Agenda item 20

Cabinet – 25 October 2017

Integrated Intermediate Care Service (Discharge to Assess)

Portfolio: Councillor Diane Coughlan – Social Care
Councillor Ian Robertson - Health

Related portfolios: None

Service: Adult Social Care

Wards: All

Key decision: No

Forward plan: Yes

1. Summary

1.1 Report purpose to provide Cabinet with an overview of the development of an Integrated Intermediate Care Service and seek approval to progress and develop a Section 75 Partnership Agreement between Walsall MBC and Walsall Healthcare Trust to govern the new integrated arrangements.

2. Recommendations

2.1 To note the development of an Integrated Intermediate Care Service in partnership with Walsall Health Care Trust.

2.2 To agree to the development of a Section 75 Partnership Agreement and Partnership Board between Walsall MBC and Walsall Healthcare Trust to govern the partnership between the two organisations.

2.3 Delegate authority to the Executive Director of Adult Social Care in consultation with the Portfolio holder for Adult Social Care to oversee arrangements for the development of the s75 partnership agreement.

3. Report detail

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

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

3.3 The new model is detailed in **Appendix 1,** in summary, the proposal is to implement a reconfigured Intermediate Care Service (ICS), that makes discharge home with timely access to the appropriate health and social care support as the default pathway. The reconfigured ICS is underpinned by consolidating disparate health and social care functions into a combined health and social care team that will provide a single service with responsibility for patients who require support to facilitate discharge from hospitals both within Walsall and outside of the borough.

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

3.6 The new model of delivery will require more integrated governance and management arrangements as detailed in the Management and Governance framework at **Appendix 2.** The proposal is that the governance arrangements will be underpinned by the development of a Section 75 Partnership Agreement, which in summary will set out, amongst other things:

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

4.0 Council priorities

4.1 The development or a new model of integrated intermediate care contributes to the Council priority – make a positive difference to the lives of Walsall People: increasing independence and improving healthy lifestyles so all can positively contribute to their communities. The way it does this is through providing support to patients to discharge home with access to the appropriate health and social care support in a more timely manner than is currently experienced.

5. Risk management

5.1 The risks relating to both the partnership and the delivery of the Intermediate Care service will be actively assessed and managed through the partnership governance arrangements and detailed within the Section 75 Partnership Agreement.

6. Financial implications

6.1 The Intermediate Care Service is funded through the Better Care Fund (CCG Minimum Contribution & Protecting Social Care allocations). For 2017/18 the total allocation of £8.831m across Adult Social Care and Walsall CCG, are currently funded as follows;

- BCF - £5.869m (ongoing funding)
- iBCF2 - £2.731m (one-off funding)
- Walsall Council mainstream - £0.231m (ongoing funding)

6.2 The draft budget profile for the reconfigured Intermediate Care service is set out on page 12 of **Appendix 1,** further work to refine this is ongoing. The draft gross budget for the Intermediate Care Service, is £8.831m in 2017/18, reducing to £6.855m in 2018/19. The cost reduction is associated with the fallout of the one off iBCF2 funding and liaison with partners to ensure that the service is affordable within the ongoing funding available in future years.

6.3 It should be noted that the Better Care Fund has a number of conditions attached to its use, with one key condition focusing on targets around Delayed Transfers of Care, which will need to be included within the Intermediate Care Model. From a financial risk perspective, should the delayed transfers of care targets (DTOC) not be met, there is the potential that BCF funding could be withheld or future allocations adjusted.

6.4 Walsall's Better Care Fund plan has been through Phases 1 and 2 of the regional assurance process. The feedback from the process to date is that Walsall's plan is 'not approved'. Implementation of the Intermediate Care service model is therefore currently unfunded until the BCF plan is agreed.

7. Legal implications

7.1 All relevant partnership arrangements must be entered into in compliance with Section 75 of the National Health Service Act 2006 and the Council's Legal Services Team will assist with developing such an agreement.

7.2 Legal Services will work with officers to ensure that all necessary legal processes are in place to minimise the risk to the Council in relation to the Section 75 Agreement.

8. Procurement Implications/Social Value

8.1 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 new community-based, integrated intermediate care teams, aligned to the four Integrated Health and Care Team Localities may require Walsall Council and Walsall Healthcare Trust to consider solutions to providing appropriate accommodation for these teams. This will be explored in parallel with the development of the service and until resolved, the service will continue to operate from existing Intermediate Care team bases.

10. Health and wellbeing implications

10.1 The health and wellbeing of the residents of Walsall will be positively influenced by the implementation of the new model of Integrated Intermediate Care as patients in hospitals will experience a more integrated approach to discharge planning which will aide a timely discharge from hospital.

10.2 The development of the integrated intermediate care service is a significant project within the Better Care Fund plan which is overseen by the Health and Wellbeing Board.

11. Staffing implications

11.1 The reconfiguration of services will inevitably lead to some changes in organisational arrangements and ways of working in intermediate care services within Walsall Council and Walsall Healthcare Trust and this will impact on staff.

11.2 Consultation will take place with staff and their Trade Unions on any proposed changes as they arise.

12. Equality implications

12.1 There are no negative equality impacts arising from the development of the integrated intermediate care service or the development of the Section 75 Partnership Agreement. Health and social care services provided through the S75 must be sensitive and ensure that they address the different needs of all of the community.

12.2 An Equality Impact Assessment will be completed as part of the implementation plan.

13. Consultation

13.1 Consultation will be undertaken as per respective partner organisation requirements at each stage of the project.

Background papers

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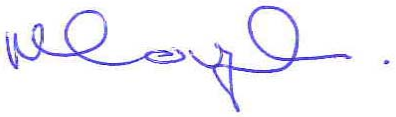
Paula Furnival
Executive Director

17 October 2017



Cllr Diane Coughlan
Portfolio Holder

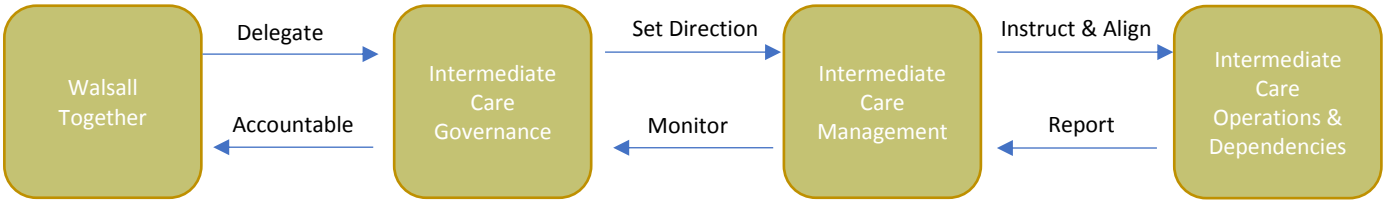
17 October 2017

Intermediate Care Service: Provider Governance and Management Framework

A critical enabler of the Intermediate Care System, compromising Health, Social Care, Mental Health, Private Providers and Voluntary Sector, to realise objectives and outcomes through 'benefits' delivered to patients / partners is a single integrated Governance and Management framework. Its remit will be to orchestrate the interconnected set of enablers across Partners / Service Providers to meet needs of internal and external stakeholders. It will oversee service design with implementation plan through to business-as-usual operations, with the initial focus to direct and monitor implementation against plan via maintaining a balance between benefits realisation, risk and resource optimisation.

Separating Governance and Management provides the required roles and accountability at different levels, including service performance as a whole as well as conformance to mandatory business requirements by individual Partners / Service Providers. The ICS management function by itself is insufficient to achieve the business objectives lacking the ability to optimise all of the factors that, individually and collectively, influence service performance and outcomes. The figure below represents the proposed Governance and Management roles, activities and relationships.

Figure 1: Governance and Management Roles



Governance Function

The proposed Intermediate Care Governance responsibilities are:

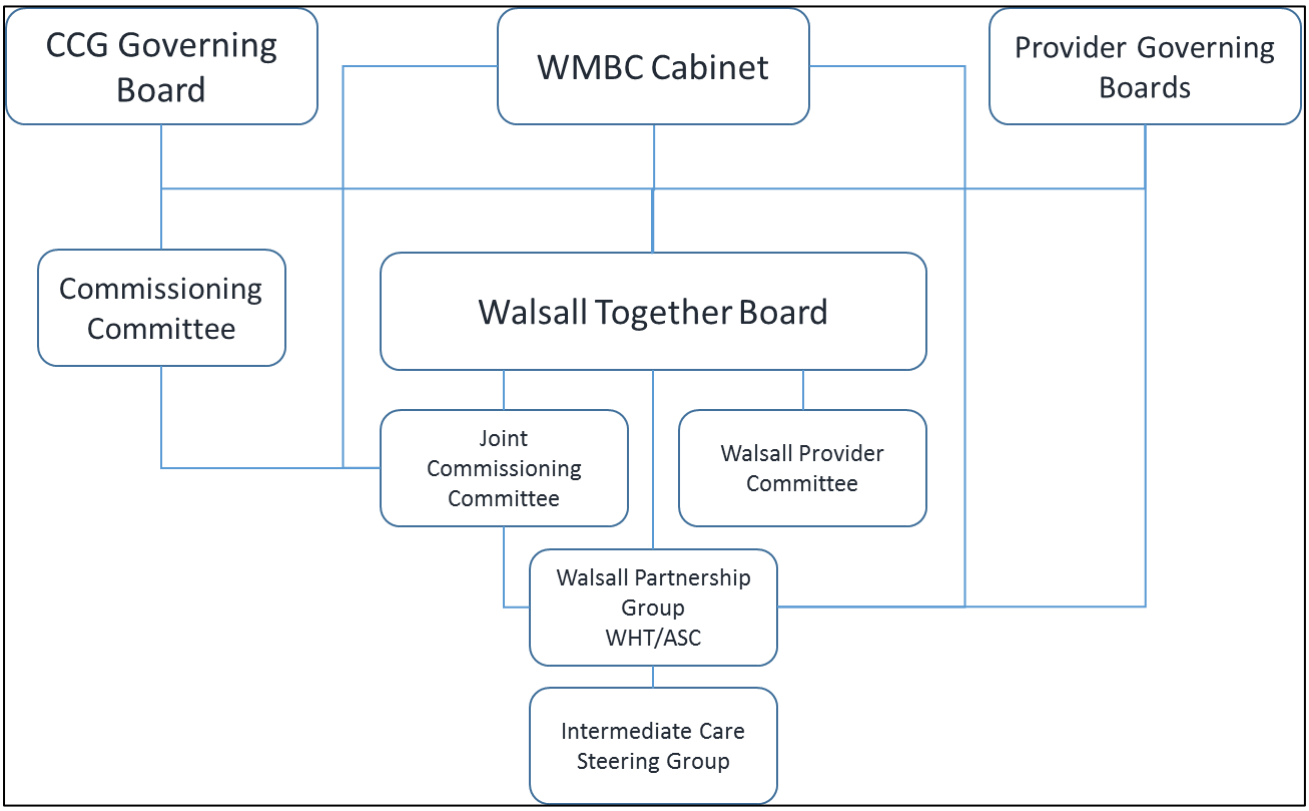
1. Agree Intermediate Care objectives, incorporating stakeholder needs, and assign mandatory enablers (business requirements) across partners
2. Determine the priorities for implementation, improvement and assurance based on benefits, risks and resource availability to realise objectives and manage risks
3. Monitor Intermediate Care Service performance, individual partner's compliance against agreed mandatory requirements and progress against agreed direction and objectives.

The proposed governance function is integrated into the Walsall Together Board, as presented below. The Health & Care Allied Services Partnership Committee membership is aligned to joint service delivery enabling strategic issues constraining performance or any risks to the partnership to be quickly identified and resolved. Membership will include:

1. CEO Walsall Healthcare Trust
2. Director of Adult Social Care
3. Service Director for ICS
4. Trust managers of services in-scope of mandatory requirements
5. Mental Health representatives
6. CCG/Council Commissioners

The challenge will be to think past tactical concerns and opportunities with each partner organisation, instead taking a collaborative approach to understand the strategic consequences of performance within an organisation across the Health and Social Care System. The Group will provide the required flexibility to address changing priorities and objectives with complex new negotiations and decision-making. The Committee will have an operational sub-committee, chaired by the Service Director for ICS which will identify and address operational delivery and performance within the scope of the specification.

Figure 2: Proposed Governance Structure



The Group will develop the levers, based on required enablers, to motivate partners to do the 'right thing' and be pro-active. Conversely, the Group will assess and determine the financial penalties where performance within a partner organisation has constrained performance of the Intermediate Care Service (assuming within the agreed demand for the services). This close alignment of operational and financial interests is really the only proven way to sustain productive long-term business partnerships. The risk share arrangements will be outlined within a Section 75 agreement & as a variation to the existing contracts of the component services.

The Chair will provide a monthly progress report coupled with issues to be escalated to the Walsall Together Board, thereby benefiting from the existing governance processes, ethics and policies.

It is proposed that the relationship between the two key organisations, Walsall Healthcare Trust and WMBC Adult Social Care is governed through a Section 75 agreement. The agreement will outline, amongst other things:

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

The Walsall Health & Care Allied Services Committee will be responsible for the delivery against this agreement and the regular updating of it to meet business requirements.

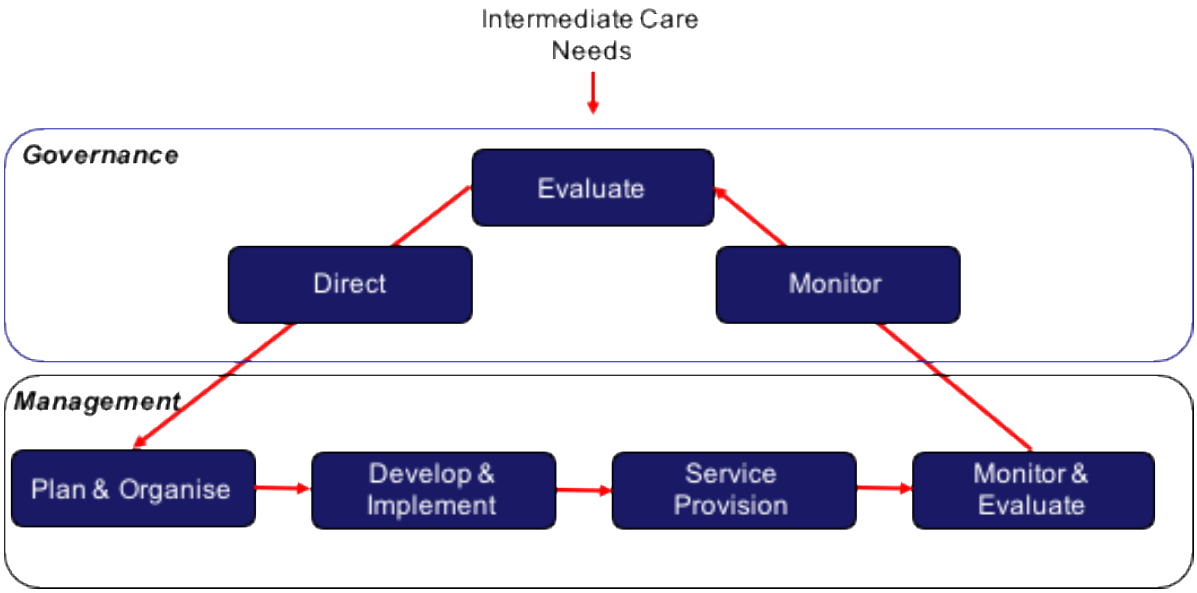
Management Function

The ICS management function is to plan / organise resources in order to develop the necessary capabilities which will be implemented to provide an efficient service that will be monitored to ensure continuous improvement in order to achieve the agreed business objectives. The role of Service Director for Walsall Health & Care Allied Services will be jointly responsible to Walsall Healthcare Trust and WMBC Adult Social Care. Responsibilities include:

1. Manage implementation strategy and implementation plan to achieve business objectives through realising business benefits and maintaining risks at an acceptable level
2. Manage Service Providers, including SLAs, in a collaborative manner to ensure required performance / quality is consistently available to the service
3. Ensure sufficient Support Services are available to the Intermediate Care Services so that efficient and effective service delivery is enabled (includes IT, HR, finance, logistics, procurement etc)
4. Develop and make consistently available the required competencies / capabilities to enable operational excellent service delivery
5. Manage operations and finances through optimising use of resources, through a co-ordinated single team approach, that makes available the right resources in the right place to satisfy the patient centric care-plans
6. Embed a multi-disciplinary approach to provide patient-centric care plans that will efficiently resolve patient needs to facilitate improved, restored or adjusted levels of independence in line with patient goals and Care Act obligations
7. Provision of IT enablement across ICS and Service Providers that will streamline information sharing, collaboration and workflow
8. Manage the business change and accompanying benefits realisation to achieve agreed business benefits
9. Monitor service performance and legal, regulatory and contractual (including mandatory business requirements) compliance
10. Manage quality and regulatory compliance

A single integrated Governance and Management Framework will enable the proposed Intermediate Care Service to be governed and managed in a holistic manner across the end-to-end service (with accompanying dependencies) considering the interests of internal and external stakeholders. The key activities of the two functions are highlighted below:

Figure 3: Integrated Governance and Management Framework



Benefits of a single Integrated Governance and Management Framework

1. Board and senior managers have transparency of service performance as a whole and conformance to mandatory requirements across partners
2. Alignment of Partner processes to achieve streamlined end-to-end service provision to achieve the business objectives
3. Better investment decisions based on benefits, risk and resource optimisation
4. Support management to determine and execute the proposed strategy and accompanying service delivery model in a holistic manner taking into account the full end-to-end processes and functions and interests of internal and external stakeholders.
5. Improves stakeholder confidence through clearly assigned roles, responsibilities and accountability based on business requirements to enable 'balanced' delivery model
6. Maintain and improve the stability and quality of services in a cost-efficient manner
7. Enables patient representatives influence strategy and service delivery model
8. Enables employee representatives to improve satisfaction and outcomes

Critical enablers (aka mandatory business requirements) span partner organisations are those functions / activities that must be available individually and collectively to enable benefits realisation. They are the necessary for the ICS delivery model to achieve what it was designed to accomplish for patients, staff, partner organisations and wider health and social care system. The business requirements define the functions / activities and accompanying behaviours that are required within each respective partner.

This provides a mechanism to gain consensus on the expectations for each of partner across the implementation phases through to business-as-usual service provision. This approach provides a method to:

- Gain consensus of the business requirements, and responsibilities across partners
- Manage modifications to business requirements
- Assign the business requirements to various implementation phases, with programme gateways to confirm readiness to proceed
- Monitor the degree of compliance against business requirements / expectations across participating partners with actions agreed to resolve timeliness and quality issues
- Provide mechanism to escalate non-compliance

- Monitor business benefits, for individual partners and the wider health and social care system, to ensure co-ordination across partners is optimised to realise business benefits.

The approach is intended to provide visibility of the contribution against responsibilities / expectations and therefore assurance to the Walsall Together Board. Oversight of the business requirements approach will by via the proposed Governance which will span the programme lifecycle, continuing through to business-as-usual service provision to monitor compliance against responsibilities and performance.

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Walsall Together: Intermediate Care Model

What Is the problem that we are trying to fix?

- The Walsall Local Health and Social Care Economy is overly reliant on a bed based model of post-acute care when national and local evidence shows that a significant proportion of this care could be provided at home (wherever that setting might be) with appropriate clinical or support services.

- Walsall Healthcare Trust (WHT) has consistently failed to meet the A&E 95% waiting target. Whilst a proportion of this is due to internal WHT issues, a significant proportion are patients deemed medically fit for discharge but waiting for something from external partners which adversely affects flow through the hospital and availability of beds for those in A&E/Medical Assessment Unit who need admission.

- Prolonged stays in hospital result in patient de-compensation and poorer outcomes.

- Intermediate Care Services in Walsall work in isolation making pathways complex to navigate, delays in hand-over, potential duplication of effort.

- Walsall CCG and Council currently invests above what the National Benchmarking suggests is reasonable for the demographic of Walsall.

Proposed Intermediate Care Service (ICS): Refreshed vision

1. A community based health and social care single service with responsibility for complex patients who require support to facilitate discharge from an in-patient hospital bed.
2. Provide a rapid response to care delivery in the right place at the right time to maximise a 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.
3. Integration through a new shared culture, mind-set, values, objectives, working processes and practice.'

Proposed Intermediate Care Service (ICS): Key Components

1. Streamlined processes with referral via a single point of access
2. Defined health and social care activities performed out of the hospital setting post discharge including assessments, therapy provision etc.
3. Information captured once and made available through patient journey
4. Allocation of the ICS care-coordinator to develop, monitor and navigate the patient via a patient centric intermediate care plan through the ICS 'journey'
5. An enabling culture to facilitate patients, with carers, to regain confidence and/or function so that patients enjoy supported Self Care to realise their goals
6. MDT collaboration to assess and provide holistic care to effectively resolve issues across health and social care domains
7. The service will operate seven days per week

IDT co-ordinators will continue to support discharge planning for patients with 'complex' support needs for 12 months

Clarify criteria, roles / responsibilities for IDT co-ordinators to optimise task allocation across ward discharge processes

Intermediate Care Service and Pathways will support Discharge from Hospital & Step up from Community Services

ICS Model Principles, Assumptions & Constraints

Principles

1. For medically fit patients, transfer clinical and social care activities, e.g. assessments, therapy etc, to least restrictive safe environment to reduce LOS & level of decompensation
2. Assign care co-ordinator to efficiently 'navigate' patient through the ICS pathways and care provision (across multiple roles and providers) and monitor progress against plan
3. Facilitate supported Self-Care to maximise independence and enable patients / carers to achieve their goals and reduce financial costs
4. Governance that takes a 'system' approach to resolve 'bottlenecks' that would otherwise constrain performance / outcomes across the whole 'system'

Assumption

1. Trust implements SAFER / Red to Green principles to optimise ward discharge processes
2. Sufficient Community Health Service capacity, including therapy, to meet the on-going health needs post discharge

Constraints

1. Current IT systems are not sufficiently mature to enable data to be captured once, maintained in a single data source, and made available for re-use
2. Current IT systems are not sufficiently mature to enable collaboration, streamlined communication and workflow across teams and partners

Trust Business Benefits

The benefits model is predicated on the Trust 'liberating' beds through facilitating earlier discharge or avoiding admissions for patients that require health and/or social care support. The actual beds liberation is dependent on the maturity of transformation, that is ability to induce staff to change behaviours / working practices, across ward processes and Community Services. The proposed scenarios and accompanying beds reduction benefits are:

1. Liberate **28 (21 phase 1) beds p.a**. IF the Trust has high transformation capability
2. Liberate **23 (16 phase 1) beds p.a**. IF the Trust has moderate transformation capability
3. Liberate **18 (11 phase 1) beds p.a**. IF the Trust has low transformation capability
4. Improved utilisation of therapy staff by significantly reducing 'Assess to Discharge' with staff reallocated to other therapy activities

Improving for Patients:

1. Reduce dis-benefits of unnecessary hospital in-patient stay (beyond MFFD) e.g. decompensation etc
2. Improved and more responsive post-discharge care, via a MDT approach, and assigned co-ordinator to meet the patient needs in the most appropriate setting.

Improving for Colleagues:

1. Defined requirements across partners setting out the respective roles and responsibilities
2. Enhanced multi-disciplinary collaboration and optimised use of skills of staff

Assumption:

1. The implementation of the ICS will have access to adequate transformation support

Benefits model takes a conservative approach to translate 'mathematical' bed days liberated to actual bed days (20%)

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Trust Business Benefits Summary Model

Ref	Phase 1: Intermediate Care Pathways to Reduce LOS	Mathematical	Reality (20% of Mathematical)	Reality
	In-patient Stay Day Liberation: Totals	**Number of Bed days Liberated per week**	**Number of Bed days Liberated per week**	**Number of Beds Liberated**
1	Reinstate Care Pathway	20	4	0.6
2	Reablement Pathway	198	40	5.6
3	DH2A Pathway	275	55	7.8
4	D2A Pathway	120	24	3.4
5	ICT bed base	25	5	0.7
6	Non-weight bearing total	84	17	2.4
7	Mental Health Pathway	80	16	2.3
	Total	**721**	**144**	**21**

Translation from Mathewmatical Model to Reaiity

1 Most patients will enjoy multiple 'enablers' of the new service , these can not be treated as additive but rather need to consolidate and rationalise multiple enablers
2 Recognition that muliple enablers need to be synchronised to deliver business benefits - singular enablers by themselve do not necessarily realise business benefits
3 Bed days need to be 'bunched-up' to liberate bays which enable reductions in staffing

Ref	Phase 2: Intermediate Care Discharge Pathways to Avoid Admission from Community Settings	Number of Bed days Liberated per week	Number of Bed days Liberated per week across Teams	Number of Beds Liberated
8	Number of additional patients per week PER Place Team accessing Intermediate Care Service that will avoid a hospital admission	1	50.0	7

Benefits Realisation Parameters

1 Seven Placed-based teams that will access the intermediate care service
2 Number of additional patients that through accessing the proposed Intermediate Care Service will avoid an admission = 1
3 Average LOS of admitted patient = 7.14 (same as used in Total Mobile Business Case)

Ref	Phases 1 & 2: Intermediate Care Discharge Pathways to Reduce LOS Avoid Admission from Community Settings	Number of Bed days Liberated	Number of Beds Liberated
9	Patients accessing various intermediate care pathways from hospital (to facilitate discharge) and avoid admission (community setting)	194	28

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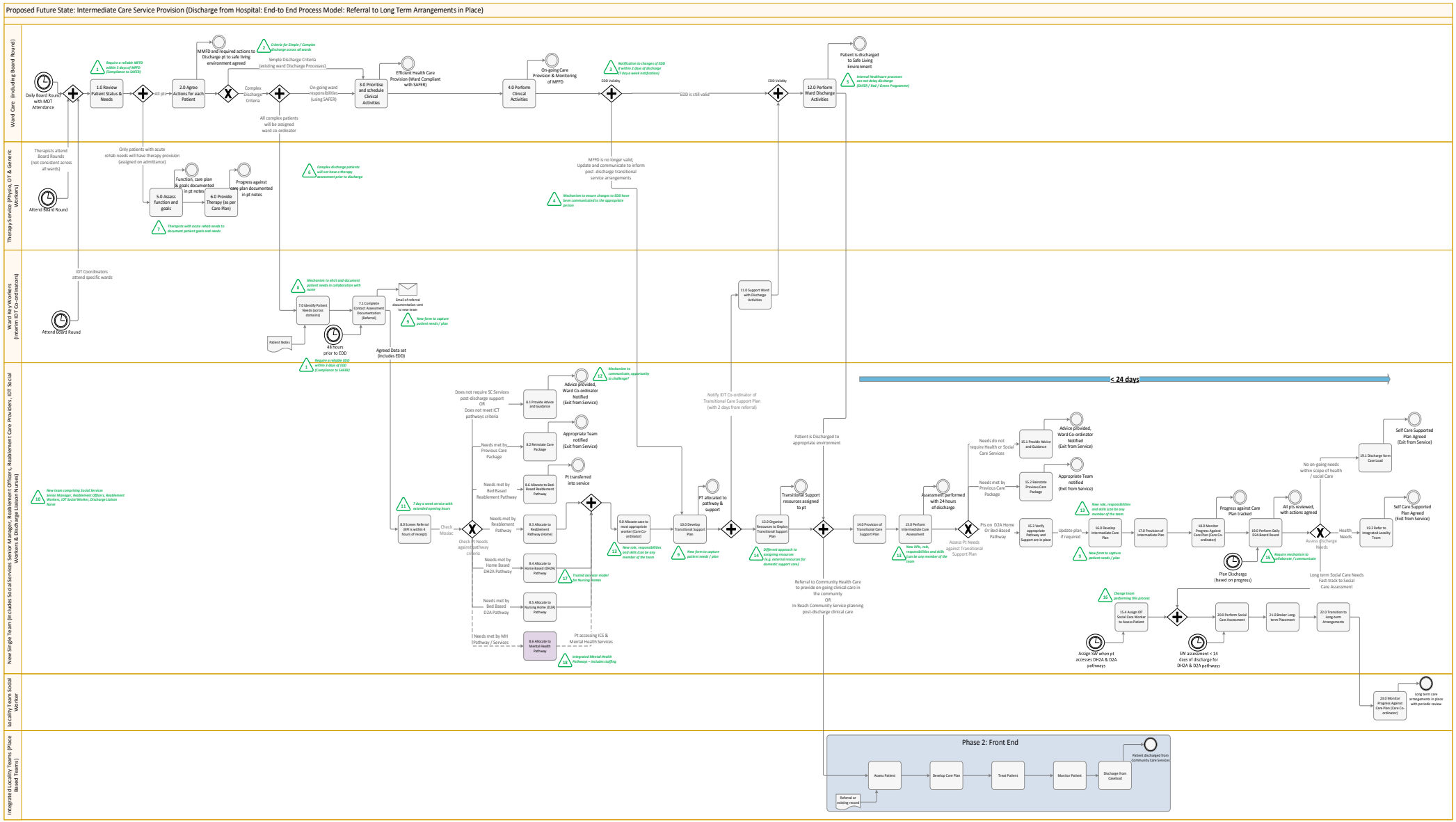
Intermediate Care Model: End-to-end Process Model



Social Services Business Benefits

The benefits model is predicated on Social Services receiving patients that are less decompensated, and therefore with less health needs, that with less resources and with MDT working realise benefits across outcomes, patient and staff experience and financials.

Patient benefits

1. Increased independence
2. Reduced impairment
3. Improved personalisation
4. Reduced delays
5. Improved continuity of care

Staff benefits

1. Improved alignment to need – providing more comprehensive care
2. Improved information sharing – better (more informed) decision making
3. Clearer accountability
4. Improved continuity of care
5. Stronger sense of team

System benefits

Enables and supports overall system changes to deliver more effective care closer to home:

1. Improved continuity of care
2. Reduced dependency
3. Reduced rate of crisis
4. Reduced acuity
5. Reduced inequality
6. Reduced total costs

Cost benefits

1. Reduced ongoing care (TBD)
2. Rebalanced bedded care
3. Improved value-for-money from bed-based services

Intermediate Care Model Objectives and the Journey

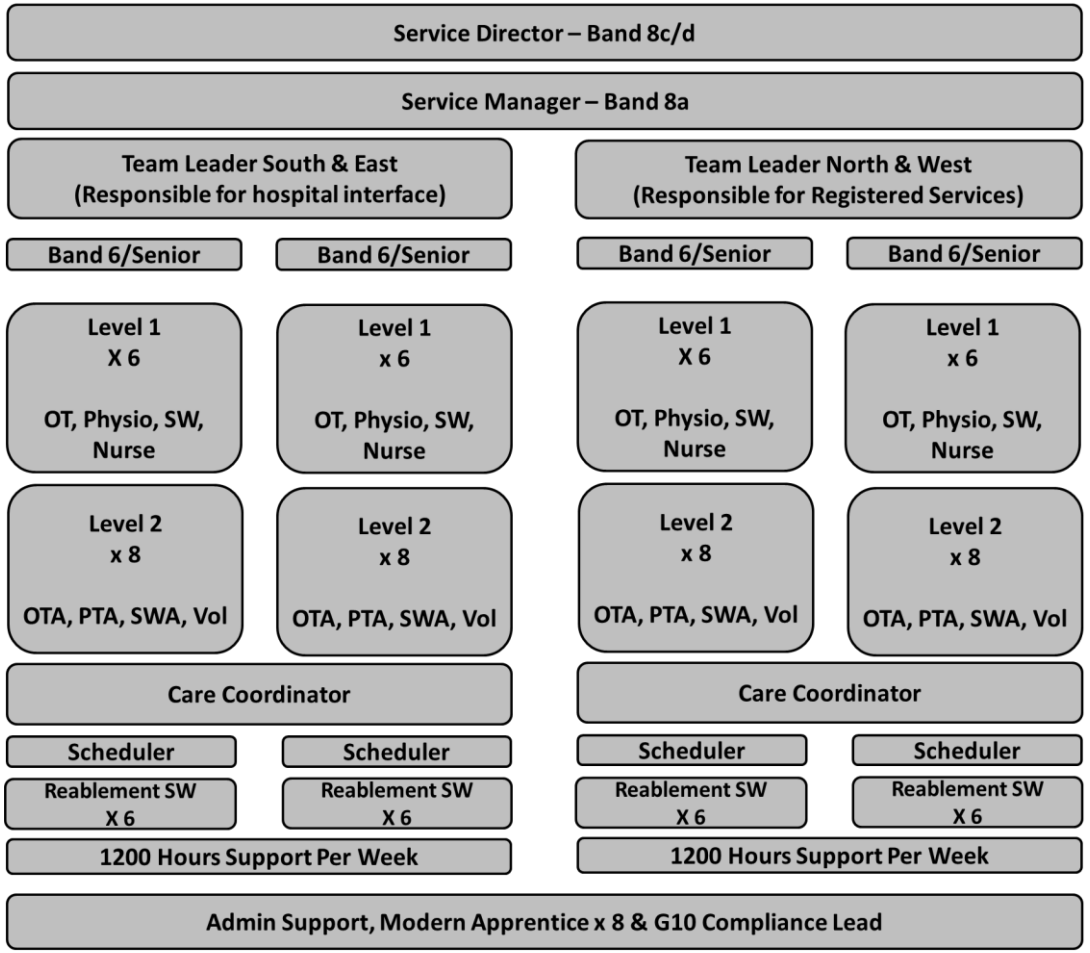
Objectives

1. Transition to more responsive and integrated ICS pathways that will reduce hospital LOS by 'transferring' clinical and social activities out of the hospital setting
2. Reduce fragmentation and complexity, via a single MDT, streamlining referrals, care assessments, co-ordination, monitoring and exit from the Intermediate Care services
3. Long-term care arrangements satisfy Care Act requirements in the least restrictive safe environment with supported Self-Care to maximise independence and reduce costs
4. Governance that effectively manages service performance and compliance to the 'mandatory' requirements across the partners / service providers

The transformation journey:

1. Obtain approval for the Intermediate Care Model, business case and specification, and high level transition plan (phase 1)
2. Phased implementation, defined scope, milestones and business change, towards the the future state ICS satisfying agreed business requirements for each partner (phases 2 - 4)
3. Implement the 'Management of Change' to 'formalise' the structures and processes underpinning the new ICS and transition to 7 day working (phase 5)
4. Deployment of IT enablement to streamline collaboration, communication and reduce manual effort across roles / teams (phase 6)

Staff Profile



Role Description:

- 1 Service Manager – responsible for overall service delivery
- 2 x Team Leaders – responsible for day-to- day management of the teams
- 4 x Senior Practitioners – responsible for coordinating team activities
- 24 x Level 1 – responsible for generic and specialist interventions/ assessments.
- 32 x Level 2 – responsible for generic interventions that do not require the skills of a registered practitioner. This could be supporting people with rehab exercises or conducting conversations about people's social needs etc
- 2 x Care Coordinators– responsible for the support work staff, CQC compliance and care purchasing
- 4 x schedulers– responsible for the co-ordination of support work staff
- 24 x Support Workers – responsible for direct care/support and reablement
- 8 x Admin assistants & Modern Apprentice admin assistants – responsible for the administrative functions to support the service.
  1 x Compliance lead is the registered manager for the reablement element of the service
- Total: 105 Staff, 2 Registered Services (inc additional 53 staff & £3m Commissioning Budget (beds & care hours)

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Intermediate Care Finance Profile v3 21/07/17

Budgets	Source	2016/17	2017/18	2018/19	Notes
WMBC Reablement	BCF (ASC)	3,600,937	3,665,970		WMBC Reablement team & SW's working in Reablement Team
WMBC IDT	BCF (ASC)	311,026	290,260		SW Team at Walsall Manor (Part budget funded through BCF)
WMBC IDT	ASC Core Budget	218,339	230,586		SW Team at Walsall Manor (Part budget funded through ASC Core Budget)
WMBC D2A (Staffing)	BCF (CCG)	1,017,750			Additional capacity in Reablement, IDT & Independent Sector
WMBC D2A (Staffing)	iBCF		1,017,750		iBCF investment releases CCG Budget in 17/18
WHT IDT	BCF (CCG)	431,000	431,000		Discharge Coordinators and CHC Nurse Assessors at Walsall Manor
WHT Medical/Therapies (Hollybank)	BCF (CCG)	700,000	700,000		Therapists at Hollybank
ICS Staffing	iBCF (ASC)		200,000		iBCF investment for pump priming implementation of ICS model
ICS Staffing	BCF (ASC)			4,046,504	New Model - ASC Elements
ICS Staffing	BCF (CCG)			1,244,727	New Model - WHT Elements - CCG to confirm
Staffing Total		**6,279,052**	**6,535,566**	**5,291,231**	
Bed Based Rehab	BCF (CCG)	1,310,262			
Bed Based Rehab	ASC Core Budget	202,903			
Bed Based Rehab	iBCF		1,310,262		iBCF investment releases CCG Budget in 17/18
Bed Based Rehab	iBCF		202,903		IBCF investment releases ASC Budget in 17/18
Bed Based D2A	BCF (CCG)	782,250	782,250		20 Commissioned D2A Beds
ICS Beds	BCF (CCG)			1,564,200	40 Commissioned ICS Beds
Beds Total		**2,295,415**	**2,295,415**	**1,564,200**	
Total ICS Budget		**8,574,467**	**8,830,981**	**6,855,431**	

Implementation Approach

A phased approach will be utilised to:

- Manage scope, complexity and less risk to implementation / current service performance
- Assist to gain commitment from staff and overcome resistance to change
- Skills and experience / insights are gained which help smooth subsequent phases
- Resolution of agreed bottlenecks to generate the ‘headroom’ to make the transition

Each phase will have it’s own dependencies and risks that will need management focus to The phases are:

1. Phase 0 & 1: Engage and confirm / Design
2. Phase 2: Phase 3: Transition
3. Phase 4:Management of Change
4. Phase 5: Consolidate & Rationalise
5. Phase 6: Relocate
6. Phase 7: Closure

Refer to appendix 1 for description of phases

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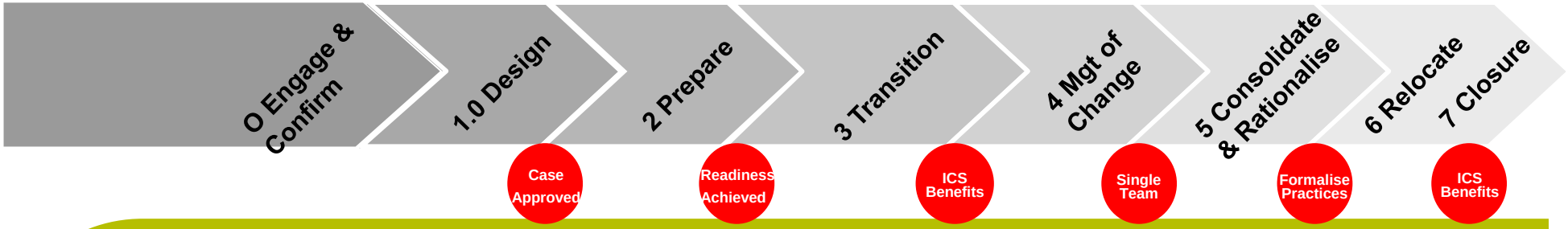
The Business Change approach



Process change

1.1 Future State Design	2.1 Change Planning Business Readiness Plan	3.1 Change Implementation Support	4.1 3.1 Change Implementation Support	6.1 Optimisation Benefits Delivered and Optimisation Plan
Process Model Business Change Key Business Change	Business Readiness Plan IT Alignment	Interim Service Delivery Models		Benefits Delivered Optimisation Plan

Strategy & Benefits

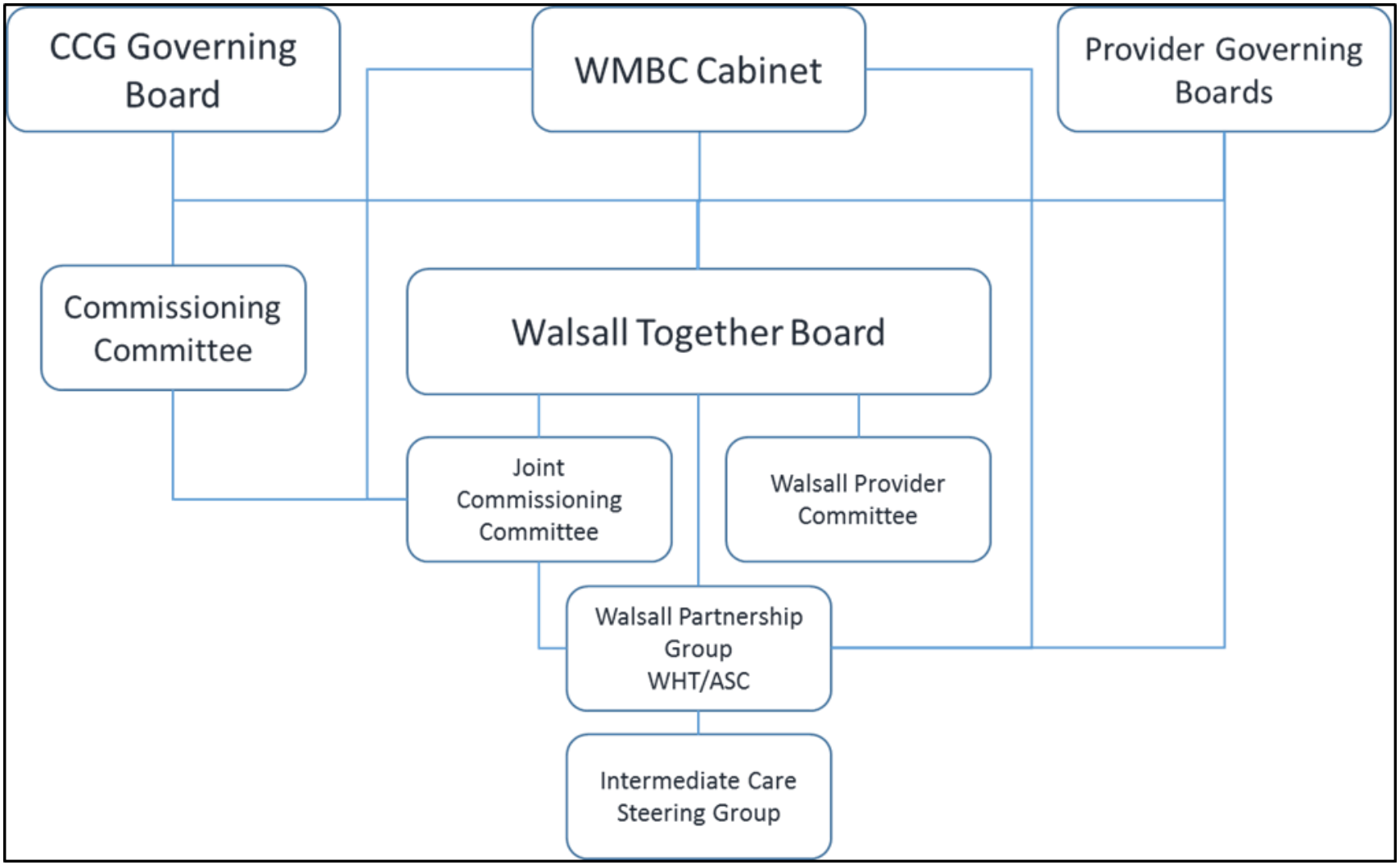
Vision and Outcomes	1.2 Confirm Project Outcomes	2.2 Confirm Benefits	3.2 Set Target Benefits	4.2 Single MDT Team	4.2 Single MDT Team Location	6.2 Measure Benefits Delivered
	Business Benefits Business Case Service Specification	Benefits Profile	Benefits Profile Tracker	Benefits Profile Tracker	Benefits Profile Tracker	Benefits Delivered Optimisation Plan

Stakeholder E&C

1.3 Stakeholder & Communications Plan	2.3 SEC Delivery & Organisational Readiness	3.3 SEC Delivery	4.3 Consultation Support & Restructure Planning	5.3 SEC Delivery	6.3 Lessons Learnt & Case Study
SEC Plan Business Readiness Plan	Stakeholder briefings Readiness Implementation Project Tracker	Stakeholder briefings Project Tracker	Consult & Restructure Communications	Stakeholder briefings Project Tracker	Lessons Learnt

Integrated Governance and Management Framework

Refer to Integrated Governance Framework Paper.



Phases 0 & 1
Confirm & Engage and Design

- *Agreement of conceptual intermediate care service (ICS) model and underpinning principles by the Walsall Together Partners*

- *Focus on logical design of ICS, including management systems, processes model / service specification with accompanying Business Change and high level implementation plan that will resolve current issues and transition to future state ICS. Determination of business benefits and ICS financials to develop a business case for the proposed ICS service.*

Phase 0 & 1: Approve Business Case & Service Specification

Objectives

1. *Trust Business Case and Specification 'signed-off' with accompanying benefits and risks*
2. *Financials, including staff costs and potential bed day liberation for the Trust agreed*
3. *Governance model to manage implementation strategy, delivery, risks and performance agreed*

The transformation journey:

1. Obtain approval for the Trust business case, includes finances
2. Obtain approval for Intermediate Care Service specification, mandatory requirements per partner and high level transition plan
3. Recruit Intermediate Care Service Director and Service Manager
4. Agree Governance model, includes scope and roles / responsibilities
5. Check demand / capacity model
6. Assess and plan readiness to prepare partners to implement required Business Change
7. Develop stakeholder engagement & communication plan

Phase 0 & 1: Current Progress, Outcomes and Risks

Progress, Outcomes: Status – On track

1. Effective engagement with respective managers / leads and staff to articulate ICS Process Model and accompanying business requirements, roles and responsibilities
2. Develop business case, including financials and benefits model, and specification.
3. Develop transition plan and define scope of phases
4. Develop Governance Model
5. On-going negotiations re ICS financials

Risks

1. Delays to approve business case and subsequent recruitment of ICS management structure will delay implementation or add to workload of existing staff
2. Current workload, including interim tactics, of team leads reduces capacity and focus on design and readiness to implement proposed ICS which will resolve a number of operational bottlenecks
3. Current community therapy capacity is insufficient to meet the therapy needs of patients discharged when MFFD but with on-going therapy required out-of-hospital
4. Duplication of scope across interim tactics and ICS implementation plan and prioritisation given to interim tactics may undermine ICS implementation plan / approach

Phase 1: Business Readiness Themes

1. *Vision & Scope - alignment with Trust objectives and current improvement initiatives*
2. *Sponsorship – sufficient to maintain focus and provide timely effective support*
3. *Benefits – ensure Business Change improvements impact the 'bottom line'*
4. *Critical success factors – agreement and focus on what 'must' be done right consistently*
5. *Capability – ensure skill and capacity to effectively meet the demand*
6. *Training & Development - develop skill in alignment with Trust workforce strategy*
7. *Resources – Business Change and Project Management resource available to the project*
8. Data / information – collect data once and share across teams through the patient journey
9. IT enablement – alignment to the business requirements to enable collaboration, streamline workflow and communication

Readiness will simplify implementation and overcome resistance to change

Phase 2: Prepare

- *Identify and drive the actions required to ensure 'partners' are adequately prepared for the implementation of the agreed Business Change to comply with mandatory requirements and be able to successfully adopt the new ways of working required to ensure sustainable business results*

Phase 2: Prepare to Transition Objectives

1. *Governance model implemented, and ICS service strategy and risks managed*
2. *Readiness assessed and remedial plan in place across partners to:*
    1. *Transfer clinical and social care activities out-of-hospital setting*
    2. *Implement Information capture and sharing mechanisms (including referral forms)*
    3. Implement interim role of IDT staff acting as Ward Key Coordinator
    4. Implement Trusted Assessor model for ward based interventions IT
    5. *Determine optimal IT enablement to streamline collaboration, communication & workflow*
    6. *Revision of policy re Therapy 'Discharge to Assess' and mechanisms to access equipment agreed*
    7. *Trusted assessor model for Nursing Home providers*
3. *Commissioning review of Bed Based Rehab undertaken*
4. *Realignment of existing ICS resources to perform clinical and social care activities out-of-hospital setting*
5. *Best practice defined across pathways, assessments and care planning*

Phase 2: Prepare to Transition Transformation Journey

1. Define the role of Ward Key Coordinator and provide training (interim resource)
2. Define Information capture and sharing mechanisms agreed (including referral forms)
3. Define ICS pathways criteria (including MH pathways)
4. Define ward interventions, and approval mechanisms, to implement Trusted Assessors
5. Assess ‘business readiness’ to implement ICS model
6. Define best practice to perform assessments in community setting
7. Develop Trusted Assessor model with Nursing Homes
8. Revise policy / practices to minimise Therapy ‘Discharge to Assess’
9. Undertake Commissioning Review of Bed Based Rehab
10. Realign staff to perform clinical and social care activities out-of-hospital setting
11. Implement stakeholder engagement & communication plan and readiness plan

Phase 3: Transition

- *Focus on implementing the required Business Change, including changes new working practices, roles and responsibilities, leadership behaviors, and cultural characteristics required to successfully establish and operate the improved ICS. Implementation of Communication & Stakeholder engagement plan to facilitate commitment and support to transition to the proposed ICS model.*

Phase 3: Transition Transformation Journey

1. *Transfer assessments from hospital to community setting*
2. *Implement new practices to capture patient needs post-discharge and generate referral to the Intermediate Care Service*
3. *Reduce therapy 'Assess to Discharge' with new practices to identify and provide equipment*
4. *Implement new referral process*
5. *Implement single referral for intermediate care referrals to ensure patients 'flow' to the appropriate pathway (based on agreed pathways) – includes out-of-borough referrals for Walsall patients*
6. *Implement Trust assessor model for ward interventions (agreed set of interventions)*
7. *Incorporate Self Care into ICS Care Planning*
8. *Implement Trust assessor model for nursing homes and governance to manage performance / quality*
9. *Implement governance arrangements for private sector providers of domiciliary care*
10. *Commission pathways, including capacity, to provide bed-based intermediate care*

Phases 4 & 5
Mgt of Change and Consolidate & Rationalise

- *Focus on undertaking a Management of Change with collective and individual consultation to align teams / staffing to the proposed ICS model.*

- *Focus on consolidating teams / staffing to create a single 'team' with single access function and assigning roles underpinning the ICS model, including MDT service delivery.*

Phases 4 & 5: Mgt of Change and Consolidate & Rationalise Transformation Journey

1. *Consult on proposed ICS organisational structure and roles with leadership and staff*
2. *Consolidate and rationalise disparate teams into a single ICS service*
3. *Assign roles / responsibilities to staff in the single ICS team*
4. *Extend service provision to 7 days a week*
5. *Improve IT enablement within and across partner organisations*

Phases 6 & 7
Relocate and Project Closure

- *Focus to relocate to ICS team to new premises to facilitate MDT collaboration with the required infrastructure to enable streamlined care delivery.*

- *Focus on 'hand-over' of the streamlined and 'stable' ICS service to the ICS management team and to evaluate the extent to which the project was successful and note any lessons learned for future projects.*

Phases 6 & 7: Transition Transformation Journey

1. *Relocate ICS team to new location with the required infrastructure*

Appendices

Appendix 1: Phase Descriptions

1. Phase 0: Engage and confirm - Agreement of conceptual intermediate care service (ICS) model and underpinning principles by the Walsall Together Partners
2. Phase 1: Design - Focus on logical design of ICS, including management systems, processes model / service specification with accompanying Business Change and high level implementation plan that will resolve current issues and transition to future state ICS. Determination of business benefits and ICS financials to develop a business case for the proposed ICS service.
3. Phase 2: Prepare - Identify and drive the actions required to ensure 'partners' are adequately prepared for the implementation of the agreed Business Change to comply with mandatory requirements and be able to successfully adopt the new ways of working required to ensure sustainable business results
4. Phase 3: Transition - Focus on implementing the required Business Change, including changes new working practices, roles and responsibilities, leadership behaviors, and cultural characteristics required to successfully establish and operate the improved ICS. Implementation of Communication & Stakeholder engagement plan to facilitate commitment and support to transition to the proposed ICS model.
5. Phase 4:Management of Change - Focus on undertaking a Management of Change with collective and individual consultation to align teams / staffing to the proposed ICS model.
6. Phase 5: Consolidate & Rationalise - Focus on consolidating teams / staffing to create a single 'team' with single access function and assigning roles underpinning the ICS model, including MDT service delivery.
7. Phase 6: Relocate - Focus to relocate to ICS team to new premises to facilitate MDT collaboration with the required infrastructure to enable streamlined care delivery.
8. Phase 7: Closure - Focus on 'hand-over' of the streamlined and 'stable' ICS service to the ICS management team and to evaluate the extent to which the project was successful and note any lessons learned for future projects.