Health and Well-Being Board

22 July 2013

Progress on integration between health and social care

1. Purpose

There has been much discussion and many statements made by politicians from all political parties about the importance of better integration between health and social care in England.
This paper outlines the current state of integrated services in Walsall and maps out a set of proposals to which both the health community and officers in the local authority are committed in plotting the journey going forward. These proposals are included in a bid that was recently submitted to the Department of Health for Walsall to become a "pioneer for integration". (Bid attached)

2. Background

There have been long established positive relationships established in Walsall between the Local Authority and the Health Community. This is characterised through a range of local initiatives that have been developed through these positive relationships.

2.1 Areas where we are already working together across Walsall

- A Joint Commissioning Unit that commissions all services for "vulnerable" people (adults) in Walsall. (Some joint commissioning around children's services)
- A joint quality programme which is driving up standards in residential and nursing care which is run by the CCG and the Council.
- A "signed up" Section 75 agreement between the Council and the Local Mental Health Partnership Trust with social work services fully integrated within the Trust.
- Regular meetings with the local Mental Health Partnership Trust which oversees the continued development of effective joint service provision for both young and older adults.
- A joint team in the local hospital to manage the discharge of patients
- An established Health and Well-Being Board with an agreed strategy with shared objectives and targets for Year One.
- The DASS sits on the Walsall Clinical Commissioning Group
- Regular executive meetings between the leaders of the health and adult social care economies
- In collaboration with the local Mental Health Partnership Trust, we have a robust review process of all residential and nursing placements.
- Shared investment in bed-based intermediate care
- A Joint Equipment Store with a system of approved assessors across health and social care who can access equipment
- Investment from health in neighbourhood/community developments
- A nationally recognised whole system commissioning approach to Dementia Care
- Shared investment in Public Health (linked to the Health and Well-Being Strategy)
- Agreed care pathway for frail elders.

2.2 The policy demands going forward are urging local leaders to look to further integrate health and social care – plans have recently been joined up by officials in both the local authority and the health economy to look to agree the areas on which we should jointly focus, beyond the delivery of the health and well-being strategy.

3. Future plans

3.1 There are four areas that have been identified that would further enhance the experience of older people in Walsall with better integrated services. These are:

- To examine the possibility of a single point of access in the Borough for community health and social care services. To ensure that people get the right help in the right way and to contribute to reducing the number of avoidable or unnecessary hospital admissions.
- To develop a way of working in the Borough this, will be based on "risk stratification" for young adults and older people. This will look at identifying those adults where there are indicators through their lifestyle or current health needs that they are likely to need more intensive support in the future. To then focus current resources in a preventive way to help the person manage their condition now to reduce the chances of further deterioration and the need for acute admissions or intensive in-puts.
- To examine how health (both primary and community care services) and social care staff can work more closely together including exploring co-locating staff around the health model of locality working.
- To develop a single Intermediate Care Service in the Borough with a single manager which both supports people who have been discharged from hospital and offers a step-up set of services to avoid unnecessary admissions to hospital.

3.2 Alongside this 4 point proposal for further integration is a set of key indicators that have been agreed as the important signs that the overall health and social care system is delivering good outcomes for older people in Walsall. These are:

- Lower emergency non-elective admissions to Hospital
- Lower readmissions to hospital
- Enhance the development of community support services for patients with Mental Health needs
- Low delayed transfers of care
- No admissions from hospital to residential and nursing care
- Lower admissions to residential and nursing care
- Reduced demand for on-going care and support (because our preventive services can demonstrate that they are successful)
- Evidence that our investments in commissioning health and social care can demonstrate that they are delivering their intended outcomes for the people of Walsall.

3.3 All of the key partners are signed up to these proposals. These are: The Walsall Clinical Commissioning Group; the Local Authority Social Care and Inclusion Directorate; Public Health in Walsall, Walsall Health Trust (the Manor Hospital), Walsall and Dudley Mental Health Trust. A Programme Board is to be established between these stakeholders to take forward the agreed agenda. The Programme Board will report its progress to this Health and Well-Being Board.

5. Recommendation

For the Board to note the contents of the report and make any contributions towards the discussions on health and social care integration in Walsall

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Improving Health and Wellbeing for Walsall

NHS Walsall Clinical Commissioning Group

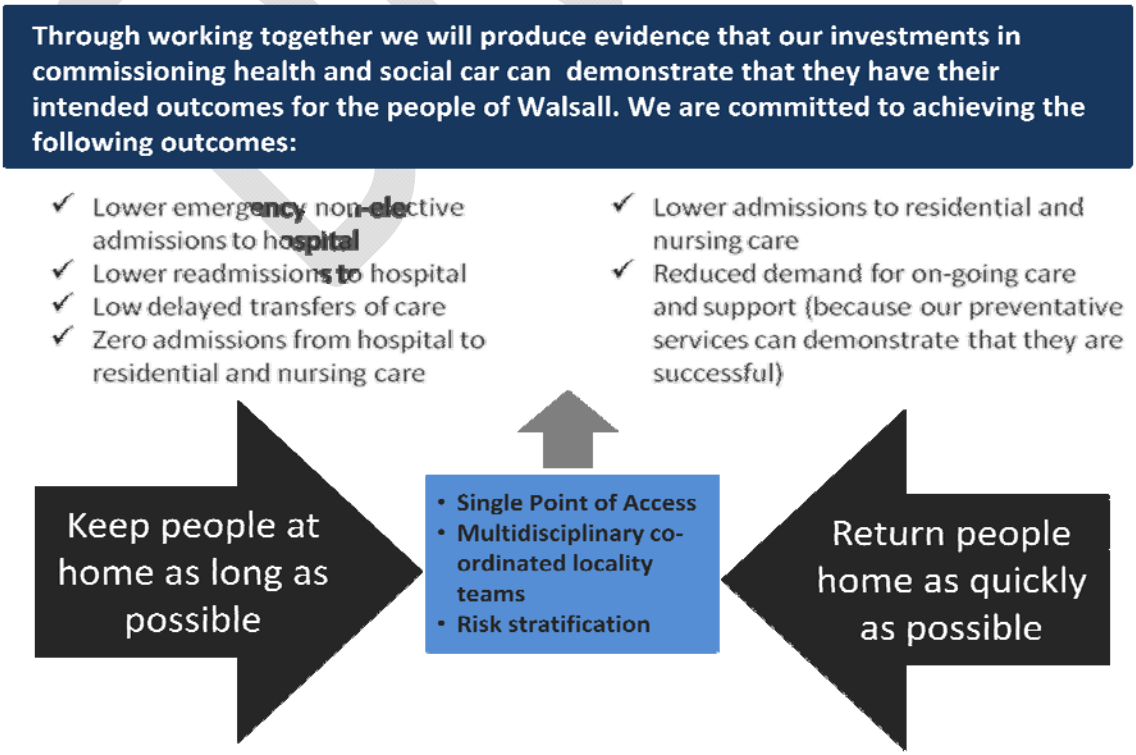
Expression of Interest for Health and Social Care Integration 'Pioneers'

Walsall health and social care economy

28th June 2013

1. Our vision: an innovative approach to integrated care and support

Walsall has one of the most deprived urban populations in the UK. Despite the foundations having been put in place to significantly improve the care of older people, the current system lets down these individuals and their carers; most care, inappropriately, remains institutionalised. Our vision is that by 2018, the older people of Walsall and their carers will experience a largely home-based model of care, centred around the specific needs of individuals. Our approach is to work in partnership, building on the successful parts of the system we have got right and taking steps to systematically implement a transformation at scale and pace. We envisage integration as a means to designing the health and social care system to deliver the outcomes we have all agreed.



Our proposal focuses on the frail elderly, a significant section of Walsall's society whom we believe will extensively benefit from an accelerated and focussed effort to integrate the health and social care services many of them receive. We will intensify support to older people so that they can live more independently and remain in their own homes. We will continue to work to promote independent living and minimise reliance on the reducing resources available from the state.

Over 45,000 people aged 65 years and older live in Walsall and this number is estimated to increase to 50,400 people by 2020. We know that too many of our older people do not have the means to live healthy and fulfilled lives and face key challenges including high level of long-term conditions, fuel poverty and social isolation. In this document, we set out our commitment to work in partnership with older people to address these issues and to support healthy ageing. We believe that we have a unique opportunity to bring a broader practitioner perspective, through a collaborative approach to integration of services for the frail elderly, we will bring local clinical intelligence from the consulting room into the boardroom, the primary care contribution to the integration agenda is a key component of our approach.[not sure this is a sentence but sounds good.

2. The Frail Elderly in Walsall

In order to reduce health inequalities Walsall CCG, Walsall Council, Walsall Healthcare NHS Trust and Dudley and Walsall Mental Health Trust recognises there is a need to achieve a more rapid improvement in health and well-being for people living in the deprived areas than those living in the more affluent, but this cannot be achieved without meaningful input and ownership from the population served. This ownership and contribution from local people would provide the input and creative solutions needed to generate positive changes to health and in turn impact on aspects of community life which are themselves determinants of health.

A range of measures demonstrate that older people in Walsall are high users of institutional care, receiving much of their treatment and care away from their homes in bedded facilities provided by general acute hospitals, mental health hospitals, nursing and residential homes. Walsall's Health and Well- being Strategy sets us the challenge of changing the way in which we use resources so that there is a better balance between ensuring those that need acute services get the quality they need but that overall the health and well-being of the population can improve so that fewer people need institutionalised care.

Our response to this seemingly enduring challenge which produces poor outcome and experiences for people is twofold:

- **First:** responding to the identified individual needs of older people, the core skills and competences traditionally provided by professionals in primary, secondary and social care, will be combined in teams with the skills of others including community volunteers and the unpaid contributions of carers, to enable to people to live well at home. For people with high care needs, there will be an intensive community response available to care for them at home where possible.

- **Second**: even in a transformed model of care for older people which is largely home-based, some people will need short periods of inpatient care. To respond to these specific short term needs, there will be an integrated team of professionals with health and social care competencies, to swiftly and safely transfer people back to their homes by accessing a range of services and/or interventions which give people the ability and confidence to live as independently as possible.

This proposal sets out the simple steps which we will take to transform the current model of service, which currently fails to identify and meet the needs of individuals, into one which will have in place services to enable older people to live at home or return swiftly and safely to home after an acute episode of bedded treatment. Currently social care use too much bedded provision because the intensive community response is not available and this programme of transformation will reverse that trend.

3. Established Relationships

Walsall has an impressive array of local leaders across the health and social care system, and relationships are characterised by mutual respect. This has enabled artificial barriers between organisations to become permeable, laying the foundation for the true integrated working across commissioning and service provision which we will deliver over the next five years.

3.1 Walsall's Joint Commissioning Unit (JCU)

An established institution in its own right, Walsall's JCU is unusual in that it is not characterised by artificial barriers and terminology. Its longevity is key to its success as the JCU has a well established culture which sees transparent joined up commissioning, particularly for new and innovative services, as the norm.

Walsall Council and NHS Walsall established a Joint Commissioning Unit (JCU) during 2009 using Section 75 of the Health Act 2006 to combine the funding/commissioning of adult social care services by the Council with associated services from the PCT i.e. mental health, learning disability, and older people services (i.e. unscheduled care; continuing health care; intermediate care).

A partnership model has been developed whereby the funding of each agency remains separate, but is simultaneously the responsibility of a joint team of both health and social care commissioners. This has a major benefit in that the funding responsibility remains within each agency, whilst still achieving improved value for money from integration. The key rationale is that all users of social care services are also users of health services, and can experience delays from the systems being separate.

An Executive Board provides governance and comprises Chair; Accountable Officer; and Directors of Finance, Quality, and Service Redesign for the CCG; and Portfolio Holder; Executive Director for SC&I; and Group Accountant in Walsall Council. The driver is all three elements of the phrase 'value for money'; meaning improved outcomes for people using services, higher standards, and greater cost effectiveness. During the period 2010/11 to 2012/13 the JCU contributed to circa £20 million of savings within the SC&I Directorate of Walsall Council. The JCU also contributed to the achievement of QIPP efficiency targets in each of the three years.

Whilst recognising that further improvements are possible, improved outcomes for service users can be evidenced in all service areas covered by the JCU. This kind of partnership may provide a potential model for other areas that could benefit from improved integration.
We are currently working with Professor Jon Glasby from Birmingham University's Health service Management Centre to review the JCU, to plan key next steps and to help us to consider strategic improvements and developments. Professor Glasby will be using the Partnership Working Assessment Tool (PAT), PAT is a nationally recognised tool for exploring the nature and quality of local working relationships. Its main advantage is that it gives a quick and accessible overview of the key strengths of local relationships as perceived by different partners, as well as areas for future developments. In addition to PAT, HSMC will

also explore how well local stakeholders feel that current commissioning arrangements help to deliver desired outcomes, key strengths and barriers, and any areas for future development.

3.2 Hospital integrated discharge team

Health and social care personnel are currently working together to accelerate the process of hospital discharge. Through the integration project, we will review this service to enhance its effectiveness and clarify the range of services available for patients through a single point of access.

Areas where we are already working together across Walsall:

- A Joint Commissioning Unit that commissions all services for "vulnerable" people (adults) in Walsall. (Some joint commissioning around children's services)
- A joint quality programme which is driving up standards in residential and nursing care which is run by the CCG and the Council.
- A "signed up" Section 75 agreement between the Council and the Local Mental Health Partnership Trust with social work services fully integrated within the Trust.
- A joint team in the local hospital to manage the discharge of patients
- An established Health and Well-Being Board with an agreed strategy with shared objectives and targets for Year One.
- The DASS sits on the Walsall Clinical Commissioning Group
- Regular executive meetings between the leaders of the health and adult social care economies
- Shared investment in bed-based intermediate care
- A Joint Equipment Store with a system of approved assessors across health and social care who can access equipment
- Investment from health in neighbourhood/community developments
- A nationally recognised whole system commissioning approach to Dementia Care
- Shared investment in Public Health (linked to the Health and Well-Being Strategy)

3.3 Leadership and transformation

The local authority and the acute hospitals have been through a programme of transformation over the last few years which has created the foundations of a sound system which is now ready to move to another level of integration. The fact that we have many joint enterprises sets a good environment for further transformation. Our Leaders all have reputations that demonstrate that they can lead transformation based on their previous track records.

4. Our plan for whole system integration

4.1 Better outcomes and experiences

In recent years pressures in the acute system have resulted in peaks of admission to residential care. Assessments of people take place in an acute setting and there appears to be an assumption that there will be limited recovery and regaining of independence in order to live at home. It is estimated that between 20% and 30% of all admissions to residential care are not appropriate and the many of these admissions are from the acute sector. In the new model of care the default position will be discharge from hospital to a person's home where there will be a period of recovery with the assessments taking place at home and it is expected that there will be a significant reduction in the number of people subsequently requiring long term bedded care.

During this programme of work specific measures of outcomes and experiences relating to individuals receiving services and their families/carers, will be developed. Nevertheless all partners are agreed that the key outcomes which we will use as our measures of success for our integration programme are:

- Lower emergency non-elective admissions to Hospital
- Lower readmissions to hospital
- Low delayed transfers of care
- No admissions from hospital to residential and nursing care
- Lower admissions to residential and nursing care
- Reduced demand for on-going care and support (because our preventive services can demonstrate that they are successful)
- Evidence that our investments in commissioning health and social care can demonstrate that they are delivering their intended outcomes for the people of Walsall.

Case study example: End of Life Care
The specialist services within the community setting are now co-located within the Palliative Care Centre and has been strengthened by further integration between specialist hospital and community palliative care teams. The service integration has led to: new relationships developed between intermediate care and palliative care team in managing patients out of hours and there is a clearly defined pathway used to manage patients out of hours; each community team has a named palliative care nurse who links with the healthcare team (GPs, Community Matrons, Ward staff and palliative care consultants) in managing patients with end of life care needs. These leads work across all health settings to ensure that care is given to palliative patients at the right time and in the right location ie their home The team works closely with the voluntary sector (also co-located within the Palliative care Centre) in delivering care to inpatients on the unit. Working with St Giles Hospice helps maximise patient care as the teams needed to treat patients are located in the same setting. Joint training, education and awareness is ongoing with social care on managing patients towards End of Life. This has further strengthened the relationships across health sectors. Gold Standard Framework co-ordinators work to support GP practices in being a first point of contact for supporting patients who are on the Gold Standards Framework for End of Life Care.

At its core the new service model will improve outcomes, deliver quality improvements which importantly include patient safety to be measured by fewer falls (e.g. from confusion/ disorientation from unfamiliar environment), less risk of acquiring hospital infection, improved nutrition. A comprehensive set of measures will be set out and agreed as part of the programme of work.

The proposed service model for health and social care integration as illustrated by Hollybank and reablement services is the basis on which to achieve a broader and more holistic model of care for older people.

Case Study: Telecare
We are focussed on using telecare to secure our shared ambition to help frail elderly people to remain safely and comfortably in their own homes for as long as possible, reducing reliance on institutionalised provision. In Walsall there are already around 100 patients, predominantly those with heart conditions, participating in a fully interactive monitoring system with nurse triage. However, we are also extensive users of lower tech telehealth and telecare systems from community alarms to remote blood pressure and glucose monitoring equipment, which is predominantly provide within people's own homes. The Walsall council community alarm system guarantees a home response within 20 minutes, and this has been instrumental in preventing admissions. The Walsall Independent Living Centre, with a demonstration site within the Tesco store, gives the people of Walsall rapid access to full OT assessment and a central hub for ordering community equipment.

4.2 Our Plan

The two objectives of our vision are:

- Keep people at home as long as possible
- Swift return home following episode of bedded care

To keep people at home as long as possible we will create an integrated team comprising the competences of primary care, acute, mental health, secondary and social care to combine with a range of other skills from other partners. This team will utilise tools such as the single point of access and risk stratifying patients using a range of health and social care data sets to understand the individual needs of people and provide the services which enable them to stay at home.

To deliver our first objective, there are three components of our new model of service:

- a Single Point of Access for health and social care
- co-ordinated locality teams
- pragmatic use of risk stratification

The second component of the new model of service, that of swiftly and safely transferring people back to their own homes following an acute episode of care, requires a coherent and efficient team, comprising skills of hospital discharge and social care, linking with the wider, co-ordinated locality teams, to agree with people the packages of care they most need at home. Through the SPA, there will be a menu of packages of services ranging from at the most intense, hospital based intermediate care beds through to at the least intense, 'reablement ' which is available within 24 hours of request and provided for a specified duration of days e.g. four days.

The Integration Board will explore the best ways of ensuring that the range of health and social care workers who work in the community alongside GPs in Walsall can be better integrated and ensure a single care pathway for older people. The co-location of staff; the development of a single point of access; the development of "virtual wards" (linked to risk stratification"); linked-workers attached to GP practices; shared service models e.g. Intermediate Care (under a single manager); the creation of care coordinator posts; and other options will all be explored to ensure that we produce the best outcomes for older people in Walsall.

Case Study: Hollybank

The local authority owned 'Hollybank 'is a residential care facility. The CCG commissions Walsall Healthcare NHS Trust to provide nursing and therapy input. At discharge from hospital after an acute episode of care, people are admitted to Hollybank for a period of on average five weeks then discharged to their homes. There is a low readmission rate and feedback from individuals and their carers regarding their experience is very good. The service has been given sufficient resources and has a high profile. It is run and provided by professionals with a real understanding of the individuals' needs for whom they care. The Hollybank service has 21 beds and as part of this work, we will identify the scale of the service needed across the whole of Walsall. It should be emphasised however that there is not an assumption that more bedded care is the solution. The current model underestimates the level of recovery and independence to be attained therefore perpetuating the need for intensive intervention; the new model should reduce the need for beds.

Through working together we will produce evidence that our investments in commissioning health and social car can demonstrate that they have their intended outcomes for the people of Walsall. We are committed to achieving the following outcomes:

- ✓ Lower emergency non-elective admissions to hospital
- ✓ Lower readmissions to hospital
- ✓ Low delayed transfers of care
- ✓ Zero admissions from hospital to residential and nursing care
- ✓ Lower admissions to residential and nursing care
- ✓ Reduced demand for on-going care and support (because our preventative services can demonstrate that they are successful)

The programme will set challenging but realistic plans (by 2018/19) for the number of:

- avoided unplanned admissions to acute care resulting in a reduction of occupied bed days.
- avoided/delayed admission to nursing and residential homes .

The internal evidence is that there have already been benefits from pathway integration in Frail Elderly Patients and other examples of success are highlighted throughout this document.

Track record of achievement through integrated working for frail elderly :

- An overall decrease in Length of Stay from 13.8 days in April 2010 to 10.5 days in April 2013
- A reduction in bed days from 7879 in April 2010 to 6680 in April 2013

We have some good local examples of integrated services, however this is not true of many areas where community nursing teams and social workers do not share a physical base and where in primary care there is little coordination across the local geography. Given the increasing mobility of some of these professionals who are spending more time out in the patch an evaluation will be made of the importance of shared physical base. There will be a plan of action to put in place the infrastructure so that teams will have a comprehensive skill set to work with individuals and their carers based on risk stratification, to put in place packages to enable them to live well at home.

This programme will establish the scale of service which is required to meet individuals' needs both in the component of the model to keep people well at home and post discharge from hospital. One element of this work will be to fully understand the current flows of people through the different services of the pathway; this has not been comprehensively quantified and is critical to shaping the investment required in the rebalancing the model.

For us the evidence base underpinning our proposals is critical. We are building the social care operational model from a sound evidence base. We are working with the Institute of Public Care – an evidence based

academic institution at Oxford Brookes University, Birmingham University and Wolverhampton University to build a stronger evidence base about what is working in our transformation.

Case Study: Anchor Meadow Community team

The Anchor Meadow Community Team' s wrapping services around the older person using the principle of locality based services, supports true integration of services within the community and hospital. This means moving away from the model of integrated community and acute teams which have social care as 'add-ons' towards an integrated health and social care model where an MDT (comprising social workers, district nurses, community matrons , GPs and specialists) manage the person across the whole of their pathway. The level of resource for Anchor Meadow is determined by the size of the GP practice population, public health data and risk stratification of the population, types of referral s and through the face to face activity of the teams. The clinical nursing team manages people across all levels of complexity with the matrons managing the most complex cases. There are link workers in place which provide specialist support for patients with COPD, Continence, Diabetes and Palliative care. The team is strengthened by having a linked social worker who the team can liaise with in the management of care. This new model is proactive in managing people who have long term conditions or are higher users of health services by putting in steps to make sure they do not reach the point at which acute intervention via urgent and emergency care services is needed.

4.3 Greater prevention and personalisation

In operating this model there is a strong emphasis on the need to constantly look towards maximising independence so that the choice is not specifically between which services to utilise but rather what skills, specific opportunities, and daily decision-making opportunities a person wants to restore and then maintain. This operating model is now focused on achieving outcomes in changing cultural outlooks; primarily a way of looking at disability, ageing and capacity that maximises individual and community assets, focuses on prevention and not solely in an approach to the provision of services.

Under the proposed operational model everyone who approaches the adult social care directorate will be offered some help based on a simple assessment of their presenting needs. From that initial contact either the person will be helped by another agency to which they have been directed or the council will give help and guidance through one of the many services offered. At each stage that help is offered, the assessment is taking place and the picture is built up of how best to meet the person's needs. At any point when those working with the person come to a view that they may need a long term service, a full assessment will take place. These services are designed to offer an immediate response to the person seeking help in a way that looks at options in which they can be assisted without assuming that they will need longer term help if this first intervention can resolve their problems. The success of preventative services would be demonstrated by fewer people needing long-term help and people getting their needs met in a timely and appropriate manner.

Track record of achievement through integrated working: Trauma Orthopaedic Musculoskeletal

- The overall trend across the 2 years shows a decrease in overall Length of Stay from 14.10 in April 2010, significant reductions can be seen at points throughout the year, for example to 5.8 in April 2013.
- A reduction in bed days from 1498 in April 2010 to 642 in April 2013.
- A reduction in readmissions 10 in April 2010 to 5 in April 2013, the trend in readmissions has remained constant throughout the period with an average of 10 per month which is important as the numbers of patients on the pathway have grown.

4.4 Financial efficiencies and reinvestment

Although the overall financial position for health and social care in Walsall is challenging, the local authority position for adult social care is stable and for the NHS, both commissioners and providers have this year

increased investment in these services. Together we have invested around £6 million in jointly developing our intermediate care services, and we want to assess the rebalancing of resources through this integration programme to ensure that we maximise our returns for the people of Walsall for that investment.

Track record of achievement through integrated working : Diabetes

- The overall trend shows a reduction in the average LOS, this has reduced from 5.5 days in April 2010 to 3.3 days in April 2013.

In June Walsall MBC agreed an additional investment in out-of-hospital community based care of £750,000 per annum. Overall this investment in preventative services should lead to a reduction in the council's costs (based on best performing councils) of between £3 to £4m per annum through the reduced use of both short and long-term residential care and reductions in the use of smaller community care based packages.

In this year's NHS commissioning round, Walsall CCG has made available an additional £1m to enhance community based services. This has enabled Walsall Healthcare NHS Trust to invest £500,000 to increase the district nursing establishment which all partners are agreed is a critical component of the integrated community services model for older people. There is therefore a further £500,000 for further investment in the capacity required to implement the new model of service.

5. Robust governance in taking forward the transformation

Walsall Health and Social Care economy is working under the leadership of the Health and Wellbeing Board. The health and wellbeing strategy for 2012/13 has a specific reference to ensuring co-ordinated provision of health and social care services focussing on recovery and re-enablement and this is a particular focus of the Vulnerable Adults Executive Board.

Walsall Vulnerable Adults Executive Board is a high profile group regularly meets to review all joint commissioning and activity taking place under pooled budgetary arrangements.

5.1 Frail Elderly steering group

We have recognised that in order to progress at pace and scale in the improvement of services for the frail elderly, key leaders need to regularly set aside time to review our strategy for integrated working and review our progress towards achieving better outcomes for our frail elderly population. As such we have set up a steering group to co-ordinate our efforts, which will report into the Health and Wellbeing board. This group will also receive and review the latest evidence from colleagues across the region, anticipate and dismantle barriers to progression of the work streams, The group has already commissioned though the local CSU a piece of work to understand better existing patient flows and highlight the potential impact of the programme both on the frail elderly population and the health and social care system. This will form a strong evidence base to guide future decision making.

The steering group are committed to sharing lessons on our journey and will welcome the opportunity to network and share learning with peers from across the country. However, it is important to note that we have laid out a vision with some proposals for further integration of Health and Social Care in Walsall. Regardless of the success of the bid, these should now be discussed within our local Governance arrangements which include the Health and Well-Being Board, and the scrutiny boards that cover Health and Social Care and Inclusion.

6. Why this programme is important and should be chosen as a pioneer

The frail elderly steering group has already been established between the health partners and the Local Authority and we are committed to working together under the oversight of the Walsall Health and Wellbeing Board. This bid is on the agenda of the Health and wellbeing Board fro further consideration.

- We have a track record of joint working in both commissioning and provision;
- We have a track record of working with our communities to deliver solutions for them;
- We face a real challenge in making a step change in the nature of the way we provide care to older people in an area of significant diversity and deprivation;
- We have the commitment of the senior leadership of all organisations;
- We are aiming to deliver at scale and at pace solutions for the whole of our patch;
- We therefore want to work with the national programme to establish a model that promotes rapid learning from best practice to support the borough wide roll out of integrated solutions.

Appendix 1: Understanding Walsall and its people

Walsall CCG delivers services to a resident population of 269,300 and a registered GP population of 270,300. Walsall has a diverse population with varied and significant health care needs. Wider determinants of health, such as education, work and unemployment, housing, and access to health care services, all affect a Walsall resident's experience of wellbeing and health.

Walsall is also a borough with great contrasts. Areas of great deprivation in the west of the borough lie close to relative affluence in the east. Differences in lifestyles, such as smoking, binge drinking, exercise and five-a-day fruit and vegetable consumption lead to much poorer health experiences for those living in the west. This translates into real differences in health outcomes for the people in these areas, including higher morbidity from coronary heart disease and diabetes. In 2010, Walsall was ranked as the 35th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th. The borough fares particularly badly in terms of education, income and employment deprivation.

The health and social care economy has a good track record of working in partnership with local people, for example the Asset based programme within the Darlaston and Bentley area and the Community Champions Programme provide a strong base on which to build. We believe this approach will make the most of the partnerships we have already developed and take the next steps toward positive and meaningful partnerships with our population going forward.

In addition Walsall also has a culturally mixed population. Indian, Pakistani and Bangladeshi minority ethnic groups form the largest minority ethnic groups in Walsall. Numbers for Indian residents have increased from 13,766 in 2001 to 19,385 in 2011. The release of 2013 Census data will most likely illustrate a great number of culturally mixed residents in Walsall. Access and the appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.

Below we have provided some highlights of the work which has been established in Walsall over many years to provide strong productive working relationships between health and social care organisations and the people of Walsall. These groups are being briefed in order to garner additional community support for our integration effort.

MyNHS Walsall - Established in 2008, it has 14,000 members and is well known in Walsall and across the region, with strong representation on key stakeholder organisations and a successful track record of engaging with the community, PCT, GPs. and WHNHST to investigate, evaluate and influence health care. MyNHS Walsall has now evolved into Healthwatch.

Walsall LINk - Had 400 members with strong member representation on national and local strategic bodies, and voluntary organisations. It has successfully engaged with CQC, the Council, public health, care homes and others to raise community concerns resulting in improved outcomes. Works collaboratively with MyNHS on areas of common concern (GP Satisfaction, Hospital discharges and Care homes).Walsall LINk has now evolved into Healthwatch.

Age UK Walsall - Has improved the quality of life for older people in Walsall by actively working to promote choice, independence, inclusion and dignity.

Walsall Housing Group - Has 40,000 customers and owns 19,000 homes, the majority of which are in deprived areas disproportionately affected by health inequalities. WHG has engaged with communities successfully tackling inequalities by investing in high quality homes and economic, social and health related regeneration.

Walsall CAB - Provides advice to local people on a range of issues including those that have an adverse impact on health, e.g. debt ; an established reputation for producing powerful evidence based documents that have influenced and changed the policies and practices that affect people's lives.

We have well developed engagement techniques which recognise the diversity of our local communities. Our Associates also have established knowledge, expertise and communication procedures geared to the needs of a range of disadvantaged people. Our strategy will be to expand our network still further to include specific hard to reach target groups such as BME, young people, older people, those with a disability, travellers etc.