00	-	-		£ 180,000	£ 40,500	£ 220,500	£ 220,500	£ 220,500	£ 661,500

Change Management Team	Position	Resource			Budget						
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Technology Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
	Estates Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
	WF Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
Total		3.00	-	-		£ 150,000	£ 40,500	£ 190,500	£ 190,500	£ 190,500	£ 571,500

External transformation support	Position	Resource			Budget						
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Tier Change Management	6.00				£ -	£ -	£ 1,000,000	£ 1,000,000	£1,000,000	£1,000,000
	Technology Transformation support	1.00						£ 6,000,000	£ 2,000,000	£2,000,000	£2,000,000
Total		7.00	-	-		-	-	£ 7,000,000	£ 3,000,000	£3,000,000	£3,000,000

Capital Investment	Position	Budget									
				Number	Unit Cost			Total (£)	Total (£)	Total (£)	Total (£)
	Estates reconfiguration	H&W HuB development		4.00	£ 500,000	£ 2,000,000		£ 2,000,000	£ 1,000,000	£1,000,000	
	Training and Development	Tier and clincial devleopment						£ 1,000,000	£ 333,333	£ 333,333	£ 333,333
Total		-	-	-		£ 2,000,000	£ -	£ 3,000,000	£ 1,333,333	£1,333,333	£ 333,333

Leadership and Governance - Summary		Resource			Budget						
		Number	Days (pa) each	total days (pa)	Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
PMO		4.00	-	-	-	£ 180,000	£ 40,500	£ 220,500	£ 220,500	£ 220,500	£ 661,500
Change Management Team		3.00	-	-	-	£ 150,000	£ 40,500	£ 190,500	£ 190,500	£ 190,500	£ 571,500
External transformation support		-	-	-	-	£ -	£ -	£ 7,000,000	£ 3,000,000	£3,000,000	£3,000,000
Capital Investment								£ 3,000,000	£ 1,333,333	£1,333,333	£ 333,333
Total		7.00	-	-	-	£ 330,000	£ 81,000	£ 10,411,000	£ 4,744,333	£4,744,333	£4,566,333

Appendix 6: Rationale for identifying Walsall Healthcare NHS Trust as recommended Host Provider

1. The WTPB agreed that the role of the Host Provider could potentially be fulfilled by one of three organisations:
   - Walsall Council ('the Council');
   - Walsall Healthcare Trust (WHT); or,
   - Dudley and Walsall Mental Health Foundation Trust (DWMHPT)

2. This is documented in the *Case for Change* agreed by WTPB in January 2018:

'*In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale.'*

Procurement and competition considerations

3. Three potential procurement and competition issues have been considered as follows:

- Procurement - The selection of the host organisation is not a procurement process. The Walsall joint commissioners (Walsall CCG and Walsall Council) will not be awarding or transferring any new contract to the host organisation upon selection. However, procurement regulations will apply to any potential future contract awarded or transferred to the host organisation by commissioners. Therefore the commissioners will need to consider case by case where an open competitive tendering process may be required.

- Merger – The selection of the host organisation does not constitute either a merger under the Enterprise Act or an NHS merger by statutory reorganisation. Firstly, because no enterprises or parts of enterprises will cease to be distinct upon selection of the host organisation this will not trigger requirements for review by the Competition and Markets Authority. Secondly, the selection of the host organisation and establishment of an Integrated Care Board and management structure will not be a Statutory Transaction requiring Secretary of State approval or statutory instrument.

- Anti-competitive conduct – NHSI maintains guidance on its approach to regulating procurement, choice and competition in the NHS[2]. The selection of the host organisation will not impact on competition in and of itself. However, anti-competitive conduct regulations would prohibit any agreement(s) to develop the Host Provider model for integrated care in Walsall having the object or effect of restricting competition against the interests of patients. Similar prohibitions would apply to the conduct of the participants in the Host Provider arrangements. For example NHSI has established licence conditions relating to anti-competitive that reflect UK competition legislation by preventing a licensee from:

  - Entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of healthcare users.

  - Engaging in any other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of healthcare users.

  NHSI applies similar regulations to prohibit restrictions on patient choice.

  NHSI also has a duty to promote integration and its guidance includes hypothetical scenarios that illustrate how cooperation between commissioners and providers to deliver integrated care should not necessarily restrict competition against the interests of patients. It should also be noted that NHSI Annual Reports for 2016/17 and 2017/18 do not include a single reference to investigations of anti-competitive conduct cases

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/354079/cc__licence_conditions_guidance.pdf

during a period where integrated care models have been developed in many local areas. The risk of a successful challenge to development of the Host Provider model of integrated care under anti-competitive conduct regulations could therefore be considered to be low.

These issues would need to be kept under review and any future conduct by participants in the Host Provider model that had the object or effect of restricting patient choice or competition could be subject to investigation. The potential risk of challenge could increase in the context of any future procurement or contract award, transfer or extension relating to services within the scope of Walsall Together. Examples of potential anti-competitive conduct could include excluding others from participating in the Host Provider arrangement or restricting access to information where this had the effect of preventing the introduction of new providers in Walsall.

Potential requirements for reporting and detailed review by NHS Improvement

4. WHT and DWMHPT will need to engage with NHSI regarding their participation in the Host Provider model under the risk assessment framework and to notify any governance changes as required under the terms of their Licence. NHSI may determine the proposed arrangement to be a new care model that amounts to a 'material' or 'significant' transaction where it affects 25%-40% of capital or income for either Trust (see Annex for details of NHI thresholds for reporting and detailed investigation). This is likely to be triggered only at the point that contracts and/or resources are transferred so may not be applicable for April 2019. However, NHSI guidance states that such issues must be considered case by case and advises early engagement with the regional team.

Detailed considerations

Walsall Council

5. The Council is a credible candidate to fulfil the role of the host organisation. It has a corporate structure within which an integrated care Board and management structure could be developed. It has statutory duties to promote health and wellbeing and to meet the needs of people in Walsall for personal care, as well as powers to provide health related services. However, the Council is not currently licenced by NHS Improvement as a provider of NHS healthcare services.

6. There may be perceived conflicts between the host provider functions and the Council's functions as a commissioner and in oversight and scrutiny of the health service in Walsall. However, these issues could be managed in a similar way to the Council currently manages boundaries between its functions as both a commissioner and a provider and in political oversight and scrutiny of social care.

7. The Council is responsible for commissioning and/or provision of a significant scope of services to be integrated within the Walsall Together programme, including social care and public health.

8. The strategic priorities of the Council are aligned to the aims of the Walsall Together programme although its focus is on developing its role as a strategic commissioner. The Council has not set out an ambition to extend its role in providing NHS services and to take on the role of the host organisation would require diversion of management resources.

9. Taking on the role of the host provider could also potentially lead to misconceptions within the community. For examples there are risks that the Council taking on the role of the host provider could lead to public perceptions that it disagrees with the view of the Parliamentary Health and Social Care Select Committee that integrated care organisations should be NHS Bodies[3]. This could also risk creating misconceptions amongst local NHS staff that

[3] House of Commons Health and Social Care Committee: *Integrated care: organisations, partnerships and systems*; Seventh Report of Session 2017–19

the development of a Host Provider model for delivering integrated care in Walsall could lead to their employment transferring to the local authority.

Dudley and Walsall Mental Health Partnership Trust

10. DWMH is also a credible candidate to fulfil the role of the host organisation and has been rated as 'Good' by the Care Quality Commission. It has a corporate structure within which an integrated care Board and management structure could be developed. It has statutory powers to provide health and care services and is licenced by NHS Improvement.

11. There should be no conflicts for DWMH in fulfilling the role of the host.

12. DWMH is responsible for providing community mental health services within the scope of the Walsall Together programme, as well as inpatient mental health services for Walsall outside of this programme. DWMHPT also provides community mental health services in Dudley and provides inpatient care across a wider geographical footprint.

13. The strategic aims of DWMH are aligned to the aims of the Walsall Together programme although it also has other key priorities to address in developing its future role position in the Dudley ICS and across the wider STP footprint.

Walsall Healthcare Trust

14. WHT is considered to be the most credible candidate at this time to fulfil the role of the host organisation, despite a current CQC rating of "Requires Improvement" and challenges meeting their financial metrics. Thus is due to the corporate structure within which an integrated care Board and management structure could be developed alongside the statutory powers to provide health and care services and is licenced by NHS Improvement. Additionally the Community Services which make up the majority of services to be delivered initially by the ICP are rated "Outstanding."

15. There should be no conflicts for WHT in fulfilling the role of the host.

16. WHT provides a significant scope of the services to be integrated over the next phase of the Walsall Together programme, including community health services and acute hospital services at the Manor Hospital. The Manor Hospital is located in Walsall. The majority of patients it serves are from the Walsall community and significant numbers of its staff are Walsall residents.

17. The strategic priorities of WHT and its medium term quality and financial improvement objectives are aligned to the aims of the Walsall Together programme.

Alternative Options

18. The alternative options of the *One Walsall* group of voluntary and community providers and the *Walsall Alliance* GP federation have not been considered as potential candidates for the Host Provider role because it is clear that neither would meet some of the basic criteria at this stage. For example, at this point in time neither of these organisations has a corporate structure within which an ICP Board could be established or the capacity to invest sufficient management capacity to develop the host functions.

Conclusion

19. The working group is recommending that WHT be selected as the host organisation as it is closely embedded within the Walsall community and provides the bulk of hospital and community services to be integrated in the next phase of the Walsall Together programme. The strategic priorities of WHT and its medium term quality and

financial improvement objectives are closely aligned to the strategic aims of Walsall Together. WHT is therefore able to prioritise investment of senior management resources to fulfilling the role of the host.

20. The alternative options are also credible, but are not recommended at this time. For the Council to fulfil the role of the host provider would risk creating public misconceptions that developing the Host Provider model in Walsall could lead to services and staff being transferred out of NHS Bodies. This could appear at odds with the recommendations of the Parliamentary Health Select Committee that integrated care organisations should be established as NHS Bodies and would be a distraction from the Council developing its role as a strategic commissioner. DWMHPT provides a smaller scope of services in Walsall compared to WHT.

Appendix 7: Terms of Reference for the ICP Board (Draft)

Walsall Together
Joining up your health and social care

INTERGRATED CARE PARTNERSHIP BOARD

TERMS OF REFERENCE: Version 0.1

RATIFIED BY THE TRUST BOARD ON:

NEXT REVIEW DUE:

1. CONSTITUTION

1.1 The Integrated Care Partnership Board is established by the Participants, who remain sovereign organisations. It is established as a Board Committee of the host provider to provide a governance framework for the delivery of the Walsall Together Business Plan.

1.2 The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

1.3 Each Partner shall delegate to its representative to the ICP Board, such authority as is agreed to be necessary in order for the ICP Board to function effectively in discharging the duties within these Terms of Reference. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation or similar.

1.4 The ICP Board is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

2. PURPOSE

2.1 The ICP Board has been established to provide strategic direction to the partnership and has responsibility for the delivery of the Walsall Together Plan.

2.2 Thus the ICP Board will have responsibility for the oversight of services contractually in scope and for the wider system integration and transformation.

3. MEMBERSHIP

3.1 As a the Sub Committee is one focused on partnership working across the borough of Walsall, the ICP Board will include members of Partner organisations.

The Membership of the Committee shall consist of;

- A newly appointed Non-Executive Director of WHT, appointed by all system partners, as Chair
- Two Non-Executive Directors
- Chief Executive Officer (Walsall Healthcare NHS Trust)
- Director of Walsall Together

3.2 Partner representative's

- Chief Executive, Dudley and Walsall Mental Health Partnership Trust
- Director of Adult Social Care, Walsall MBC
- Director of Public Health, Walsall MBC.
- Director of Children's Services, Walsall MBC
- Chief Officer, Walsall CCG
- Chief Executive, One Walsall.
- GP representation.

3.3 Professional Representation

- Consultant, professional lead for in-scope hospital services.
- Professional lead for Primary Care.
- Consultant, professional lead for mental health.
- Professional lead for nursing and AHPs.
- Professional lead for Adult Social Care.
- Professional lead for Children's Services.

4. ATTENDEES

4.1 Other executive directors/managers from across the partnership should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

5. ATTENDANCE

5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year.

6. QUORUM

6.1 A quorum shall be 2 Non-Executive Directors and one Executive Director from the host organisation

6.2 In addition to the above quorum also requires two thirds of its partner and professional representation are present

6.3 Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Deputies must be able to contribute and make decisions on behalf of the Participant that they are representing. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet 10 times a year additional meetings may be arranged as required.

8. CHANGES TO TERMS OF REFERENCE

8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.

9. ADMINISTRATIVE ARRANGEMENTS

9.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Walsall Together. The Committee shall be supported administratively by the Executive PA who's duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers with all partner organisations
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the committee on pertinent issues / areas
- Enabling the development and training of Committee members

All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.

10. ANNUAL CYCLE OF BUSINESS

10.1 The Committee will develop an annual cycle of business for approval by the Trust Board. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.

11. REPORTING TO THE PARTNER ORGANISATIONS

11.1 The Chair of the ICP board will on behalf of the Board provide a highlight report monthly to each of the partner organisations outlining key actions taken with regard to the issues, key risks identified and key levels of assurance given. A report will also be provided to the Walsall Health & Wellbeing Board.

12. STATUS OF THE MEETING

12.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.

13. MONITORING

13.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided

14. DUTIES

14.1 The primary responsibility of the ICP Board will be the integration of services deemed to be “in scope” and not for the delivery of those services.

14.2 The functions of the ICP Board would be to:

- To provide strategic leadership and oversight of service delivery for in-scope services and for ICP programme work streams;
- To ensure alignment of all organisations to the Walsall Together vision and objectives;
- To promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;
- To oversee the development of, and transition to, new models of care in priority areas/in scope services;
- To consider investment and any disinvestment decisions across the partnership;
- To collectively hold ICP partners to account for upholding the commitments made in the Business case, and the Alliance contract.
- To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements
- To respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;
- To ensure that the risks associated with the delivery of the programme are identified and managed where necessary with the Participants' own risk management arrangements;
- To generally ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders;
- To review the governance arrangements for the Alliance at least annually.

Appendix 8: WHT IT Strategy as an enabler to the transformation

Within the architecture outlined in section we have assumed that everything above level 4 has to be scalable (i.e. deployed once, on an integrated care system level, and with the opportunity for significant growth in terms of patient numbers and transactions across an integrated network of provider organisations).

What this means is that each organisation within the Walsall Together system can have a separate operational plan (run by a local IT team) for day-to-day clinical/professional/operational IT at level 4 – that interoperates with a wider group strategy in all other tiers.

This is important given that the existing makeup of the provider system has differential systems and strategies at a level 4. It also allows for operational choices to be made at Level 4 (e.g. replacing Lorenzo in the hospital or moving from Oasis to Rio in the mental health trust) without affecting the overall strategy (provided that the choices made at Level 4 are supportive of the wider strategy).

So what does this approach mean for our key user groups in the future?

1. Level 1 Patients/Public All – would have access to specific health and care related services, delivered on-line and through mobile channels (i.e. as a central web/app service). This should include:
    a. Content services – syndicated advice from services such as NHS Choices, plus group specific content designed to encourage patients/citizens to follow the optimal pathway for their care;
    b. Non personalised self-care tools, advice and service finding (e.g. where do I go for my cough);
    c. The ability for customer/citizen feedback and ratings to be embedded from the outset – giving transparency in terms of service feedback and response and creating a 'customer service' culture from the outset;
    d. Act as a gateway and referral pathway to Level 2, where patients/personalised have a personalised experience within a single joined up approach.
2. Level 2 Personalised Patients/Public – the establishment a single, registered patient facing digital service as a single platform/framework for citizens. This service must:
    a. Provide a common identity standard and consent framework for patients/citizens wishing to access health and care services on-line;
    b. Be personalised...i.e. it is about me and my health...or indeed about my carers supporting my health;
    c. Be deployed agnostic of digital devices (e.g. via smartphone apps, web browser etc.)
    d. Act as a framework through which different services and applications can be deployed over time (telehealth, appointment booking, on demand access to content, joining groups etc.);
    e. Be based on the principle of 'connected', personalised, health and care records (PHRS) where people are able to store and share their own data (with consent) within their own PHRs (note most are moving to mobile here);
    f. Enable device and app connectivity to PHRs via APIs (application program interface). Essentially this means that I can connect my Fitbit, digital scales, Bluetooth telehealth devices in to my own personal single data repository;
    g. Receive content, messages and services from Tier 3.
3. Level 3a Clinicians, Service Managers and Executives – the establishment of a unified approach and toolset to support unified service management, and care coordination across the group (population management), this should include:
    a. A very mature approach to data exchange and interoperability. Within your model this will need to handle four types of data (patient owned/held, clinically owned/held, operational capacity and

demand, communications). Level 3a therefore requires an ability to hold, and interface each of these types of data in various formats (e.g. flat file, messages, images etc..) and handle them at different frequencies (e.g. some real time, some daily, some weekly etc..). This requires an interoperability engine that is dedicated to resolving these specific challenges.

   b. A single data repository, that is separate to each of the individual clinical/professional systems at Tier 4 and enables you to build up a longitudinal view of patients across all providers and (with consent) from the patient (and carers themselves).
   c. A common user interface for service managers and clinicians (the "clinical portal) that is separate to individual clinical systems at Level 4. This enables clinicians, care coordinators and managers to manage care across settings with a single version of the truth ("population management"). Within your context this would include functionality such as patient index and spine services, remote booking and scheduling, contact centre and communications management, a view on the single clinical data repository itself, clear access to reports and management information, and the ability to deliver virtual caseload management from a single application. In itself this component of the architecture de-risks a number of the operational challenges at Level 4 and enables greater clinical efficiency and workflow management.

4. Level 3b Finance and Business Intelligence Users – the creation of a direct link to Level 3a for finance and business intelligence users as secondary users of whole pathway data to include functionality such as:
   a. Risk stratification, population identification and predicative analytics;
   b. Whole pathway commissioning/payment data including expenditure, activity tracking, and touch points across all providers etc.
   c. Planning, monitoring and budgeting;
   d. Prescribing, medicines adherence, drugs monitoring etc.
5. Level 4 Point of Care Professionals – where it is assumed that all individual providers will continue to utilise their own/current operational IT systems*. To achieve this the following will be required:
   a. Utilisation of clinical systems adapters to exchange data (where possible) with each clinical system. These are invisible to users at Level 4, but critical in delivering the overall model;
   b. An exposure of the Level 3a user interface at Level 4 (e.g. providing a view on the whole pathway within individual providers).
6. ALL – across all Level a common approach to communication which implies the need for a single, cloud based telephony solution, combined with VOIP communications, secure messaging and recording etc.
7. ALL - Deploying all of the above within a scalable architecture that can be easily deployed to new sites/services as the group grows and indeed offered on a commercial basis to other providers if required.

*This architecture will broadly enable the individual operational IT plans of the group to remain as-is at Level 4. From an operational perspective it makes logical and financial sense to consolidate operational/IT systems wherever possible at this level – but that is a secondary issue to the strategy overall. I.e. the strategy has to be right for the group overall without the need to change all the clinical systems in individual providers.

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