Agenda item 11

Cabinet – 6th September 2017

Integration and Better Care Fund Plan 2017-2019

Portfolio: Councillor Robertson

Related portfolios: Councillor D. Coughlan

Service: Adult Social Care

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary

1.1. The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The Better Care Fund, previously the 'Integration Transformation Fund' is now in its 3rd year having been in place since 2014/15.

1.2. With the exception of the Improved Better Care Fund (IBCF) grant investment to Local Authorities for 2017-2020 which was the subject of a report to Cabinet in July 2017 and inflation on existing services, there is no 'new' money within the Better Care Fund. The fund represents c£20m of CCG and £4m of WMBC Adult Social Care existing budgets and the services that those budgets represent.

1.3. This report sets out the Integration and Better Care Fund Planning Requirements as issued by the Department of Health on the 4th July 2017 and seeks approval to the Walsall Integration and Better Care Fund Plan in 2017/19.

1.4. The planning requirements and Better Care Fund Plan cover the period from 1st April 2017 – 31st March 2019. It is recognised that these plans therefore are in part retrospective, this was regrettably unavoidable as the Planning Requirements were delayed, finally being released in July 2017.

1.5. The Health and Wellbeing Board considered the BCF plan on 21 August 2017 and has made recommendations to Cabinet as set out in paragraph 2.

2. Recommendations

2.1 That the content of this report regarding the Better Care Fund Planning Requirements are noted.

2.2 That the Walsall Integration and Better Care Fund Narrative Plan as attached at **Appendix 1** be approved for submission to the Department of Health.

2.3 That the BCF Expenditure Plan as set out in Tab 3 of the attached Better Care Fund Planning Template at **Appendix 2** be approved for submission to the Department of Health.

2.4 That the target metrics for the Better Care Fund as set out in Tab 4 of the attached Better Care Fund Planning Template at **Appendix 2** be approved for submission to the Department of Health

2.5 That delegated authority is given to the Executive Director of Adult Social Care and Accountable Officer for the CCG in consultation with the Portfolio Holder for Health and the Portfolio Holder for Adult Social Care to make minor amendments to the plan on receipt of the assurance feedback from the Department of Health.

3. Report detail

3.1 BCF Planning Requirements

3.1.1. The intention of the Better Care Fund is to provide a pooled budget between local authority and health services in support of integration.

3.1.2. This is the third year of Better Care funding**.** This year's planning moves from 1 year to 2-year planning and also sees a new source of funding Improved Better Care Fund (iBCF) which is devolved directly to Councils**.**

3.1.3. There are stringent guidelines for the use of funding, and there is a requirement for quarterly performance monitoring.

3.1.4. Each Better Care Fund Plan should consist of:

- A jointly agreed narrative plan including details of how they are addressing the national conditions; how their BCF plans will contribute to the local plan for integrating health and social care and an assessment of risks related to the plan and how they will be managed.
- A BCF planning template that includes:
  - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
  - A scheme-level spending plan demonstrating how the fund will be spent;
  - Quarterly plan figures for the national metrics.

3.2. National Conditions

The National Conditions have been reduced to four conditions for this submission, with a greater focus in this period on managing Delayed Transfers of Care. This is a move away from the previous conditions which focussed more on the enablers for integration. The four National Conditions for 2017-2019 are as follows.

3.2.1. Jointly agreed plan

- Agreed by Health & Wellbeing Board(s) (HWB).
- Involvement of other stakeholders
- All minimum funding requirements met.
- Clinical Commissioning Group (CCG) minimum contribution to increase in line with CCG overall budgets.

- Agreement on use of IBCF money to ensure that the local social care provider market is supported.
- Agreement on use of DFG funding.

3.2.2. Social care maintenance
- Applies to contribution from CCG minimum.
- Uplift of minimum required contribution from 2016-17 baselines in 2017-18 and 2018-19.
- Local areas can agree higher contributions from the CCG minimum or additional contributions.
- Planning template will be pre-populated with figures – including 2016-17 baseline as assured.
- Opportunity to query baseline if all parties agree it is wrong.

3.2.3. NHS commissioned out of hospital services
- Ring-fenced amount for use on NHS commissioned out of hospital services. This will be set out in allocations.
- This applies to the CCG minimum and covers any NHS commissioned service that is not acute care – can include social care.
- Areas are expected to consider holding funds in a contingency if they agree additional targets for Non-Elective Admissions (NEA) above those in the CCG operational plan.

3.2.4. Managing transfers of care
- All local areas must implement the high impact change model for managing transfer of care.
- This is also a condition of the iBCF grant. We expect the plans to be jointly agreed and funded.
- Some local areas may already be implementing this model – this should be reflected in plans.
- Discussions should involve trusts.

3.2.5. In addition to the National Conditions the BCF guide to assurance of plans indicates a further eleven planning requirements that contain twenty four ‘Key lines of enquiry’ that should be evidenced within the document. A copy of these can be found at **Appendix 3.**

3.3. Assurance Process and Timeline

3.3.1. As in 2016/17, plans will be assured regionally. Assurance will be co-ordinated by the Better Care Managers (BCMs) but decisions will be jointly made between NHS and local government assurers.

3.3.2. Assurance of plans in 2017 will take place in one stage, after which plans deemed to meet the requirements set out in the Policy Framework and Planning Requirements will be put forward for approval.

3.3.3. Plans rated ‘approved with conditions’ will be given permission to enter into s75 agreements on condition that any outstanding requirements are met by the date specified in the notification

3.3.4. Final decisions on plan approval will be agreed by NHS England and the Integration Partnership Board (IPB). These decisions will be based on the moderated recommendation of the regional assurance panel.

3.3.5. The assurance timeline is as set out in **Table 1** below**.**

Table 1

4 July	BCF Planning Requirements, BCF Allocations published
w/c 10 July	Planning Return Template circulated.
21 July	First Quarterly monitoring returns on use of iBCF funding from local authorities.
21 July	Local areas to confirm draft DToC metrics to BCST
11 September	BCF planning submission from local Health & Wellbeing Board areas. All submissions. All submissions need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net
12-25 September	Scrutiny of BCF plans by regional assurers.
w/c 25 September	Regional moderation.
2 October	Cross regional calibration.
From 6 October	Approval letter issued giving formal permission to spend (CCG Minimum).
w/c 10 October	Escalation panels for plans rated as 'not approved'.
31 October	Deadline for areas with plans rated as 'approved with conditions' to submit updated plans.
30 November	Section 75 agreements to be signed and in place.
November	Government will consider a review of 2018-19 allocations of iBCF for areas poorly performing. The funding will remain within local government, to be used for adult social care.

4. Council priorities

The partnership arrangements with WCCG contributes to the Council priority for *Improving health and wellbeing, including independence for older people and the protection of vulnerable people*. The way it does this is through providing information, advice, assessment, support planning and support packages to adults with eligible mental health and learning disability needs.

5. Risk management

Risks and risk management is identified on page 24 of the Better Care Fund Plan at **Appendix 1.** A more detailed risk management plan will be included within the S75 agreement.

6. Financial implications

The approved funding streams for the Better Care Fund are as follows in Table 2.
Table 2

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 Top-Up Funding – CCG	5,000	1,831,000
LA Funding (DFG)	3,163,922	3,432,630
iBCF1 Funding	917,597	5,953,156
iBCF2 Funding	6,501,577	4,083,786
OVERALL	**30,261,391**	**35,348,040**

6.2 A summary of forecast expenditure allocated by Walsall Together Work-streams is detailed below in Table 3.

Table 3

	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	**19,657,315**	**21,837,065**
Access to Services	229,420	233,420
Intermediate Care	12,337,233	14,434,983
Locality Working	4,081,019	4,143,019
Other	1,086,550	1,107,550
Resilient Communities	1,923,093	1,918,093
Improved Better Care Fund	**7,419,154**	**10,040,345**
Intermediate Care	2,810,915	200,000
Locality Working	1,626,917	6,838,516
Resilient Communities	2,286,132	2,418,132
Other (tbc)	695,190	583,697
Local Authority Contribution	**3,184,922**	**3,470,630**
Resilient Communities	3,184,922	3,470,630
Grand Total	**30,261,391**	**35,348,040**

6.3 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.

6.4 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.

6.5 These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.

7. Legal implications

As with previous years, the Better care Fund will be governed by a S75 agreement between Walsall MBC and Walsall CCG. There is an expectation that agreements will be put in place by November 2017.

8. Procurement Implications

Related procurement activity has been identified within the Adult Social Care Commissioning Intentions and has been entered onto the Procurement Plan.

9. Property implications

9.1. The development of individual services within the Better Care Fund may have property implications, the exact impact of these developments is not yet known. As and when services are developed property implications will be considered through the relevant committees.

10. Health and wellbeing implications

10.1 Sustaining a range of high services will contribute to maintaining the health and wellbeing of people who need health and social care services. The Care Act 2014 places a duty upon local authorities to promote health and wellbeing in the population and to provide a sufficient level and range of services to meet need.

10.2 The Better Care Fund is a key part of the delivery of the Health and Wellbeing Board Strategy.

11. Staffing implications

11.1 The development of individual services will have implications for staffing within the directorate, the exact impact of these developments is not yet known, although, in the main it is likely to be positive. As and when services are developed staffing implications will be considered through JNCC and other relevant committees.

12. Equality implications

12.1. The plan does not favour any particular client group or individual with protected characteristics and therefore there are no equality implications to consider.

12.2 The development of individual services within the Better Care Fund may well have implications for Equality. The exact impact of these developments is not yet known, although, in the main it is likely to be positive. As and when services are

developed Equality Impact Assessments will be undertaken to determine any Equality impact.

13. Consultation

13.1 Formal public consultation in relation to the development of these proposals is not a requirement. Where required, there will be public consultation in the development of services that these proposals will fund.

13.2 The Health and Wellbeing Board considered the BCF plan on 21 August 2017 and has made recommendations to Cabinet as set out in paragraph 2.

Background papers

Cabinet Report 26 July 2017 - Improved Better Fund (iBCF) Funding Allocations and Spending Plan

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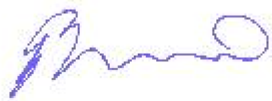

Paula Furnival Executive Director	Councillor Robertson Portfolio holder
18 August 2017	18th August 2017

Local Government Association

NHS England

Walsall Integration and Better Care Fund

Narrative Plan Template 2017/19

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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.

Guidance recommends that this a succinct document, therefore references are made to other relevant documents where applicable.

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2.1 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:

"***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

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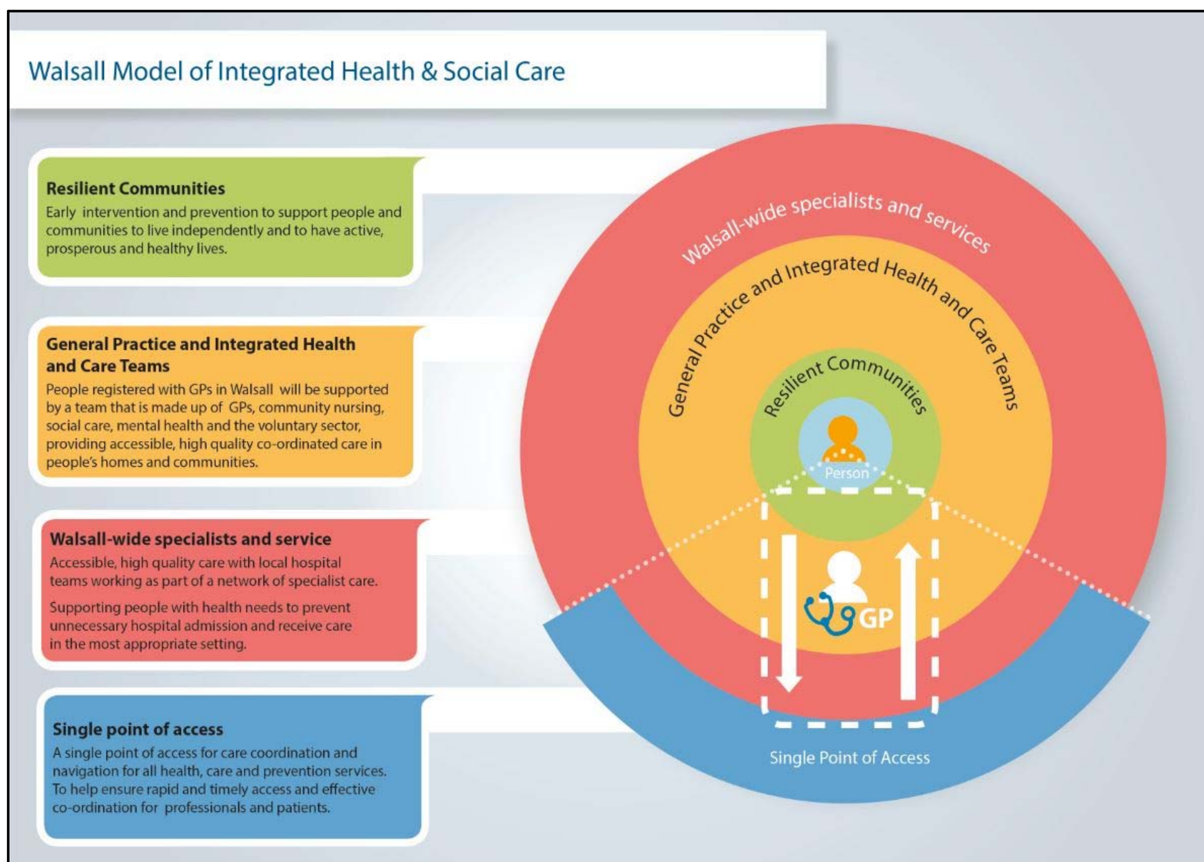

2.5. As part of this work a new Model of Integrated Health & Social Care has been developed. It will build on some of the joint work that is already taking place, as well as improving outcomes and delivering a better experience for those that use services, in a more financially sustainable way. To achieve this, we are focussed on the following four areas:

2.5.1. **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.

2.5.2. **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.

2.5.3. **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.

2.5.4. **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.

2.6. 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.

2.7. 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.

2.8. 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.

2.9. 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 and social care. 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

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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 G.P 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.

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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, 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 the progress of two of the schemes in 2016/17 follows

4.3.1. *Nursing and Residential home case management.* Walsall Healthcare have a substantive team 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.

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.

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- 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 Nursing 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.

4.3.7. *Frailty team across acute and community*. 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 patients own home. This may facilitate a reduced length of stay in the acute hospital as care is available outside of the hospital environment.

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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.

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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

5.2 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.

5.3. Statistics 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.

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5.4. 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.

5.5. 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.

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6.0 Better Care Fund plan 2017-19

6.1 Priorities 2017-2019

The plan for 2017/19 focusses on the 4-areas described within the Walsall Together Programme which make up the Walsall Model of Integrated Care, specifically:

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

The four work streams are described in detail below.

The priority areas over the next 2-years are:

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

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 (e.g. 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

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- 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

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.

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.

6.3 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

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- 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, e.g. 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 on-going 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 **

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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 e.g. 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.

6.4 Intermediate Care Service

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6.4.1 Intermediate Care provides a range of services to patients that require additional social care / health care post-acute care to enable timely discharge to a safe living environment with the necessary assistance 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 (includes no further social / health care support required)..

6.4.2. An assessment of Walsall's current Intermediate Care Pathways, supporting both discharge from hospital and admissions avoidance, highlighted numerous weaknesses, including:

- Over reliance on bed based models for discharge
- Patients not 'directed' to the appropriate Intermediate Care Pathways (inconsistent compliance with pathway entry criteria)
- Over provision of Intermediate Care Service, typically due to unnecessary delays to 'exiting' the Intermediate Care service
- Silo working across health and social care teams
- Misalignment of resources to meet the patient needs in a community setting
- Inconsistent ward processes, including unreliable EDD and inadequate compliance to SAFER principles resulting in delays to identify patients with complex discharge needs

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 vision for integrated intermediate care aims to provide a rapid response to care delivery in the right place at the right time to maximise patient's independence, deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to return home.

6.4.5. The proposed solution is to implement a reconfigured Intermediate Care Service (ICS) Model that makes discharge home with timely access to the appropriate health and social care support as the default pathway. The focus of ICS will be to work in partnership with patients to set patient-centred goals coupled with a MDT approach to enable and monitor progress against goals / plan. 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.

6.4.6. The refreshed vision for the Intermediate Care Services is:

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- 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.
- Provide a rapid response to care delivery in the right place at the right time to maximise patient's independence, deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to return home.
- Integration through a new shared culture, mind-set, values, objectives, working processes and practice.'

6.4.7. 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 i.e. 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

6.4.8. 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

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- Single team taking a MDT approach to identify needs, support patients and monitor against patient goals.

6.4.9. Implementation of the reconfigured ICS will require significant transformation across process, organisational (including teams, structures, roles and responsibilities), data and governance domains. A phased approach to implement the required business changes and the achievement of desired outcomes will be utilised to manage the Business Change complexity and associated risks.

6.4.10. Critical to delivery of this scheme is the robust implementation of SAFER and Red to Green to ensure management of in hospital flow. It is the intention of the scheme to support the hospital in this by providing the mechanism for supported discharge which includes joint planning for discharge.

6.4.11. 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.

6.4.12. The detailed implementation plan is seen in appendix xxx of which the key milestones are:

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 utilization and minimise duplication. Allow better utilization of resources. Look to implement best practice from national schemes/programmes to:

- 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 sign posting 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

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- 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.

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7. 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 better care fund 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. The plan has been agreed at these forums

Forum	Agreed Date
Joint Commissioning Committee	14/08/2017
Health and Wellbeing Board	21/08/2017

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 & 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 allocated against the 'Protecting Social Care' criteria, the rebalancing has resulted in an actual increase in funds allocated against this criteria.

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.

7.3. 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 investment in out-of-hospital services this continues to be the case for 2017-2019.

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. A summary of how it meets the requirements is set out in **Table 2.**

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Table 2

High Impact Action	Plan
Early Discharge Planning	The new model of integrated intermediate care expects that discharge planning starts at a much earlier point at a patients hospital admission and will aim to facilitate discharge of patients within 48 hours of being 'medically fit for discharge'.
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. A copy of this report can be found at Appendix ?
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.
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 for assessments will be completed in the patient's own home (or alternative setting) within 24 hrs of discharge.
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.
7 Day Services	The new model of Integrated Intermediate Care is working towards a phased implementation of 7 day working.
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.

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8. Risk and Risk Management

The key programme risks identified are:

Risk Description	Inherent Risk	Actions	Residual Risk
New models of care fail to positively impact on performance and outcomes.	**16**	Regular programme oversight to monitor and agree mitigation of risk.	**12**
New model of care delivery and commissioning is dependent on sound relationships and trust between stakeholders, risk of relationship breakdown impacting on delivery.	**16**	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.	**12**
Increase in resources (financial and staffing) required to implement the new model of care.	**16**	Regular programme oversight to monitor and agree mitigation of risk.	**12**
Commissioning of services to deliver financial viability of BCF will require radical changes to services and potentially have a detrimental impact on provider income streams.	**12**	Full engagement with providers through the Walsall Together programme to identify risks and agree mitigation.	**8**
Unable to optimise the multi-disciplinary approach and the cultural change required to implement the new integrated model of care. Duplication of assessments & care plans.	**9**	Co-locate service providers where appropriate and agree single multi-disciplinary approach. Incremental management of cultural change	**6**
Data not available for monitoring impact of Change Schemes Evaluation not possible.	**12**	Agree with CSU and Council & Provider Performance teams data required and where this is collected	**6**

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9. Overview of funding contributions

Add

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10. National Metrics

Metric	Data Required	Target	Collection Method
Non-elective admissions (General and Acute)	NEA National Data Set – no additional data required.	Total NEA 17/18 **34,360** Total NEA 18/19 **34,445**	Through Unify 2 template - set at CCG level
Admissions to residential and nursing care homes	Total number of admissions to care homes Population data	Total admissions per 100,000 population 17/18 **340** Total admissions per 100,000 population 18/19 **340**	Collected by WMBC
Effectiveness of reablement	Total number of people (over 65 discharged from hospital. Of the total discharged, number of patients at home 91 days later	Proportion of people at home after 91 days 17/18 **82.1%** Proportion of people at home after 91 days 18/19 **82.1%**	Collected by WMBC
Delayed transfers of care	National Data Set Total number of 'delayed days'	Number of delayed days per 100,000 population 17/18 **3154** Number of delayed days per 100,000 population 18/19 **3154**	Collected through Unify template A local collection method is in development so as to provide more real time data for monitoring.

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10.1. National Metrics Supporting Narrative

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.

10.1.2. 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 was 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 a decision to allow the use of residential provision, where it is appropriate to do so and brings Walsall in line with regional and national comparators.

10.1.3. 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.

10.1.4. An independent review of DToC reporting was undertaken this year, the outcome of which will impact on the recording of DToC as the system implements the recommendations. The impact will be a reported increase in DToC levels during the year which once plans to reduce DTOC are implemented, such as the integrated intermediate care service, will return to below the national target but not significantly below the outturn for 16/17. Implementing the recording changes without the corresponding improvement in performance would see a significant increase in the number of delayed transfers of care.

10.2. The National Metrics will be supported by local metrics in order to monitor delivery of individual schemes

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11. Programme Governance

11.1. 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.

11.2. 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.

11.3. 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 to inform the Walsall Health and care Transformation programme.
- 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.

11.4. 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

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11.5. 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.

11.6. 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.

11.7. 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 GP's, Elected Members, Academic Health Science Networks, ADASS, LGA, NHSE, Clinical reference Group, and other stakeholders, as appropriate.

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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	

a) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	Walsall CCG
By	
Position	Accountable Officer, Walsall CCG
Date	

Signed on behalf of the Council	Walsall Metropolitan Borough Council
By	
Position	Executive Director of Adult Social Care
Date	

Signed on behalf of the Health and Wellbeing Board	Walsall Health and Wellbeing Board
By Chair of Health and Wellbeing Board	
Date	

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Planning Template for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Health and Well Being Board	**Walsall**
Completed by:	Kerrie Allward
E-Mail:	kerrie.allward@walsall.gov.uk
Contact Number:	01922 654713
Who signed off the report on behalf of the Health and Well Being Board:	Cllr Ian Roberston

	Role:	Title and Name:	E-mail:
Area Assurance Contact Details*	Health and Wellbeing Board Chair	Cllr Ian Robertson	Cllr.Ian.Robertson@walsall.gov.uk

	Clinical Commissioning Group Accountable Officer (Lead)	Simon Brake	simon.brake@walsall.nhs.uk
	Additional Clinical Commissioning Group(s) Accountable Officers	None	None
	Local Authority Chief Executive	Paul Sheehan	Paul.Sheehan@walsall.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Paula Furnival	Paula.Furnival@walsall.gov.uk
	Better Care Fund Lead Official	Kerrie Allward	kerrie.allward@walsall.gov.uk
	LA Section 151 officer	James Walsh	James.Walsh@walsall.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->			

***Only those identified will be addressed in official correspondence**

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Incomplete Template

	No. of questions answered
1. Cover	6
2. HWB Funding Sources	29
3. HWB Expenditure Plan	16
4. HWB Metrics	31
5. National Conditions	12

Please go to the Checklist for further details on incomplete questions - Link here

Planning Template for BCF: due on 11/09/2017

Summary of Health and Well-Being Board 2017-19 Planning Template

Being Board: Walsall

Data Submission Period: 2017-19

Summary

<< Link to the Guidance tab

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£3,163,922	£3,432,630
Total iBCF Contribution	£7,419,154	£10,037,302
Total Minimum CCG Contribution	£19,673,315	£20,047,108
Total Additional CCG Contribution	£0	£0
Total BCF pooled budget	**£30,256,390**	**£33,517,040**

Specific Funding Requirements for 2017-19	2017/18 Response	2018/19 Response
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes
2. In areas with two tiers of local government:		
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?		
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.		
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£1,411,627	£1,437,627
Community Health	£10,516,074	£9,878,909
Continuing Care	£0	£0
Primary Care	£287,000	£292,000
Social Care	£13,531,002	£19,365,627
Other	£3,500,472	£3,790,180
Total	**£29,246,175**	**£34,764,343**

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£1,411,627	£1,437,627
Community Health	£8,259,909	£9,152,909
Continuing Care	£0	£0
Primary Care	£287,000	£292,000
Social Care	£0	£0
Other	£1,086,550	£1,107,550
Total	**£11,045,086**	**£11,990,086**
NHS Commissioned OOH Ringfence	£5,590,598	£5,696,819

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£1,411,627	£1,437,627
Community Health	£8,922,909	£9,878,909
Continuing Care	£0	£0
Primary Care	£287,000	£292,000
Social Care	£7,629,203	£9,120,979
Other	£1,086,550	£1,107,550
Total	**£19,337,289**	**£21,837,065**

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19	
Minimum Mandated Expenditure on Social Care from the CCG minimum		£10,487,884	£10,687,154	
Planned Social Care expenditure from the CCG minimum	£10,303,452	£7,629,203	£9,120,979	
Annual % Uplift Planned		-26.0%	19.6%	*Below minimum mandated uplift*
Minimum mandated uplift % (Based on inflation)		1.79%	1.90%	

4. HWB Metrics

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Total HWB Planned Non-Elective Admissions	8,512	8,468	8,779	8,600	8,531	8,487	8,802	8,624	**34,360**	**34,445**
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	**0**	**0**
HWB NEA Plan (after reduction)	8,512	8,468	8,779	8,600	8,531	8,487	8,802	8,624	**34,360**	**34,445**
Additional NEA reduction delivered through the BCF									**£0**	**£0**

4.2 Residential Admissions

		Planned 17/18	Planned 18/19
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Annual rate**	676	668

4.3 Reablement

		Planned 17/18	Planned 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	82.1%	82.2%

4.4 Delayed Transfers of Care

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	**Quarterly rate**	825	822	756	752	793	752	714	714

5. National Conditions

National Conditions For The BCF 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?
1) Plans to be jointly agreed	Yes	Yes
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes
4) Managing transfers of care	Yes	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:

Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;

Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)

Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)

Source of Funding = CCG Minimum Contribution

*****Summary of BCF Expenditure from Minimum CCG contribution** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' form the minimum CCG contribution that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:

Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

Source of Funding = CCG Minimum Contribution

Planning Template for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Walsall

Data Submission Period:

2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Walsall	£3,163,922	£3,432,630
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£3,163,922**	**£3,432,630**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
<Please Select Local Authority>		
Total Local Authority Contribution	**£3,163,922**	**£3,432,630**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Walsall	£7,419,154	£10,037,302
Total iBCF Contribution	**£7,419,154**	**£10,037,302**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Walsall CCG	£19,673,315	£20,047,108
Total Minimum CCG Contribution	**£19,673,315**	**£20,047,108**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
<Please Select CCG>		
Total Additional CCG Contribution	**£0**	**£0**

Comments - please use this box clarify any specific uses or sources of funding

	2017/18	2018/19
Total BCF pooled budget	**£30,256,390**	**£33,517,040**

Funding Contributions Narrative
Agreed - no issues

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?	<Please Select>	<Please Select>	
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.	<Please Select>	<Please Select>	
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:

Walsall

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,769,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654

Running Totals	2017/18	2018/19	
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979	Below Minimum Mandated Spend
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086	

		Scheme Descriptions Link >>		Expenditure											
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
4	Single point of access	10. Integrated care planning	1. Care planning		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£229,420	£233,420	Existing
3	Frail Elderly Pathway OOH's A&E	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£79,847	£81,847	Existing
3	Development of Intermediate Care service including additional OT and SW posts to support this service	11. Intermediate care services	5. Other	All areas covered	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	2017/18 Only	£2,635,799		Existing
3	NEW Intermediate Care Team	11. Intermediate care services	5. Other	All areas covered	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,048,985	£4,080,810	New
3	Intermediate Care Services and Community Health Service within service level agreement with Walsall Healthcare Trust	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£524,533	£534,533	Existing
3	Intermediate Care Services and Community Health Service within service level agreement with Walsall Healthcare Trust	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£683,205	£696,205	Existing
3	Stroke Non bed based Home Care	16. Other		Long term rehabilitation	Community Health		Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,000	£84,000	Existing
3	Walsall Cardiac Rehabilitation Trust	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£338,630	£344,630	Existing
3	Frail Elderly pathway	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£358,785	£364,785	Existing
3	Integrated Discharge Team	11. Intermediate care services	5. Other	All areas covered	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	2017/18 Only	£0		Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£801,250	£1,594,250	Existing
3	Frail Elderly Pathway Additional Community Investment	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£834,600	£850,600	Existing

Selected Health and Well Being Board:
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Data Submission Period:
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3. HWB Expenditure Plan

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Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654
Running Totals	2017/18	2018/19
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086

Below Minimum Mandated Spend

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
3	Spot Purchase of Intermediate Care Residential Services directly funded by CCG (e.g. Care home beds; Frail Elderly Pathway, Hollybank House) - spot purchase residential placements	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£355,772	£362,772	Existing
3	Blakenall Doctors Phoenix (Medical Cover to ICT Beds)	11. Intermediate care services	4. Reablement/Rehabilitation services		Primary Care		CCG			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£25,000	£25,000	Existing
3	Intermediate Care LES	11. Intermediate care services	4. Reablement/Rehabilitation services		Primary Care		CCG			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£21,000	£21,000	Existing
3	Intermediate Care Services and Community Health Service within service level agreement with Walsall Healthcare Trust	11. Intermediate care services	5. Other	All areas covered	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£949,334	£967,334	Existing
3	Intermediate Care Services and Community Health Service within service level agreement with Walsall Healthcare Trust	11. Intermediate care services	5. Other	All areas covered	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,166,000	£1,188,000	Existing
3	Bed Based Reablement (Hollybank)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	2017/18 Only	£31,000		Existing
3	Psychiatric Liaison Team (Adults)	11. Intermediate care services	5. Other	Combination of all services	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£584,239	£595,239	Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	CCG Minimum Contribution	2017/18 Only	£18,000		Existing
3	Psychiatric Liaison Team (OP)	11. Intermediate care services	5. Other	Combination of all services	Mental Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£602,388	£613,388	Existing
3	Home from Hospital Services required in the reablement pathway for people with dementia and frail elderly	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£61,840	£62,840	Existing
3	Stroke Non bed based Home Care	16. Other		Long term rehabilitation	Community Health		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£80,000		Existing
3	Bed Based Reablement (Hollybank)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£1,310,262		Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	Improved Better Care Fund	2017/18 Only	£379,963		Existing

Selected Health and Well Being Board:

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3. HWB Expenditure Plan

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Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979	Below Minimum Mandated Spend
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	Improved Better Care Fund	2017/18 Only	£312,840		Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	Improved Better Care Fund	2017/18 Only	£85,237		Existing
3	Social Workers to support clients	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£239,710		Existing
3	Intermediate Care Pump Priming	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£200,000	£200,000	New
3	Bed Based Reablement (Hollybank)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£202,903		New
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	CCG Minimum Contribution	2018/19 Only		£412,963	Existing
2	Community Nursing In reach team	10. Integrated care planning	1. Care planning		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£140,485	£143,485	Existing
2	Enhanced case management approach in nursing and residential care	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£329,476	£335,476	Existing
2	Evening and Night Service	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£74,791	£75,791	Existing
2	Co-ordination of Personal Health Budgets	12. Personalised healthcare at home	3. Other	Both MH & Physical wellbeing	Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£25,000	£25,000	Existing
2	Protecting Social Services - care act element additional staffing	10. Integrated care planning	1. Care planning		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£275,227	£280,227	Existing
2	End of life divisionary beds	14. Residential placements	5. Nursing home		Community Health		CCG			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£179,848	£182,848	Existing

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3. HWB Expenditure Plan

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Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086

Below Minimum Mandated Spend

		Scheme Descriptions Link >>			Expenditure										
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
2	Protecting Adult Social Care Services	16. Other		ASC services	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£3,056,192	£3,100,192	Existing
2	Protecting Adult Social Care Services	16. Other		ASC services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£688,097	£1,488,379	Existing
2	Protecting Adult Social Care Services	16. Other		ASC services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£229,500	£229,500	New
2	Protecting Adult Social Care Services	16. Other		ASC services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£119,320		New
2	Community Reablement	10. Integrated care planning	2. Integrated care packages		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£100,000	£250,000	New
2	Increase OT & SW posts	10. Integrated care planning	1. Care planning		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£420,000	£565,000	New
2	Recruit transition lead for complex care	10. Integrated care planning	1. Care planning		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£70,000	£70,000	New
2	Protecting ASC	16. Other		ASC services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	2018/19 Only		£4,235,637	Existing
1	Integrated Community Equipment Store - Council element	1. Assistive Technologies	4. Other	Equipment Services	Social Care		Local Authority			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£128,000	£128,000	Existing
1	Integrated Community Equipment Store (CCG allocation)	1. Assistive Technologies	4. Other	Equipment Services	Community Health		Local Authority			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£630,000	£642,000	Existing
1	Disabled Facilities Capital Grant	4. DFG - Adaptations			Other	Equipment	Local Authority			Private Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£2,413,922	£2,682,630	Existing
1	Integrated Community Equipment Store (DFG)	5. DFG - Other Housing			Social Care		Local Authority			NHS Community Provider	Local Authority Contribution	Both 2017/18 and 2018/19	£771,000	£788,000	Existing
1	Integrated Equipment Service	1. Assistive Technologies	4. Other	Equipment Services	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£441,093	£449,093	Existing
1	Dementia support workers (based in Manor Hospital). Dementia advisors (Information & Advice). 7 dementia cafes	13. Primary prevention / Early Intervention	2. Other - Mental health /wellbeing		Mental Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£225,000	£229,000	Existing
1	Support to Carers	3. Carers services	4. Other	Combination of all services	Social Care		Local Authority			Private sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£461,000	£470,000	Existing
1	Shared Lives & Employment Services	16. Other		ASC services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£60,000	£110,000	New

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3. HWB Expenditure Plan

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Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086

Below Minimum Mandated Spend

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
		Scheme Descriptions Link >>			**Expenditure**										
1	Community Alarms	1. Assistive Technologies	1. Telecare		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£100,000	£100,000	New
1	Increase capacity of commissioning and business support function	7. Enablers for integration	11. Other	Combination of support services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£340,000	£460,000	New
1	Increase corporate support functions	7. Enablers for integration	11. Other	Combination of support services	Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£100,000		New
1	Market Uplift	16. Other		ASC services	Social Care		Local Authority			Private sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,686,132	£1,748,132	New
5	Potential risk of unachieved reduction in admissions	16. Other		Contingency	Other	Contingency	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,086,550	£1,107,550	Existing
3	Redesign of Stroke/ Rehab/ Falls Service	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£648,000	£660,000	New
3	Enhanced Primary Care to Nursing Home (inc D2A beds)	8. Healthcare services to Care Homes	3. Other	All areas covered	Primary Care		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£241,000	£246,000	New
3	Social Workers to support clients	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£6,000	£250,710	Existing
1	Independent Living Centre	11. Intermediate care services	5. Other	All areas covered	Community Health		CCG			Local Authority	CCG Minimum Contribution	2017/18 Only	£38,000		Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	CCG Minimum Contribution	2018/19 Only		£312,840	Existing
3	Walsall Healthcare Trust (DTA)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private sector	CCG Minimum Contribution	2018/19 Only		£85,237	Existing

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3. HWB Expenditure Plan

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Running Balances	2017/18	2018/19
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654

Running Totals	2017/18	2018/19	
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979	Below Minimum Mandated Spend
Ringfenced NHS Commissioned OOH spend	£11,045,086	£11,990,086	

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Selected Health and Well Being Board:

Walsall

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£1,010,215	-£1,247,303
Local Authority Contribution balance exc iBCF	-£21,000	-£38,000
CCG Minimum Contribution balance	£336,026	-£1,789,957
Additional CCG Contribution balance	£0	£0
iBCF	£695,190	£580,654
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£7,629,203	£9,120,979
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Below Minimum Mandated Spend

		Expenditure														
		Scheme Descriptions Link >>														
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Link back to the top of the sheet >>

Scheme Type	Description	Sub type
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery	1. Telecare
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also support self-management. Also, the assistance	1. Care coordination
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional	1. Carer advice and support
4. DFG - Adaptations	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic	1. Dom care packages
7. Enablers for integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas	1. Data Integration
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home	1. Other - Mental health / wellbeing
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the	1. Early Discharge Planning
10. Integrated care planning	A co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop	1. Care planning
11. Intermediate care services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable	1. Step down
12. Personalised healthcare at home	Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home.	1. Other - Mental health /wellbeing
13. Primary prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby	1. Social Prescribing
14. Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or	1. Supported living
15. Wellbeing centres	Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them	
16. Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the	

Planning Template for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Walsall

Data Submission Period:
2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	8,512	8,468	8,779	8,600	8,531	8,487	8,802	8,624	34,360	34,445

Are you planning on any additional quarterly reductions?	No

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HWB Quarterly Plan Reduction %	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Are you putting in place a local contingency fund agreement on NEA?	Yes

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£5,590,598	£5,696,819

Cost of NEA as used during 16/17***	£1,490	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***	£1,490	
Cost of NEA for 18/19 ***	£1,490	

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Total 17/18
Additional NEA reduction delivered through BCF (2017/18)	£0					£0
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 18/19
Additional NEA reduction delivered through BCF (2018/19)	£0					£0
HWB Plan Reduction % (2017/18)	0.00%					
HWB Plan Reduction % (2018/19)	0.00%					

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF planning,

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	551.3	602.1	675.6	667.7	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 targets for 17/18 and 18/19 reflect a decision to allow the use of residential provision, where it is appropriate to do so and brings Walsall in line with regional and national comparators.
	Numerator	271	300	340	340	
	Denominator	49,154	49,824	50,326	50,919	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.1%	82.1%	82.1%	82.2%	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.
	Numerator	254	308	308	370	
	Denominator	317	375	375	450	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	699.9	932.0	1055.5	819.4	824.6	822.2	755.6	751.9	793.4	751.9	714.1	713.9	An independent review of DToC reporting was undertaken, the outcome will impact on the recording of DToC as the system. The impact will be a reported increase in DToC levels during the year which once plans to reduce DTOC are implemented, will return to below the national target but not significantly below the outturn for 16/17. Implementing the recording changes without the corresponding improvement in
	Numerator (total)	1,484	1,976	2,238	1,747	1,758	1,753	1,611	1,611	1,700	1,611	1,530	1,537	
	Denominator	212,026	212,026	212,026	213,200	213,200	213,200	213,200	214,267	214,267	214,267	214,267	215,293	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Walsall

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	Significant work has been undertaken to review the financial profile within the BCF to ensure that whilst the fund is pooled and utilised to commission health & care services in a joined up way, that budgets and commissioning responsibility are clearly set out and agreed. 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 allocated against the 'Protecting Social Care' criteria, the rebalancing has resulted in
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	

4) Managing transfers of care	Yes	Yes	

BCF Planning Requirements – Key Lines of Enquiry July 2017

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)
National condition 1: jointly agreed plan (Policy Framework)	**1.Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well being board?** **2.In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?**	1.Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2.Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3.Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?
National condition 2: Social Care Maintenance (Policy Framework)	**3.Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19** **1.79% for 2017/18 and a further 1.90% for 2018/19*	4.Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5.If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6.In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7.Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision
National condition 3: NHS commissioned Out of Hospital Services (Policy Framework)	**4.Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	8.Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9.If an additional target has been set for Non Elective Admissions; have the partners set out a clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the

		plan seeks to avoid? 10.If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	**5.Is there a plan for implementing the high impact change model for managing transfers of care?**	11.Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12.Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13.If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?
Management of risk (financial and delivery)	**9.Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?**	21.Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22.If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23.Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?
Funding contributions: 1.Care Act, 2.Carers' breaks, 3.Reablement 4.DFG 5.iBCF	**10.Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?**	24.For each of the funding contributions, does the BCF evidence: •That the minimum contributions set out in the requirements have been included? •How the funding will be used for the purposes as set out in the guidance? •That all relevant stakeholders support the allocation of funding? •The funding contributions are the mandated local contributions for: •Implementation of Care Act duties •Funding dedicated to carer-specific support •Funding for Reablement •Disabled Facilities Grant?

		25.Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26.Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has not been offset against the contribution from the CCG minimum? 27.Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?
Metrics – Non Elective Admissions	**11.Has a metric been set for reducing Non Elective Admissions?**	28.Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29.Has a further reduction in Non-Elective Admissions, additional to those in the CCG operating plan, been considered?
Metrics – Non Elective Admissions (additional)	**12.If a metric has been set for a further reduction in Non-Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?**	30.Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? See also National Condition 3.
Metrics Admissions to residential care homes	**13.Has a metric been set to reduce permanent admissions to residential care?**	31.Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?
Metrics – Effectiveness of Reablement	**14.Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?**	32.Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?
Metrics Delayed Transfers of Care	**15.Have the metrics been set for Delayed Transfers of Care?**	33.Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34.Is the metric in line with the expected reductions in DToC for social care and NHS

		attributed reductions for the HWB area set out in the DTOC template? 35.If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36.Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37.Have NHS and social care providers been involved in developing this narrative?
Integrity and completeness of BCF planning documents	**16.Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?**	38.Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)