Health and Wellbeing Board

12 February 2018

Agenda item 8

Integration and Better Care Fund Plan 2017 – 2019 Update

1. Purpose

This report provides an update on the resubmitted Integration and Better Care Fund (BCF) Narrative Plan, Quarter 3's Better Care Fund and Improved Better Care Fund (iBCF) returns and a financial monitoring update.

2. Recommendations

2.1 That members note the contents of this report.

3. Integration and Better Care Fund Narrative Plan

3.1 Walsall's Narrative Plan has been through the Regional and National Assurance process and was classified as 'approved with conditions'. Informal notification, advising on the areas for improvement was received on 7th November 2017. The areas for improvement were noted on the following Key Lines of Enquiry (KLOE):

- KLOEs 11,12: The plan for the High Impact Change model needs to be augmented with distinct timescales for implementation over the life of the BCF plan; and outline costings to demonstrate KLOE 12 (delivering and funding actions).
- KLOEs 14, 16: Set out clearly the anticipated changes to patient and service user outcomes that this plan will deliver; Describe how Housing is/will become more strategically involved in developing the plan; Set out, in a distinct section of the document, how the former National Conditions (7 day services; data sharing; joint assessments) will be progressed.
- KLOEs 18, 19: Set out how governance arrangements have developed since the proposals articulated in Appendix 9 (System Governance); and/or confirm what has been implemented as the governance mechanism for the duration of this plan.
- KLOE 19: Set out what arrangements are in place to ensure that any health inequalities for people with protected characteristics under Equalities legislation can be identified, and the actions taken to reduce these.
- KLOE 22: Articulate the way in which risks to the minimum contribution to social care and iBCF funding are managed, particularly concerning questions of affordability of service provision.
- KLOE 26: Confirmation required that iBCF funding has not been offset against the contribution from the CCG minimum following the re-basing of the planning template.
- KLOE 31: Set out clear rationale for why the residential care metric is not reducing
- KLOEs 33-36: DToC measures will need to be re-addressed, in particular a clear articulation for KLOE 36 for how BCF funded schemes will impact on the metric for DToC.

3.2. The Plan was amended to address the improvement areas and a revised plan was submitted to the National team for assurance on 8th December 2017. A copy of the final submission can be found at **Appendix 1.**

3.3. Formal notification of the 'Approved with Conditions' status was received on 20th December 2017 and we now await notification of the classification of the resubmitted plan.

4. Quarter 3 BCF and iBCF Returns

4.1 Within the Better Care Fund guidelines, there is a requirement for Quarterly national performance reporting. Quarter 3's iBCF and BCF returns were submitted on 22nd and 29th January 2018 respectively, as attached at **Appendix 2 and 3.** These submissions were authorised on behalf of the Health and Wellbeing Board (HWBB), through agreed delegation to the Chair of the HWBB.

4.2. The key messages from the Quarter 3 returns are:

iBCF

- All initiatives funded through the iBCF funding are on track for delivery and any underspends in year have been accounted for and reprofiled to deliver the priorities in years 2 and 3.
- Performance metrics have been developed for half of the initiatives and challenges in identifying appropriate data sources are being addressed so that a clear performance monitoring framework for the iBCF is in place for Quarter 1 of 2018/19.

BCF

- All National Conditions are being met.
- Metrics for Residential and Nursing Admissions and Outcomes of Reablement are on Track to meet the target.
- The number of non-elective admissions is not on track to achieve the target and actions to address this have been developed through the A&E Delivery Board.
- Walsall is not on track to meet the DTOC target. The challenge faced is that more robust monitoring of DTOC has been partially implemented which has resulted in a rise in the number of delays reported.
- Good progress is being made against the High Impact Change model to support hospital discharge.

5. Better Care Fund Budget Monitoring

5.1. The Better Care Fund budget monitoring report can be found at **Appendix 4.**

5.2. The forecasted position as at Quarter 3 (April to December 2017) is an under spend of (£1.253m) against the overall BCF budget of £29.561m (including BCF, iBCF1 and iBCF2).

The (£1.253m) under spend can be split as:

- (£0.250m) of BCF funding mainly on Intermediate Care Services and Resilient Communities work streams
- (£1.003m) of iBCF2 funding which will be carried forward into 2018/19, and the iBCF2 plan is under revision

6. Health and Wellbeing Priorities:

6.1 Services delivered through iBCF and BCF will enable the Council and Health service to :

- Support Independent Living
- Enable those at risk of poor health to access appropriate health and care, with informed choice
- Keep vulnerable people safe through prevention and early Intervention

as part of the 'Maximising People's Health, Wellbeing and Safety Health and wellbeing priority'.

Background papers

None

Appendices

Appendix	Title	Attachment
1	Integration and Better Care Fund Narrative Plan	
2	iBCF Quarter 3 Return	
3	BCF Quarter 3 Return	
4	BCF Q3 Budget Monitoring	

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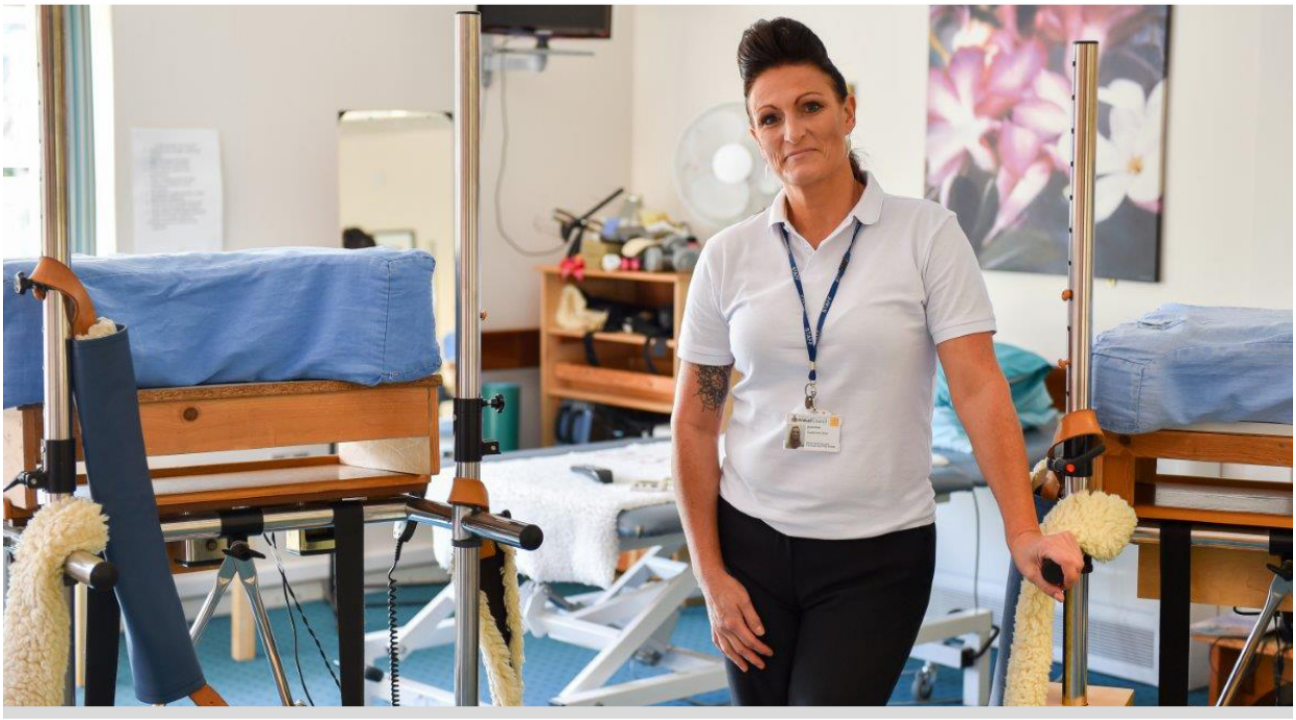
Walsall Integration and Better Care Fund

Narrative Fund 2017/19



Walsall Council

Local Government Association

NHS England

NHS Walsall Clinical Commissioning Group

Contents

1.0 Introduction / Foreword

This document forms part of the 2017-19 Better Care Fund submission along with the 'template for BCF submission' spreadsheets, which contains financial and performance targets. The purpose of this submission is to:

- Outline our 2020 vision for integration in Walsall and how this has developed over recent years. Key to that vision is the aspiration to incrementally maximise opportunities for integration moving towards the national direction of new models of care.
- Describe our specific priorities for delivery of further integrated working over the next two years 2017-19.
- Describe the context for the vision and priorities, including an overview of changes across Walsall and a brief overview of progress against the BCF plan for 2016/17.
- Describe our approach to the Improved Better Care Fund budget in 2017-19.
- Describe how we will meet each of the national BCF conditions.

Throughout this document there will be references to the Walsall Together Programme (WTP). The WTP is the integrated delivery mechanism for the Better Care Fund plan in Walsall. Members of the Walsall Together Board include: Walsall CCG, Walsall Adult Social Care and Public Health as Commissioners, Walsall Healthcare Trust, Dudley and Walsall Mental Health Trust, GP Federations, Adult Social Care provision, One Walsall (Voluntary Sector) as providers and Healthwatch, Patient engagement lead. There are plans to incorporate housing onto the board.

A summary of the Walsall Together Programme and its execution plan can be found at **Appendix 1.**

A reference document for the location of evidence of compliance with the Key Lines of Enquiry within this document, can be found at **Appendix 10**.

2.0 The local vision and approach for health and social care integration

2.1 The 2017-19 BCF plan builds on the preceding 2-years plans derived from the Joint Health and Wellbeing Strategy which aims to: ***"maintain and where possible improve the independence, health and well-being of the people of Walsall. In doing so we aim to reduce the prevalence of unnecessary admissions to hospital and to reduce the number of older people who are receiving on-going social care services, especially admissions to care homes."***

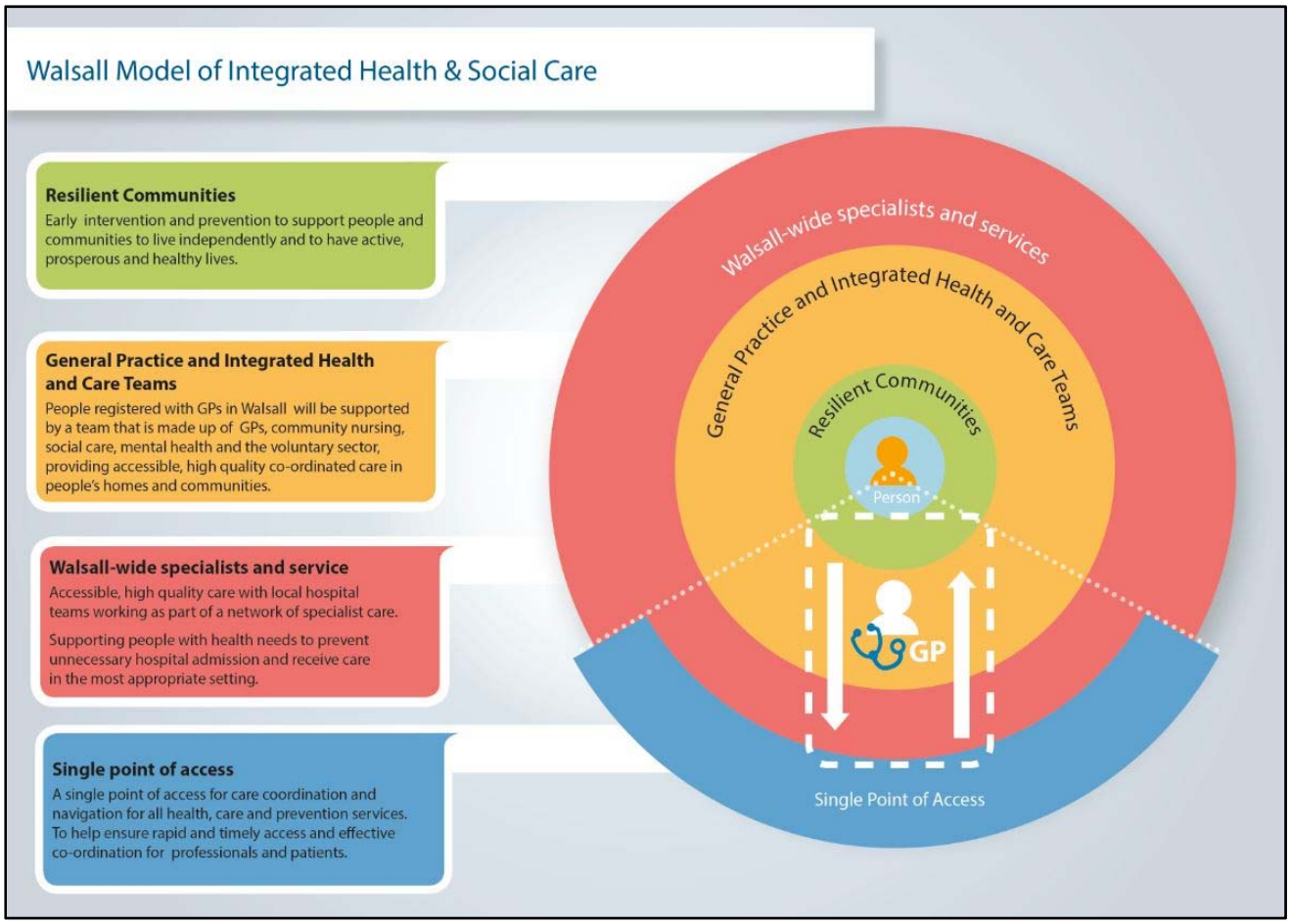
2.2 This aim is threaded throughout our major transformation programme The Black Country and West Birmingham Sustainability Transformation Plan. The plan is a collaboration of 18 organisations across primary care, community services, social care, mental health and acute and specialised services across the Black Country and the west of Birmingham, and The Walsall Together Programme which is the vehicle for local implementation, which aims to:

"***address 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."***

2.3 We have recently reviewed and made changes to our commissioning arrangements, this has given us greater clarity and focus on our aspiration to move towards greater integration of provision in Walsall and achieve the national direction of developing new models of care. Building on our existing integrated teams and harmonising services that duplicate effort to efficiently expedite flow out of hospital. In doing this, we will embed a system cultural shift of working across professional and organisational boundaries and facilitate the development of an Alliance Model of delivery from April 2018 and a more formalised contracting model by 2019, in line with the ambition for Health and Social Care integration by 2020.

2.4 The illustration set out in Figure 1, captures the essence of the vision with communities and Primary Care at its heart.

Figure 1



2.5 As part of this work, new models of Integrated Health & Social Care have been developed. It builds on some of the joint work that is already taking place, and is focussed on improving outcomes for those that use services, including:

- Promoting health and well-being and tackling health inequalities
- Better support for people with long term conditions, minimising their need to rely on institutional care
- Better support for people to live independently
- Improved clinical effectiveness (outcomes)
- Improved experience of care, including ease of access and coordinated care

2.6 It will do this in a more financially sustainable way. To achieve this, we are focussed on the following four areas:

2.6.1 **Resilient Communities** – Early intervention and prevention to support people and communities to live independently and to have active, prosperous and healthy lives. For example, a new borough wide initiative between health, social care, the voluntary sector and community groups called 'Making Connections Walsall' is being developed by Walsall Council's Public Health team to improve the health and wellbeing of residents by tackling

loneliness. It will commission and work with the voluntary sector to utilise social networks and community groups to improve the health and wellbeing of the community (targeted interventions to build social relationships amongst isolated groups). The aim is to utilise existing expertise and knowledge in voluntary sector organisations by taking referrals from health and social care professionals. In the next phase of the Resilient Communities work stream the wider community support network will be reviewed to ensure that the prevention/community 'offer', including, housing, equipment, assistive technology, voluntary sector support, advice and information is aligned and delivered in a coordinated way.

2.6.2 **General Practice and Integrated Health and Care Teams** – Person-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health and care systems. For example, 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 in line with the 5 Year Forward View vision.

2.6.3 **Walsall-wide specialist and services** - Accessible, high quality care with local hospital teams working as part of a network of specialist care. Supporting people with health and care needs to prevent unnecessary hospital admission and receive care in the most appropriate setting. For example, a person who no longer needs to be in hospital but may need extra support to help them recover, will be able to access care at home which is appropriate to their needs. This could include physiotherapy, social care, specialist services and equipment to enable them to live independently. An important aspect of this is the development of a new model of integrated intermediate care.

2.6.4 **Access** – A single point of access for care coordination and navigation for all health, care and prevention services. To ensure rapid and timely access, effective co-ordination and improve efficiency for professionals and patients. For example, this will avoid patients being signposted to and from one service to another service. Instead patients and professionals will have one point of access.

2.7 Progress has been made over the last year in the development of collaborative arrangements across the borough through the Walsall Together Partnership, the Provider Partnership Board and the GP Leadership Group.

2.8 Alongside the Walsall Together Partnership Board, local providers have established a Provider Partnership Board as a forum for developing an integrated approach to the delivery of the model of care. The Provider Partnership Board includes in its membership: Walsall GPs, Walsall Healthcare Trust, Dudley and Walsall Mental Health Partnership Trust, Adult

Social Care, Public Health, One Walsall. The Terms of Reference for this can be found at **Appendix 2.**

2.9 As part of the development of the new model of care in Walsall we need also to determine the contractual arrangements that will underpin a more integrated approach to commissioning and service delivery.

2.10 Looking ahead to 2018/19, we will be establishing arrangements for more joined up commissioning and provision of the new model of care across health, social care and housing. The Walsall Together Partnership are working towards an 'Alliance' model by April 2018 as the basis for establishing a more robust commissioning and governance framework.

3.0 Background and context to the plan

3.1 Walsall serves a population of 274,000 and we have a coterminous CCG and Metropolitan Borough Council. Our Borough is characterised by great contrast, with significant deprivation in the West of the Borough and relative affluence in the East.

3.2 Differences in deprivation levels and lifestyles such as smoking and excessive consumption of alcohol lead to poorer health outcomes for our communities living in these localities. This translates into high levels of infant mortality and lower life expectancy in our adult population. High levels of morbidity from a range of diseases such as coronary heart disease and diabetes sits alongside often poorer experiences of health services.

3.3 The Walsall health and social care system faces unprecedented challenges. The CCG has an underlying deficit and is not currently achieving the national 4-hour A&E waiting time standard or the national Referral to Treatment Time (RTT) standards for elective care.

3.4 Our main acute provider Walsall Healthcare NHS Trust is rated "Inadequate" by the Care Quality Commission (CQC) and has a significant financial deficit. Adult Social Care budgets have been reduced by 26% in real terms over the last four years, despite Walsall Council protecting Adult Social Care budgets as far as possible, the directorate has been required to have made £26m of savings and efficiencies with a further £17.8m planned over the period 2017-20.

3.5 6% of GP practices that have been inspected by the CQC have been rated as "inadequate" and 14% "requiring improvement" along with 26% of Walsall care homes that have been rated as "requiring improvement" or "inadequate".

3.6 The number of people who may need social care support in the future is expected to rise significantly. The numbers of people living with dementia, learning disabilities, poor mental health and multiple co-morbidities, will all increase and the rise in demand for health and social care comes at a time when funding is decreasing. Projections estimate that the number of people aged over 65 in Walsall will increase by 13.8% by 2022 and the borough will be home to an additional 6,500 over 85 year olds.

3.7 The Care Act 2014 brought new responsibilities for local authorities, with new eligibility for services, support for carers, new areas of work around information, advice, prevention, support for the care market, and safeguarding. This impacts on capacity of Social Care resources in order to deliver the new requirements.

3.8 The Walsall Local Health and Social Care Economy is not alone in its drive to deliver solutions to unprecedented demands on Health and Social Care services, this is indeed a

national complex issue that has arisen from a combination of causal factors. Essentially, the successful implementation of the National Health Service in 1948 has improved the health of the nation such that people are living longer, and doing so with complex, multiple health needs.

3.9 The symptoms of these systemic pressures are seen in areas such as:

- The number of people attending accident and emergency departments
- Failure to achieve NHS constitutional targets such as spending less than 4-hours in A&E
- The number of hand-offs patients and service users experience between services which compromises their experience
- Workforce recruitment and retention issues
- The number of GP trainees
- Financial deficits for health and care providers and commissioners
- The flow of patients from hospital admission to discharge home.

3.10 The number of people who may need social care support in the future is expected to rise significantly. The numbers of people living with dementia, learning disabilities, poor mental health and multiple co-morbidities, will all increase and the rise in demand for health and social care comes at a time when funding is decreasing.

3.11 The ambition of the BCF Plan submission has not changed since 2016/17 and we continue to develop solutions where we focus on prevention of illness rather than treatment; where we care for patients and residents in the community more than we do within hospital settings; and where we focus on the correct level of care for the individual rather than placing patients in care settings that are of a higher dependency than their needs require. We must also continue to make radical changes to how we apportion our funding and on what services we focus our scarce resources and on building community capacity and resilience to help people and communities help themselves. They continue to require us to work even better together.

4.0 Progress to date

4.1 The BCF plans have been reviewed regularly to review progress and adjust delivery as required. In 2015/16 plans were adjusted and some ceased because they were not delivering the benefits that were expected. 2016-17 plans are regularly monitored through the BCF governance arrangements that exist between CCG and Council, including HWBB oversight.

4.2 BCF schemes that were monitored through 2016/17 have progressed the integration and demand management agenda and form a sound platform for the work streams of the Walsall Together programme, these schemes were:

- Multi-disciplinary Locality Teams/Risk Stratification for Long Term Conditions
- Rapid Response Service and Single Point of Access
- Frail Elderly Pathway / Service
- Support to Nursing Homes for Reducing Hospital Admission
- Early Supported Discharge
- Ambulatory Care in the Emergency Department of the Hospital
- Delayed Transfers of Care (DTOC)
- Aids/Adaptations and Assistive Technology (including Telehealth)
- Support for People with Dementia

4.3 An example of progress of two of the schemes in 2016/17 follows

Health in Care Homes –

4.3.1 Walsall Healthcare have a substantive team, funded through the BCF, working across the borough of Walsall supporting enhanced care in nursing homes. The team comprises of Senior Advanced Nurse Practitioners and Senior Clinical Sisters to support enhanced case management in Nursing homes. Their role is to identify and undertake comprehensive holistic assessment of residents who are high risk of hospital admission, develop a personalised written management plan and provide care co-ordination for identified caseload. This team is now an established element within the Walsall model of care and contributes to the High Impact Change model for managing delayed transfers of care.

4.3.2 The case manager visits each nursing/residential home on a regular basis to:

- Increase the number of early intervention/emergency passports in place.
- Reduce the number of inappropriate 999 West Midlands Ambulance calls.
- Reduce the number of patients being admitted into hospital inappropriately.

- Improve access for Nursing Home staff to educate and training, in-order to enhance the quality and consistency of care that has been provided for patients and reduce avoidable patient harms.
- Provide clinical assessment and deliver nursing care.

4.3.3 Weekly Board rounds have been in operation across the homes for the past year with the aim of ensuring appropriate medical cover and supporting multi-disciplinary care.

4.3.4 To date there has been a significant reduction in the number of 999 calls to nursing homes which in-turn has decreased the number of patients being inappropriately conveyed to hospital.

4.3.5 Following the success of the work stream in health in care homes, the work stream was expanded to actively support quality improvement at our residential care homes with registered care managers regularly completing our self-assessment quality tool which informs our allocation of additional resources/training as required.

4.3.6 Furthermore, end of life training has been provided by WHT to all residential and nursing homes in the borough following a successful application to Health Education England for additional funding.

Frailty team across acute and community

4.3.7 An enhanced Frailty model was implemented during 2015/16 and developed further in 2016/17. Building on the current management of Frailty, via Rapid Response, Frail and Elderly Service and other Walsall Healthcare's community services pathways as described above, this team of enhanced practitioners work in the acute emergency department and also have ring fenced beds on an acute ward for short stay intervention. The frailty service, with enhanced capability and capacity, direct the majority of frail patients accessing ED, to be managed with an agreed care plan in the community with the appropriate support. Also, for those patients that are admitted the Frailty service will continue to oversee the care plan for 72 hours to expedite the discharge.

4.3.8 The Frailty service is a critical component of the Walsall Together transformation programme that seeks to enable a single community team approach to manage frail patients. The team utilise common assessments, standards, care plans, skills and roles. This enhanced service has been operational since 11th Janauary 2016.

4.3.9 The Virtual ward element of the service provides a structure to streamline care for acutely ill patients within the community to prevent avoidable hospital admissions and deliver care at

patient's own home. This may facilitate a reduced length of stay in the acute hospital as care is available outside of the hospital environment.

4.4 Alongside monitoring delivery of the existing schemes, the development of an integrated intermediate care pathway for Walsall has been a significant focus for the health and care system, through the Walsall Together programme, over the past 12 months. The model has now been agreed and moves into implementation phase with a refreshed vision that aims to deliver a locality based health and social care single service with responsibility for complex patients who require support to facilitate discharge from an in-patient bed.

4.5 Significant work has also been undertaken to build on the work of the Multi-disciplinary Locality Teams scheme with a renewed focus under the Walsall Together programme.

5.0 Evidence base and local priorities to support plan for integration

5.1 Implementation of major transformation across Health and Social Care is complex, particularly at a time of diminishing funding where the balance between funding transformation and delivering core services creates system tension. In Walsall, the case for change that has been described in previous years remains valid.

5.2 Research to support the case for integration tells us that there is wide variation in the models of integration and indicates that there is no right or wrong way. Findings are that improved integration delivers:

- Improved access to care
- Improved waiting times
- Processes were more efficient with the increased collaboration and information sharing, improved referral and assessment
- Service innovation/redesign as a result of identifying gaps and solutions to these
- Improved recruitment and retention
- Improved identification of vulnerable families
- Opportunities for health promotion

5.3 The 2016 local demographic intelligence tells us that Walsall's overall population is predicted to increase by 5.1% from 270,900 in 2012 to 284,700 in 2022. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 13.8%, with the number of people 85 years and older increasing from 47,200 in 2012 to 53,700 in 2022.

5.4. Intelligence regarding health inequalities for people with protected characteristics, detailed within the Joint Strategic Needs Assessment (JSNA) inform us that locally:

- An ageing population in Walsall shows a projected need to ensure suitable provision is in place.
- Ethnicity figures demonstrate a more diverse population in the Borough which is set to increase with a skewer towards more elderly dependent people from BME groups with a particular support need.
- An increase in those suffering with Physical, Learning Disability and Mental Health need in particular for females.
- Long-term projections show a greater proportion of people over 85 requiring some form of support (either care provided privately or by a local authority).
- There is a predicted increase in the number of people who are aged over 65 and are also carers providing unpaid care.

5.5 Recognising the local context, the context of Walsall within the wider Black Country Sustainable Transformation Plan footprint and progress of the integration agenda with BCF as a key enabler, we have planned for the BCF plan for 2017-19.

5.6 The BCF Plan plans to reduce health inequalities in the borough by the implementation of the new models of integrated care. In addition, each work stream is required to complete robust Equality Impact Assessments in line with duties contained in the Health and Social Care Act 2012 and Equality Act 2010 for any project work undertaken as an integral part of the governance processes.

5.7 The Walsall Together programme is the local delivery vehicle for vertical placed based health and care which is one strand of the Black Country and West Birmingham Sustainable Transformation Plan.

6.0 Better Care Fund plan 2017-19

6.1 The Better Care Fund plan for 2017/19 focusses on the 4-areas that together make up the Walsall Model of Integrated Care described within the Walsall Together Programme and are described in detail below. They are:

- Resilient Communities
- General Practice and Integrated Health and Care Teams
- Walsall-wide specialist and services
- Single point of access

6.1.1 The priority activities over the next 2 years are:

- Implementation of the integrated Intermediate Care model
- Further development of the Integrated Health and Care teams
- Development of an Alliance Model of delivery for the new model of care
- Development of a joint commissioning approach for the new model of care

6.1.2 The Walsall Together programme is aligned to deliver the 8 High Impact Change model, primarily through the Intermediate Care Service and the Integrated Health and Care Teams and best practice in this area has been used to develop the models of delivery.

6.2 Resilient Communities

6.2.1 The vision for the Healthy Resilient Communities work stream is to increase its healthy community resilience by developing and maximising the current assets whilst also seeking additional resources to sustain and build communities. Although funding for this work currently comes from Public Health rather than the BCF, it is a critical component in managing the health and wellbeing of the Walsall community, particularly the aging population who we know proportionately are most likely to require acute support.

6.2.2 Healthy Resilient communities require commitment and support to transfer power, resources and enable communities to take ownership. It is not a quick fix; it requires time and commitment to develop the community sufficiently to have an impact. The process needs to happen right across the health and social economy structure.

6.2.3 This work stream is about building resilience of the local community, working towards keeping people well and at home for longer by helping them remain connected within their community. The priorities of Making Connections Walsall are to:

- Help people to stay well and out of hospital

- Help to address behaviour around the increased use of urgent care services (eg A&E, GP out of hours)
- Contribute to improving the health of the most vulnerable older people, and in particularly men
- Promote greater partnership working between the community and health service
- Help people to find out how to improve their own health and promoting emotional wellbeing and encourage people to be more self-reliant
- Encourage people to connect with others and contribute to improving the health of local people in their communities
- Encourage the use of self-care and new technologies
- Ensure that people are supported to remain as independent as possible in communities through appropriate housing and housing support

6.2.4 The approach is to build and adjust social capital across the borough of Walsall with a view to improving population health and wellbeing and reducing health inequalities. It is important to remember that the needs of Walsall residents vary significantly and so too do the community assets. The approach taken is to;

- Map community and voluntary sector assets for people
- Build on information held within the Community Living Directory
- The Making Connections Walsall Programme
- Community engagement and consultation
- Support and secure community groups and organisations as MCW Providers
- Develop people's wellbeing plans

6.2.5 The elements detailed above are either in place or currently being tendered. Significant delivery of these components is undertaken by the voluntary sector in Walsall who are ideally placed to deliver local support. An update on the work to date can be found in **Appendix 3**.

6.2.6 In 2018 we plan to evaluate the model and also to expand the model to include a broader range of provision. This will include the existing services currently within the BCF budget that align to the Resilient Communities work stream, such as equipment, assistive technology and advice/information services.

6.2.7 Housing is central to the Resilient Communities work stream of the Walsall Together programme. Walsall has a sound history of working in Partnership with housing providers and as a result Walsall has a good supply of 'Extra care' and 'Extra care Light' and respite/step-down housing provision in the borough that works well and meets the current needs of Walsall residents. However, it is recognised that in considering the future needs of

Walsall residents, aligned to the Walsall Together work programme, housing representatives should have a place on the Walsall Together Board and be more involved in the project groups. We are currently working with the Board to make this happen.

6.2.8 Work to date, specifically relating to the BCF has focussed mainly on the Disabled Facility Grant element.

6.2.9 Improvements to the DFG service have meant that more DFGs have been approved, a rise from 135 in 2009/10 to 488 in 2016/17. Major service improvements have led to:

- Faster delivery – schemes approved 88% faster in 2016 than in 2008
- Less waiting – 83% reduction in waiting list 2008 to 2016
- Major procurement work has seen average DFG costs reduce dramatically for example a 47% reduction in stair lift costs from 2008/9 to 2016/17. Work with social housing providers has helped create newly adapted homes and share the cost of adaptations to existing properties.
- Overall average DFG costs have reduced by 55% from 2009 to 2016.

The service improvements have led to two commendations from the National Charity (Foundations) for Best Home Adaptation Service of the Year 2017 and 2015 for our service.

6.2.10 Priorities for 2017-19 include:

- Aligned to the Walsall Together work streams, help people stay safe and well in their homes for as long as they choose to
- Ensure support is delivered as soon as practical and at lowest reasonable cost (making funds go as far as possible)
- Prioritise support for families caring for a palliative relative
- Prioritise support to members of the armed services in line with the Council's Armed Forces Community Covenant
- Assist colleagues from West Midlands Fire Service in reducing accidental home fires and injuries from the same by joint working
- To help identify and support households in fuel poverty through delivery of a comprehensive adaptations service.

6.3 Walsall Integrated Health and Care Service

6.3.1 The Walsall Together Integrated Health and Social care model's aim is to significantly improve the overall health and wellbeing of their local population. With National models of care delivery clearly beginning to demonstrate their initial successes it has been useful to benchmark Walsall's redesign of services over the past 3-5 years against these models.

There is currently a wide variety of care models across Great Britain and it is becoming apparent that Walsall has delivered sucesses similar to many of the National Vangaurd models. The model for Walsall is made up of a number of components:

6.3.2 The locality integrated Health and Social care teams work in collaboration with the Primary Care Teams. The multi-disciplinary workforce is aligned to each team dependant on:

- GP Practice populations
- Caseload analysis
- Co-morbidities and patient dependencies
- Geographical areas
- Public health priorities
- Partnership priorities

6.3.3 Patients are referred for care across these teams through multi-faceted referral sources however the frailest are identified through risk stratification jointly between Primary care and the health and social care professionals and/or working with our acute hospital identifying patients who are known high users of the service. The team proactively manage this group of patients stepping the patient across to multiple members of the MDT as required.

6.3.4 Based on the Kaiser Permanente model the patient will move with the integrated care model as required. As patients become unwell or frailer they may need an enhanced level of service, eg Community Matrons, or may need to be stepped up to the Rapid Response Team, to treat and stabilise. Likewise, as they become more stable they will be stepped down to the appropriate member of the team, for ongoing management, monitoring, social or mental health support.

6.3.5 There is considerable staff resource across health and social care, with over 300 health and social care staff across the integrated teams whom comprise of social workers, therapists, nurses, clinicians, and administrative staff covering an approximate caseload population of 5000 patients/clients.

6.3.6 The Integrated health and social care team aim to implement a proactive coordinated integrated assessment and case management service bringing together health and social care workers who are able and skilled to provide rapid response assessment and subsequent on-going support to the most vulnerable adult population in Walsall. In addition to serving the most vulnerable population the services also aim to risk stratify adult patients who are at risk of becoming vulnerable and being able to offer help and support to keep people healthy and as independent for as long as possible.

6.3.7 Through the Walsall Together Collaboration, there was an agreement to redesign the 5 locality teams into 4 'place based teams'.

Table 1 below illustrates the redesigned Integrated Health and Social care teams practice population and provides the geographical and demographic profile of these teams.

Table 1

Primary Care Group	Practice Population 2016	Base
North	48,969	Pinfold
South1	32861	Beechdale
South 2	46298	Broadway
East 1	32511	Brownhills
East 2	41841	Anchor Meadow
West 1	37,410	Darlaston
West 2	39,812	Darlaston

6.3.8 A Rapid Response element of the service manage sub-acutely ill patients who require rapid, intensive interventions to either avoid a hospital admission, or support them stepping down from an acute setting as soon as it's safe to do so. Rapid Response clinician's work closely with Therapies both in health and social care reablement and are also aligned to one of the Integrated Health and Social Care teams.

6.3.9 Transformation over the past 3 years have provided a wealth of information relating to high user patients eg where they live, admission themes, GP practices aligned to and causative factors for admission. Going forward the model will enhance this intelligence by capturing this patient information aligned to each specific Integrated Health and Social care team. Information such as:

- High users of acute services
- Admission to residential and nursing care homes
- Citizens receiving a social care service
- Co-morbidities
- Length of stay in hospital, bed days for each Locality team

6.3.10 A business case is progressing to implement mobile technology for integrated health and care teams. This will have multiple benefits including diary management, tracking of staff to support lone working, referral management and mobile/flexible working.

6.3.11 Mental Health Services are currently undertaking initial service reviews to assess feasibility of some virtual integration into locality health and care teams.

6.3.12 An update regarding the progress to date and the future direction of travel for Integrated Health and Care Teams was presented to the Walsall CCG Board in July '17. This report is attached at **Appendix 4**.

6.4 Intermediate Care Service

6.4.1 Intermediate Care provides a range of services to patients that require additional social and/or health care, post-acute care to enable timely discharge to a safe environment, with the necessary support to regain function and/or confidence. This support is provided in the patient's own home (or usual residence) or transitional residence, until long-term arrangements are in place (this could include no further social/health care support required).

6.4.2 A review of the current Intermediate Care Pathways, supporting both discharge from hospital and admissions avoidance, has highlighted numerous weaknesses. In essence, the current 'System' does not consistently support timely and responsive discharge of patients that require additional health and/or social care support needs, this in turn has an impact on the individual and on system resilience.

6.4.3 The numerous weaknesses combined has resulted in fragmentation, misalignment of priorities and synchronisation of resources across health and social care teams. This has resulted in increased costs and reduced overall Intermediate Care capacity. In essence, the current 'System' does not consistently support timely and responsive discharge of patients that require additional health and/or social care support needs with obvious ramifications impacting the resilience of the 'System'.

6.4.4 The new model is detailed in **Appendix 5,** in summary, the plan is to implement a reconfigured Intermediate Care Service (ICS), that makes discharge home with timely access to the appropriate health and social care support as the default pathway. The reconfigured ICS is underpinned by consolidating disparate health and social care functions into a combined health and social care team that will provide a single service with responsibility for patients who require support to facilitate discharge from hospitals both within Walsall and outside of the borough. The Intermediate Care service is the mechanism that will progress the 8 High Impact Changes to address Delayed Transfers of Care.

6.4.5 The new model of delivery will demand greater integration through a new shared culture, mind-set, values, performance objectives, working processes and practice are key to the refreshed model with a single line management structure accountable to both Walsall MBC and Walsall Healthcare Trust.

6.4.6 The key components of the model are:

- Streamlined processes to identify patient needs and make a referral via a single point of access for all Intermediate Care Service pathways
- Assessments required to develop an intermediate care plan to be performed out of the hospital setting post discharge including therapy, social care assessments etc.
- Patient information, via a referral underpinned by a common data set, to be shared across settings so that patients do not have to re-tell their story and reduce the duplication of work for care services
- Allocation of the appropriate Intermediate Care Service members to develop, monitor and support the patient via a patient centric intermediate care plan to enable independence and recovery from a period of ill-health before they are assessed for their longer-term health and social care needs.
- Assessments to determine the long-term health and social care needs to be performed in a community setting ie social work or CHC assessments
- An enabling culture to facilitate patients, with carers, to regain confidence and/or function so that patients are supported to realise their life goals
- Sufficient intermediate care staff working as an effective MDT that will be able to manage the demand for patients for ICS services post-discharge in a responsive manner
- The service will ensure effective interfaces with the wider system to ensure seamless and coordinated care.
- The service will operate seven days per week

6.4.7 There are numerous benefits of the proposed ICS model to the Citizen, Healthcare Trust, Social Services and the CCG including:

- Streamlined process and responsive provision that will ensure patients have access to appropriate care in the right place at the right time closer to their home
- Earlier discharge from hospital, ideally when the patient is deemed medically fit for discharge liberating bed capacity at the hospital
- Reduced decompensation and patient needs with accompanying reduction in transitional and long-term care packages to resolve/satisfy the presenting patient needs
- Single team taking a MDT approach to identify needs, support patients and monitor against patient goals.

6.4.8 The new model of delivery will require more integrated governance and management arrangements**.** The proposal is that the governance arrangements will be underpinned by the development of a Section 75 Partnership Agreement, between Walsall Healthcare Trust and Walsall MBC which in summary will set out, amongst other things:

- Budget
- Staff Profile
- Governance arrangements
- Risk Share Agreements
- Dispute resolution procedures

6.4.9 The timescale for design and implementation is challenging but realistic, and will be phased in such a way that allows for evidence of good practice and realisation of some of the benefits for patients, service users and staff before management of change is undertaken from January '18. The key milestones for delivery of the Integrated Intermediate Care Service are detailed in **Table 2** below.

Table 2

Phase	Key Activities	Timescale
Phase 0-1 Approve Business Case and Service Design	• Effective engagement with respective managers/leads and staff to articulate ICS process model and accompanying business requirements, roles and responsibilities • Business case signed off by Walsall Together for Phases 0-3, progressing through Walsall MBC and Health Care Trust Governance • ICS Financials agreed	April – September 2017
Phases 2 & 3 – Prepare to transition and transition	• ICS implementation programme launched 29/08/2017 • Partnership Group, Steering Group and Sub Groups commence • Staff align to single leadership structure • Transfer assessments out of the hospital • Implement business changes • Extended ICS pathways in place with reduction in medically fit for discharge and DToC	September – March 2018
Phases 4 & 5 Management of Change - Consolidate and Rationalise	• Consult on proposed ICS organisational structure and roles with leadership and staff • Consolidate and rationalise disparate teams into a single ICS service • Assign roles/responsibilities to staff in the single ICS team • Extend service provision to 7 days a week • Improve IT enablement within and across partner organisations	March – August 2018

Phases 6 & 7 Relocate and Project Closure	• Focus to relocate to ICS team to new premises to facilitate MDT collaboration with the required infrastructure to enable streamlined care delivery. • Focus on 'hand-over' of the streamlined and 'stable' ICS service to the ICS management team and to evaluate the extent to which the project was successful and note any lessons learned for future projects.	August - October 2018

6.5 Single Point of Access

6.5.1 The vision of the model for Access is to develop a single, tiered customer/professional access, care coordination and care navigation point for all health, care, and prevention services in Walsall. The aim of the work stream is to streamline and improve access to services for residents of Walsall, to minimise delay, encourage appropriate utilisation and minimise duplication, allow better utilisation of resources and look to implement best practice from national schemes/programmes. The objectives of the work stream are:

- Reduce the number of Single Access points in the system to reduce confusion. The access point will be in a position to take over the care for a patient at the point of the call rather than simply a signposting service.
- Production of a Directory of Services that suitably maps out the services available and how to get access to them in a timely manner. This will be public and heath professional facing.
- Access points will be designed so that GPs and Specialist Consultants can communicate freely to coordinate care.
- The system should be designed to ensure rapid and timely access to planned care, outpatient appointments and diagnostics with a more prevalent use of telemedicine.
- The primary care system should be developed to ensure that all patients are able to access high quality primary care in a timely manner irrespective of where they live in Walsall.
- Consistent application of best practice to care pathways, eliminating unwarranted variation and waste.

6.5.2 The scope formalises the current Access model and includes the following organisations from a management and service delivery perspective:

- Walsall CCG commissioned services
- Walsall Council commissioned services

- Walsall Council Public Health
- GP Practices & Federations
- Voluntary Sector services
- Mental Health commissioned services
- West Midlands Ambulance services
- NHS England

6.5.3 The project is engaging with the recent procurement of a new NHS 111 service (went live on 8th November 2016) to ensure that the benefits of the new specification are effectively realised in Walsall, including reviewing the directory of services.

6.5.4 To support the service redesign a number of listening events will be held with all frontline staff, Service Users and Carers to guarantee that all stakeholders have a voice in the design and delivery of the new service.

7.0 National Conditions

7.1 National Condition 1 - Jointly agreed plan

7.1.1 Walsall Council and Walsall CCG are committed to the deliverables in the Walsall Together Programme for which the BCF spending plan is a significant enabler. The level of engagement and joint work on schemes such as the Intermediate care programme demonstrates the commitment of both parties and engagement with providers including the VCS through the delivery mechanism of the Walsall Together Board. The plan has been formally agreed at the meetings detailed below in **Table 3.**

Table 3

Forum	Agreed Date
Joint Commissioning Committee	14/08/2017
Health and Wellbeing Board	21/08/2017
CCG Governing Body	26/09/2017
Cabinet	06/10/2017

7.2 National Condition 2 – Social Care Maintenance

7.2.1 Significant work has been undertaken since the last submission to review the financial profile within the Better Care fund to ensure that whilst the fund is pooled and utilised to commission health and care services in a joined up way, that budgets and commissioning responsibility are clearly set out and agreed.

7.2.2 This appears in the budget profile as a reduction in funds identified as 'Protecting Social Care' however in reality, because 'health' responsibilities were in previous years coded against the 'Protecting Social Care' criteria, the rebalancing has resulted in an actual increase in funds allocated against this criteria.

7.2.3 Protecting Social Care contributions for 2017-19 meet the criteria for services to benefit health in that they are largely aligned to NHS out of hospital budgets to fund Intermediate Care and Integrated Health and Care services, such as reablement, social work in localities etc.

7.2.3 Walsall's Adult Social Care investment (iBCF 2) amongst investment to stabilise the social care market, will be used to support the service to design and implement place-based commissioning and the delivery of new models of care. The most significant work streams in relation to this are Integrated Health & Care Teams and the Integrated Intermediate Care Service.

7.2.4 An application to re-base the 15/16 and 16/17 budgets has been made, with the changes detailed in **Appendix 6** attached. The plan is compliant with the expected 1.79% for 2017/18 and a further 1.90% for 2018/19 increase.

7.3 National Condition 3 – NHS Commissioned out of hospital services

7.3.1 Our plan for the BCF in Walsall has from the outset included a majority of the investment in out-of-hospital services this continues to be the case for 2017-2019. The amount allocated to out-of-hospital is detailed within the planning template and does exceed the expected minimum amount.

7.3.2 In addition to the out-of-hospital services, the sum of £1,086,550 in 2017/18 and £1,107,550 in 18/19 is allocated on a non-recurring basis as a contingency for not achieving a reduction in emergency admissions. This sum allows for an increase of 729 emergency admissions against the 2017/18 plan (at £1,490 per EA) and 743 against the 2018/19 plan. Any further increase in emergency admissions will be met from funding that currently sits outside of the BCF.

7.3.3 The contingency will be held in the BCF and released in tranches to Walsall Healthcare Trust to fund additional expenditure directly related to any increase in emergency admissions.

7.3.4 A risk-share agreement is detailed within the Section 75 Partnership Agreement between Walsall CCG and Walsall MBC, this details that if performance of non-elective admissions improves and does level off, or start to decrease, then consideration can be given to investing this sum in out-of-hospital services to provide further support for reducing the rate of emergency admissions.

7.4 National Condition 4 - Implementation of the High Impact Model for managing transfers of care

7.4.1 The schemes set out within the Better Care Fund plan meet the requirements within the High Impact Model for Managing Transfers of Care, as outlined in 6.4.1 and 6.3. A summary of how it meets the requirements is set out in **Table 4.**

Table 4

High Impact Action	Plan
Early Discharge Planning	The new model of integrated intermediate care (ICS) expects that discharge planning starts at a much earlier point of a patient's hospital admission and will aim to facilitate discharge of patients within 48 hours of being 'medically fit for discharge'. For the ICS implementation, plan and funding profile please see **Appendix 5.**
Monitor Patient Flow	A report commissioned by the A&E Delivery Board highlighted the areas of focus required to gain a better oversight of patient flow and delayed transfers of care. A plan was developed based on the finding in the report and it is being implemented.
MDT Discharge Teams	The model of the Integrated Health and Care Team and the model of Integrated Intermediate Care both rely on the development of multi-disciplinary teams working seamlessly and collectively to meet the outcomes of individuals. MDT's, not including Social Care, are in operation in all 7 Locality Integrated Health & Care Teams with plans for Social Work to join these MDT's by January 2018. No additional funding has been allocated to achieve this – this will be undertaken within the funding profile already allocated within the BCF plan.
Discharge to assess	The new model of Integrated Intermediate Care is based on the model of discharge to assess. It is expected that the default position on discharge is that assessments will be completed in the patient's own home (or alternative setting) within 24 hours of discharge. For the ICS implementation plan and funding profile please see **Appendix 5.**
Trusted Assessors	The new model of Integrated Intermediate Care relies on the development of acute hospital staff to undertake 'trusted assessments' on behalf of the team. For the ICS implementation plan and funding profile please see **Appendix 5.**
7 Day Services	The new model of Integrated Intermediate Care is working towards a phased implementation of 7 day working. 7 day working will be implemented in the service by October 2018. Integrated health and care teams already work over 7 days a week.
Choice	The model of discharge to assess will mean that there will be

	an expectation that patients who require ongoing social care provision will transfer either home or to an 'intermediate care setting' where they will be supported to exercise their choice whilst not in a hospital bed.
Health in Care Homes	Care homes will continue to be supported through the 'Support to Care Homes' work stream to identify residents who are high risk of hospital admission, develop a personalised written management plan and provide care co-ordination for identified caseload. The continued funding for this service sits within the Better Care Fund.

Former National Conditions

7.5 Joint assessment and accountable lead professional for high risk populations

7.5.1 Through using risk stratification processes supporting identification of patients in GP Practice population who are older, frail and vulnerable with long term conditions and co-morbidities. The risk stratification model identifies patients who have had 4 or more admissions during previous 12 months to the Manor Hospital. This information has been used to provide "Wrap Around" services to support patients in their own home with a view to avoiding unplanned hospital attendance/admission. The team proactively manage this group of patients "the Virtual Ward" stepping up to the Matron, (who has advanced skills in disease management), when the patient is deemed unstable, or reviewing these patients on a more frequent basis to stop them going into crisis.

7.5.2 The model also includes providing an enhanced visiting/assessment regime throughout a period of transition. This period is defined as 30 days following a period of hospitalisation, or transfer of care from rapid response or intermediate care services.

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

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

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

7.5.6 With the introduction of Joint Health and Social Care MDT's in January 2018, information regarding these high risk patients will be shared and joint health and social care plans will be developed for these individuals.

7.6 7 Day Services

7.6.1 Current seven day services include social care reablement and social work services, and have been incorporated in to the redesign of the Community Health Services which is now complete and aligned to primary care. Two Urgent Care Services are open seven days a week. There is also seven day access to primary care and rapid response intermediate care services to prevent hospital admissions and supported discharges.

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

7.6.3 Ongoing review of progress against the 7 day working standards is built in to the contractual arrangements with Healthcare providers and transformed, integrated services developed through the work streams will work to an expectation that appropriate access over 7 days is essential.

7.7 Data Sharing

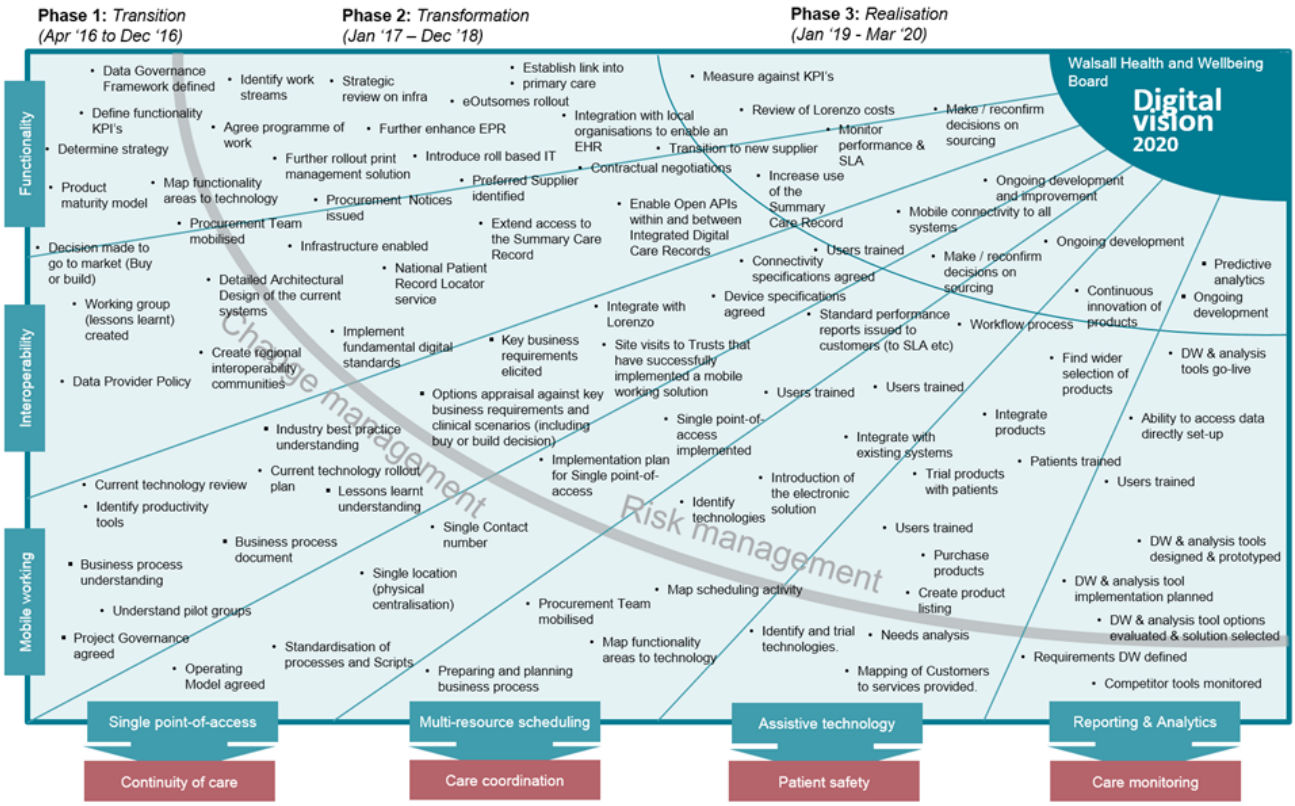
7.7.1 The use of the NHS number in all social care records was introduced on 1st April 2014. The NHS number has been the primary identifier since April 2015.

7.7.2 The Walsall Health and Social Care 'System' Digital Roadmap emphasises the key themes of partnership working across Health and providers, creating new relationships with patients

and co-creating new models of care to meet the challenges of increasing demand within resource constraints.

7.7.3 The Digital Roadmap, below at Figure 2, seeks to establish a more responsive system that allows Commissioners to design and implement enhanced service delivery models for our local population. This is underpinned by a significant increase in the use of technology to enable seamless information flows across the patient journey, help patients engage with their care plan, streamline communication and planning across health and service providers.

Figure 2.



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

- Mobile working: Improve productivity through continuous access to functionally rich clinical systems coupled with user-friendly productivity tools to reduce travel time and effort on non-clinical activities to enable more time to be spent with patients.
- Interoperability (with data sharing): Platform to integrate with multiple IT clinical systems e.g. Fusion Clinical Portal, EMIS, Lorenzo, eChemo etc. and provide connected/disconnected capability to enable continuous 'access' to patient data/functionality for mobile workers. The NHS number will be used as the primary identifier in all settings when sharing information.

- Operational reporting: Accurate and time activity reporting with financial reporting across different health needs
- Business analytics: Determine the cause of ill health and the development of total cost data for individual patients across multiple health and care settings

8 Risk and Risk Management

8.1 Commissioning risks are managed through the Joint Commissioning Committee as described in the 'governance' section of this plan. The existing Section 75 partnership agreement governs the approach to risk and risk sharing between the partners. The S75 will be updated by November 2017 in line with the Planning Requirements.

8.2 Delivery risks of individual projects are managed within the work streams and reported to the Walsall Together Board, risk share arrangements between providers are developed where necessary. An example of a risk share agreement that was developed for the Integrated Intermediate Care delivery can be found at **Appendix 7**.

8.3 A summary of the programme risks are detailed in **Table 5** below.

Table 5

ID No.	Risk and Impact	Consequence	Likelihood	Rating	Mitigation	Residual risk score
1	Failure to reduce Emergency Admissions creating financial pressure and poor user outcomes.	Moderate	Likely	12	A&E Delivery Board plan; Integrated Intermediate Care and Integrated Health & Care Teams project delivery	9
2	Unable to implement 7 day working, services not available 7 days per week	Moderate	Likely	12	Redesign of services through work streams with expectation of 7 day delivery where required	6
3	Walsall Council unable to achieve budget savings due to rising demand for adult social care meaning that Walsall Council would have to make adjustment to budgets impacting on other services.	Major	Possible	12	Ongoing monitoring and deliver the projects that will reduce demand and release savings	8
4	Destabilisation of health care providers meaning that NHS Providers would need to adjust financial plans and capacity	Major	Likely	16	Full engagement in delivery plan by provider units and development of risk share arrangements	8
6	New models of care fail to positively impact on performance and outcomes.	Moderate	Likely	15	Regular programme oversight to monitor and agree mitigation of risk.	6

7	Unable to optimise MDT working as workforce development unable to deliver integrated job roles/training	Moderate	Likely	15	Engagement with Workforce Development and development of WD plans	6
8	Unable to achieve improved outcomes following change as unable to achieve cultural/behavioural change that is required	Moderate	Likely	15	Workforce Development plans, clear sign-up from Chief Officers and Communication engagement throughout organisation.	6
10	Quality of NH/RH Home Care fails to meet agreed Walsall Council/CCG Standards resulting in an increase in suspensions and restrictions and restricted market capacity.	Major	Possible	12	Joint quality improvement programme between CCG & LA and regular monitoring/engagement with providers.	8
11	New model of care delivery and commissioning is dependent on sound relationships and trust between stakeholders, risk of relationship breakdown impacting on delivery.	Major	Possible	12	Understand the risks for all partners, develop risk share agreements and memorandum of understanding to detail the behaviour expectations. Meet regularly to monitor and resolve any risks that develop, with the use of external support/ mediation if required.	8
12	Financial sustainability of partners resulting in the withdrawal of funding streams/resources creating pressures on other partners.	Major	Possible	12	Work in partnership to understand the financial pressures and opportunities to recover. Develop risk share arrangements where appropriate.	8
13	Data not available for monitoring impact of Change Schemes. Evaluation not possible.	Moderate	Likely	12	Agree with CSU and Council and Provider Performance teams data required and where this is collected	6
14	Mandated targets in relation to DTOC are not achieved resulting in funds available being reduced meaning that other areas of spend would need to be reduced impacting on outcomes for individuals.	Major	Likely	16	A&E Delivery Board Plan; Integrated Intermediate Care project. Develop a de-commissioning plan to offset the impact of any reduction in iBCF funds.	12

9.0 Overview of funding contributions

9.1 iBCF

9.1.1 Walsall's Adult Social Care iBCF investment will be used to support the system to design and implement place-based commissioning and the delivery of new models of care as per the Walsall Together delivery plan. The most significant work streams in relation to this in 2017-19 are Integrated Health and Care Teams and the Integrated Intermediate Care Service.

9.1.2 A summary of the proposals and the spend profile can be found at **Appendix 8**. The proposals cover four main themes, all of which meet the national conditions and follow the Walsall Together delivery plan:

- Services: £4.230m (over the 3 years) investment in improving the model of intermediate care so that citizens do not stay in a hospital bed when not required and will deliver improved outcomes and recovery for patients. Also investment in early intervention and prevention services to keep people well and independent in their own home.
- Staffing: £2.31m (over 3 years) staffing to ensure all known customers have an allocated worker who is based in a locality team to oversee and coordinate their care and support. These teams are joint with GP's, community health and in time some mental health and outreached hospital services.
- Commissioning, brokerage, and business support: £700k (over the 3 years) to enable the most effective means of commissioning, procuring and negotiating care costs aligned to place based commissioning functions. The spending plan is detailed below and is signed off by both Walsall CCG and WMBC.
- Market uplift: £5.4m (over 3 years). It is well documented that the care market is not sustainable at its current rates of pay. A national survey found a high percentage of market failure and providers who are voluntarily handing back contracts to local authorities as they struggle to recruit, retain and fund a long term care model. Walsall has traditionally been a low payer of domiciliary and residential care and thus investment will be added to the increase in fees paid to ASC providers to enhance market sustainability.

9.1.3. It is recognised that the iBCF funding stream ceases at the end of 2019/20. Should no further funding be announced, the current planned spend includes the potential for ongoing annual costs of £3.3m per year if services were to continue post 2019/20. Included within this amount is £1.700m per year of market uplift costs for social care providers where it was acknowledged in the 21st June 2017 Cabinet Report 'Adult Social Care increases in rates' that these rates will need to be sustained in future years and as such the MTFO has been updated to incorporate this assumption.

9.1.4. It is proposed that should further announcements on the direction of Social Care funding not be made via Central Government before the commencement of the 2019/20 financial year, Adult Social Care will develop an action plan to set out how the remaining potential ongoing costs of £1.62m (total ongoing annual costs of £3.3m set out in paragraph 9.1.3. excluding the approved market uplift of £1.7m) will be removed to avoid a potential ongoing financial pressure from 2020/21.

9.2 Implementation of Care Act duties

9.2.1 Walsall's share of the £130 million identified as support for Implementation of the Care Act was included in the local plan for the BCF in 15/16 and 16/17. The ready reckoner calculates this as a total of £823,000 and a sum of £840,000 was agreed which was spent as follows in 15/16 and 16/17:

- £400k Additional social work posts
- £ 73k Independent Living Centre
- £ 47k Walsall Disability Forum
- £ 39k Information and Advice from Age UK
- £220k Dementia Support Workers
- £ 61k Home from Hospital support to carers

9.2.2 As the Care Act is now embedded in practice, the allocation towards implementation of the Care Act has been incorporated into the 'Protecting Social Care' allocation which is aligned to the four work streams within the Walsall Together Delivery Plan.

9.2.3 There is an expectation that the new models of care that are developed are clearly able to demonstrate how it meets the Care Act duties.

9.3 Funding dedicated to carer-specific support

9.3.1 The sum of £450,000 that was originally allocated to Walsall from the Carers Grant has remained within our BCF pooled fund and there is an investment programme for supporting informal carers that is aligned to the Resilient Communities work stream within the Walsall Together programme.

9.4 Funding for Reablement

9.4.1 Reablement is a key feature of the new model of care being developed through the Walsall Together Programme. The spending plan for Integrated Intermediate Care includes a budget of just over £4m which in the main related to reablement provision.

9.5 Disabled Facility Grant

9.5.1 As detailed on page 16 of this plan, a comprehensive plan for the successful delivery of Disabled Facility Grants is in place and the full DFG allocation is pooled into the BCF and ring-fenced to spending to meet this plan.

9.6 The funding streams for the Better Care Fund are allocated as per **Table 6**.

Table 6

Funding Stream	**2017/18 (£)**	**2018/19 (£)**
CCG Minimum – LA	8,114,069	8,268,236
CCG Minimum – CCG	11,559,246	11,778,872
CCG Additional – CCG	0	1,726,597
LA Funding (DFG)	3,163,922	3,432,630
iBCF1 Funding	917,597	5,953,516
iBCF2 Funding	6,501,557	4,083,786
OVERALL	**30,256,391**	**35,243,997**

9.7 Significant work has been undertaken since the last submission to review the financial profile within the Better Care Fund to ensure that whilst the fund is pooled and utilised to commission health and care services in a joined up way and that budgets and commissioning responsibilities, including ownership of risks for each scheme, are clearly set out and agreed.

9.8 BCF funding is subject to being used in accordance with the final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2017-18 and the BCF planning guidance for 2017-18, and which include the funding being transferred into pooled funds under a section 75 agreement.

10 National Metrics

10.1. Non-Elective Admissions

Metric	Data Required	16/17 Baseline	Target	BCF Scheme where impact is achieved
Non-elective admissions (General and Acute)	NEA National Data Set – no additional data required.	**32,9147**	Total NEA 17/18 **34,360** Total NEA 18/19 **34,445**	Integrated health & care service

10.1.1 Demand modelling has demonstrated that demographic changes will see an increase of non-elective admissions over the next two years. The targets that have been set recognise this and identifies that the planned improvements in admission avoidance activity should largely offset this.

10.2 Admissions to residential and nursing care homes

Metric	Data Required	16/17 Baseline	Target	BCF Scheme where impact is achieved
Admissions to residential and nursing care homes	Total number of admissions to care homes Population data	**309**	Total admissions per 100,000 population 17/18 **340** Total admissions per 100,000 population 18/19 **340**	Integrated health & care service

10.2.1 Admissions to residential and nursing care homes in Walsall has been supressed for a number of years due to a previous decision to avoid care home admissions 'at any cost'. The impact of this is that Walsall was in the bottom quartile, nationally, for the number of care home admissions, cost of care at home was above national and regional comparators and some individuals whose choice was to have their needs met in residential care were denied this choice. The targets for 17/18 and 18/19 reflect that although admissions from hospital will reduce as a result of the implementation of the Integrated Intermediate Care Service, a decision to allow the use of residential provision for long term needs, where it is appropriate to do so will bring Walsall in line with regional and national comparators.

10.3 Effectiveness of Reablement

Metric	Data Required	16/17 Baseline	Target	BCF Scheme where impact is achieved
Effectiveness of Reablement	Total number of people (over 65 discharged from hospital. Of the total discharged, number of patients at home 91 days later	**81%**	Proportion of people at home after 91 days 17/18 **82.1%** Proportion of people at home after 91 days 18/19 **82.1%**	Intermediate Care Service

10.3.1. It is the ambition of the integrated intermediate care work stream that more individuals will be discharged from hospital into reablement services and so, although the target for those who remain at home 91 days later remains unchanged from 17/18 to 18/19, it will be more of a challenge to meet this target as a there will be a higher number of people accessing the service.

10.4 Delayed Transfers of Care

Metric	Data Required	16/17 Baseline	Target	BCF Scheme where impact is achieved
Delayed transfers of care	National Data Set Total number of 'delayed days'	3498	Number of delayed days per 100,000 population 17/18 **2780** Number of delayed days per 100,000 population 18/19 **2136**	Intermediate Care Service

10.4.1 The implementation of an Integrated Intermediate care model is one of the significant developments across Walsall Council and Walsall Healthcare Trust which will have a positive impact on delayed transfers of care. The model is being implemented across all hospitals where Walsall Residents are patients. Further information on the model can be found at **Appendix 5.**

11 Programme Governance

11.1 Walsall's BCF is overseen by the Health and Wellbeing Board (HWBB). The specific BCF programme is managed through the Joint Commissioning Committee which is co-chaired by the Accountable Officer at Walsall Clinical Commissioning Group (WCCG) and the Executive Director of Adult Social Care at Walsall Council.

11.2 The programme is underpinned by a formal Section 75 agreement between WCCG and WMBC.

11.3 The delivery arrangements for the BCF are through the Walsall Together Board, which a joint commissioner and provider board.

11.4 Each work stream within the Programme has an allocated Senior Responsible Officer and work stream leads from the key organisations involved in that work stream. Members of the Joint Commissioning Committee have delegated responsibility from both partner organisations to hold the Senior Responsible Officers to account and make necessary decisions from a planning and performance management perspective.

11.5 Each work stream has dedicated project management support and is required to complete and maintain project management control tools.

11.6 The Joint Commissioning Committee provide oversight and monitoring of the Pooled budget, supported by their respective organisation Finance leads and receives an update from the Programme Director of the Walsall Together programme as to the progress of the delivery work streams.

11.7 Walsall CCG and Council have recently disestablished their Joint Commissioning Unit which reported to the Joint Commissioning Committee and had responsibility for managing and reporting delivery of BCF funded schemes. The outcome of the disestablishment is widely considered a positive in that it has allowed a much clearer focus on funding of key schemes. Going forwards this is the basis of aspirations to jointly invest more into progressing the local economy towards greater levels of integration, economies of scale and new models of care including an Alliance model of delivery and commissioning.

11.8 The Joint Commissioning Committee is still meeting, however, it is currently developing the Terms of Reference for a new board to replace it. Although this process may see slight changes to membership, the principles are unlikely to change and the JCC/'new board' will remain the mechanism of Governance for the duration of the plan.

11.9 The proposed purpose and remit of the board is to set up to drive forward the commissioning transformation of the health and social care system in Walsall, and more specifically:

- To bring together in one place the Council and CCG commissioning programmes of work that will deliver significant change in the Walsall health and care system.
- To oversee the delivery of the Better Care Fund arrangements and to inform the Walsall Health and care Transformation programme.
- To monitor progress against key performance indicators for the Better Care Fund plan and take corrective action is required.
- To monitor the Better Care Fund budget against plan and take corrective action, in line with the BCF Risk Sharing agreement where risks against the budget occur.
- Ensuring the delivery of the shared vision and priorities of the Health and Wellbeing Board through promotion of collaborative commissioning arrangements, including the commissioning of local place based integrated care.

11.10 The proposed membership of the board:

- Chief Officer, Walsall Clinical Commissioning Group
- Director of Adult Services Walsall Council
- Director of Children's services Walsall Council
- Cabinet Member for Adult Social Care, Walsall Council
- Director of Commissioning Walsall Clinical Commissioning Group
- Director of Primary care Walsall Clinical Commissioning Group
- Chief Nurse Director of Quality Walsall Clinical Commissioning Group
- Head of Integrated Commissioning, Walsall Council
- GP Clinical Executive (Commissioning) Walsall Clinical Commissioning Group
- Patient and public representative
- Director of Public Health, Walsall Council.
- Finance reps

11.11 Walsall Council and Walsall Clinical Commissioning Group have their own statutory and non-statutory responsibilities and accountabilities. It is proposed that individual partners remain responsible and accountable for decisions about their own services and resources.

11.12 The purpose of the new board is to work through collaboration to transform the commissioning of health and care services for the benefit of everyone living in Walsall. It will therefore:

- Provide the overarching governance mechanism for the Walsall Health and Care commissioning transformation programme
- Ensure that the Walsall Health and Care commissioning transformation programme is driven by a single vision and values and agreed guiding principles
- Ensure that programme leads are adequately supported in their work and held to account for the delivery of their responsibilities.

11.13 More specifically, it is proposed that the new board will:

- Ensure that transformational changes developed and agreed through the Walsall Together programme are effectively translated into commissioning decisions.
- Ensure there is strong patient and the public engagement in the work of the group and that patient choice is a key consideration for the programme by ensuring that an over-arching Communications and Engagement Strategy is in place and that key messages are circulated to partner organisations.
- Ensure changes to the health and care commissioning arrangements in Walsall are made on the basis of strong evidence and best practice (national and international)
- Monitor the impact of transformation commissioning programmes, including unintended consequences/dis-benefits, and agree appropriate strategic response
- Ensure effective coordination of the planning and commissioning of services, in particular utilising the benefits and opportunities of the BCF.
- Provide regular reports to the Health & Wellbeing Board on the operation of the BCF Agreement.
- Engage with GPs, Elected Members, Academic Health Science Networks, ADASS, LGA, NHSE, Clinical reference Group, and other stakeholders, as appropriate.

11.14. The Walsall Together Partnership Board is working to develop new System Governance arrangements for Commissioning and Providing Integrated Services and New Models of Care. A paper detailing the proposals that were agree at the Walsall Together Board can be found at **Appendix 9.**

11.15. Since agreement of the proposal, the Provider Board has commissioned KPMG to support the development of an Outline Business Case (OBC) that details how the Alliance could work, and the Risks and Benefits for provider partners. The OBC will be completed in January 2018 with a plan to sign off at respective provider boards in February 2018.

11.16. An initial planning session has taken place to look at how the Joint Commissioning arrangements could be organised to facilitate the Alliance Contracting. The CCG and LA are aiming to conclude this work by April 2018.

Appendices

Appendix	Title	Attachment
Appendix 1	Walsall Together Programme Execution Plan	Walsall Together Programme Executio
Appendix 2	Walsall Provider Board Terms of Reference	TOR for Walsall Together Partnership
Appendix 3	Resilient Communities Project Update	Resilient Communities Update
Appendix 4	Update to Walsall CCG Governing Body re: Integrated Health & Care Teams (Place-based teams)	Integrated Health and Care Teams (Plac
Appendix 5	Intermediate Care Model	Intermediate Care Model - October 2017
Appendix 6	Protecting Social Care – Rebasing Rationale	2015-16 to 2017-18 Protecting Social Care
Appendix 7	Example provider Risk Share Agreement	ICS Risk Sharing v3 13072017.docx
Appendix 8	iBCF Spending Plan	Walsall ASC Areas for Investment - April
Appendix 9	System Governance	Walsall Together Partnership Board_Sys
Appendix 10	Key Lines of Enquiry Reference Matrix	

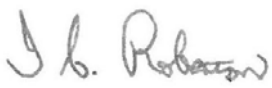
12 Approval and sign off

Local Authority	Walsall Metropolitan Borough Council
Clinical Commissioning Groups	Walsall Clinical Commissioning Group (CCG)
Boundary Differences	The boundaries are within the Borough of Walsall
Date agreed at Health and Wellbeing Board:	21/08/2017
Date submitted:	12/09/2017
Total agreed value of pooled budget: 2017/18	£30,256,391

a) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	Walsall CCG
By 	Simon Brake
Position	Accountable Officer, Walsall CCG
Date	08/12/2017

Signed on behalf of the Council	Walsall Metropolitan Borough Council
By 	Paula Furnival
Position	Executive Director of Adult Social Care
Date	08/12/2017

Signed on behalf of the Health and Wellbeing Board	Walsall Health and Wellbeing Board
 **By Chair of Health and Wellbeing Board**	Councillor Ian Robertson
Date	08/12/2017

QUARTERLY REPORTING FROM LOCAL AUTHORITIES TO DCLG IN RELATION TO THE IMPROVED BETTER CARE FUND

IMPORTANT: Please DO NOT alter the format of this spreadsheet by inserting, deleting or merging any cells, rows or columns. The data from this spreadsheet are transferred directly into a DCLG database using a macro and your return may flag as an error if you attempt to alter the format. You can, however, resize the height and width of rows and columns if you need more space.

Instructions:
1. Select your local authority from the drop-down menu in Cell C11.
2. Enter the password provided in your email from DCLG into Cell C13.
2. Complete Sections A and C below by filling in the pink boxes as instructed. If copying and pasting in content from another document please paste your text directly into the formula bar
3. Save the completed form in the original MS Excel macro-enabled workbook format. Do not convert this spreadsheet to another file format or provide any information in additional attachments.
4. Once completed and saved, please e-mail this MS Excel file by 19 January 2018 to: CareandReform2@communities.gsi.gov.uk

Local authority: (Select from drop-down menu)	**Walsall**
Enter password (as provided in email from DCLG)	DBMP69
E-code	**E4606**
Period	**Quarter 3 (October 2017 – December 2017)**

Section A

A1. Provide a narrative summary for Quarter 3 which follows up the information you have provided in Section A in previous returns. What are the key successes experienced? What are the challenges encountered?

1. Although initially delayed, the implementation of the integrated intermediate care service has progressed well. The impact of the implementation has been masked by demand through the Christmas/winter period but actions are in place to progress. 2. Adverts for Social Work and Occupational Therapy posts recieved a good response and recruitment is progressing well. Within the next quarter we will be in a position to reduce the average Social Work/Occupational Therapy caseload and work in closer partnership with Locality Health partners. 3. Recruitment and restructuring of the Commisioning, Business Support and Brokerage service is progressing well. In Quarter 4 we expect that the new Business Support and Brokerage service will be fully operational. 4. Uplifts to the market were implemented in 2017/18 - Commissioners are now working to undertake comparator work to determine uplifts for 2018/19.

A2. Provide progress updates on the individual initiatives/projects you identified in Section A at Quarters 1 and 2. You can provide information on up to 5 additional initiatives/projects not cited in previous quarters to the right of the boxes below if needed.

	Initiative/Project 1	Initiative/Project 2	Initiative/Project 3	Initiative/Project 4	Initiative/Project 5	Initiative/Project 6	Initiative/Project 7	Initiative/Project 8	Initiative/Project 9
A2a. Individual title for each initiative/project. Automatically populated based on information provided in previous returns. Please ensure your password is entered correctly in cell C13. Scroll to the right to view all previously entered projects.									
A2b. Use the drop-down options provided or type in one of the following 5 answers to report on progress since Quarter 2: **1. Planning stage** **2. In progress: no results yet** **3. In progress: showing results** **4. Completed** **5. Project no longer being implemented**	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	4. Completed					
A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).	Integrated Intermediate Care implementation is progressing well with local improvement on inpatient length of stay. Community Reablement and Shared Lives are planned for development in Q4	Recruitment underway for Social Worker and Occupational Therapists with some having now started.	Commissioning posts now filled. Interviews as part of Business Support and Brokerage restructuring currently taking place.	Uplifts have been awarded to the care home and domiciliary care markets. Additional Commissioning Capacity has given us thecapacity to conduct a market review of our cost and quality and we are now considering uplifts for 2018/19					

Section B: Information not required at Quarter 3

Section C

	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	Metric 6	Metric 7	Metric 8	Metric 9
C1a. List of up to 10 metrics you are measuring yourself against. Automatically populated based on information provided in Quarter 2. Please ensure your password is entered correctly in cell C13. Scroll to the right to view all previously entered metrics. You can provide information on up to 5 metrics not cited previously to the right of these boxes if needed.									
C1b. Use the drop-down options provided or type in one of the following 4 answers to report on any change in each metric since Quarter 2: **1. Improvement** **2. Deterioration** **3. No change** **4. Not yet able to report**	3. No change	3. No change	1. Improvement	3. No change	4. Not yet able to report	4. Not yet able to report	4. Not yet able to report	4. Not yet able to report	4. Not yet able to report
C1c. Provide any additional commentary on the metric above, if you wish.	Progress has been made to resolve historic reporting issues which is now causing an increase in reported delays.	On track to meet end of year target	On track to meet end of year target	Improvements not planned until Q4	NA	NA	NA	NA	NA

Better Care Fund Template Q3 2017/18

Checklist

[<< Link to Guidance tab]

Complete Template

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? If no please detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3	F8	Yes
Chg 2 - Systems to monitor patient flow Q3	E9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3	F10	Yes
Chg 4 - Home first/discharge to assess Q3	F11	Yes
Chg 5 - Seven-day service Q3	F12	Yes
Chg 6 - Trusted assessors Q3	F13	Yes
Chg 7 - Focus on choice Q3	F14	Yes
Chg 8 - Enhancing health in care homes Q3	F15	Yes
UEC - Red Bag scheme Q3	F19	Yes
Chg 1 - Early discharge planning Q4 Plan	G8	Yes
Chg 2 - Systems to monitor patient flow Q4 Plan	G9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 Plan	G10	Yes
Chg 4 - Home first/discharge to assess Q4 Plan	G11	Yes
Chg 5 - Seven-day service Q4 Plan	G12	Yes
Chg 6 - Trusted assessors Q4 Plan	G13	Yes
Chg 7 - Focus on choice Q4 Plan	G14	Yes
Chg 8 - Enhancing health in care homes Q4 Plan	G15	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	H8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	H10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	H11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	H12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	H13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	H14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	H15	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	I10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I13	Yes
Chg 7 - Focus on choice,, if Mature or Exemplary please explain	I14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I19	Yes
Chg 1 - Early discharge planning Challenges	J8	Yes
Chg 2 - Systems to monitor patient flow Challenges	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J10	Yes
Chg 4 - Home first/discharge to assess Challenges	J11	Yes
Chg 5 - Seven-day service Challenges	J12	Yes
Chg 6 - Trusted assessors Challenges	J13	Yes
Chg 7 - Focus on choice Challenges	J14	Yes
Chg 8 - Enhancing health in care homes Challenges	J15	Yes
UEC - Red Bag Scheme Challenges	J19	Yes
Chg 1 - Early discharge planning Additional achievements	K8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K11	Yes
Chg 5 - Seven-day service Additional achievements	K12	Yes
Chg 6 - Trusted assessors Additional achievements	K13	Yes
Chg 7 - Focus on choice Additional achievements	K14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K15	Yes
UEC - Red Bag Scheme Additional achievements	K19	Yes
Chg 1 - Early discharge planning Support needs	L8	Yes
Chg 2 - Systems to monitor patient flow Support needs	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L10	Yes
Chg 4 - Home first/discharge to assess Support needs	L11	Yes
Chg 5 - Seven-day service Support needs	L12	Yes
Chg 6 - Trusted assessors Support needs	L13	Yes
Chg 7 - Focus on choice Support needs	L14	Yes
Chg 8 - Enhancing health in care homes Support needs	L15	Yes
UEC - Red Bag Scheme Support needs	L19	Yes

Sheet Complete:	Yes

5. Narrative

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

Appendix 4

Walsall Healthy Partnerships Workstreams	Source of Funding	2017/18 Budget	Q1 & Q2 actual	Q3 actual	Q4 forecast	Total Forecast	Variance
		£	£	£	£	£	£
Access to Services	CCG minimum - CCG	229,420	114,710	57,355	57,355	229,420	-
Intermediate Care	CCG minimum - CCG	8,289,423	3,987,462	2,029,270	2,126,934	8,143,666	- 145,757
Locality Working	CCG minimum - CCG	749,600	369,072	184,537	185,643	739,252	- 10,348
Other	CCG minimum - CCG	1,086,550	543,275	271,638	271,637	1,086,550	-
Resilient Communities	CCG minimum - CCG	1,334,093	679,683	324,771	283,929	1,288,383	- 45,710
Intermediate Care	CCG minimum - LA	4,063,810	1,933,249	1,191,541	939,028	4,063,818	8
Locality Working	CCG minimum - LA	3,331,419	1,654,348	834,773	842,588	3,331,709	290
Resilient Communities	CCG minimum - LA	589,000	220,311	112,451	207,534	540,296	- 48,704
Subtotal CCG minimum		**19,673,315**	**9,502,110**	**5,006,335**	**4,914,648**	**19,423,093**	**- 250,222**
Locality Working	iBCF1	917,597	458,799	229,399	229,399	917,597	-
Subtotal iBCF1		**917,597**	**458,799**	**229,399**	**229,399**	**917,597**	**-**
Intermediate Care	iBCF2	2,779,915	1,093,075	- 488,454	1,735,304	2,339,925	- 439,990
Locality Working	iBCF2	740,320	59,660	157,320	208,107	425,087	- 315,233
Resilient Communities	iBCF2	2,286,132	943,066	496,608	598,622	2,038,295	- 247,837
Subtotal iBCF2		**5,806,367**	**2,095,801**	**165,474**	**2,542,033**	**4,803,308**	**- 1,003,059**
Resilient Communities	LA	3,163,922	1,171,378	791,589	1,200,955	3,163,922	- 0
Subtotal LA Capital		**3,163,922**	**1,171,378**	**791,589**	**1,200,955**	**3,163,922**	**- 0**
Total BCF, iBCF1 & iBCF2		**29,561,201**	**13,228,088**	**6,192,797**	**8,887,034**	**28,307,919**	**- 1,253,282**