Health and Wellbeing Board

September 2023

Walsall Together Update

For Assurance

1. Purpose

This report provides an update on the development of Walsall Together (WT). It provides an overview of the progress of the partnership since the previous report was presented in September 2022.

2. Recommendations

2.1 The Board is asked to note the contents of the report.

3. Background

3.1 Walsall Together is a place-based partnership between Walsall Healthcare NHS Trust (WHT), Black Country Healthcare NHS Trust(BCH), Walsall Council (Adult Social Care, Children's Services and Public Health), Black Country Integrated Care Board (ICB), Walsall Community Network, One Walsall, Primary Care Networks, Healthwatch, and whg (representing the housing sector).

3.2 The Walsall Together business case, approved by Cabinet in 2019, outlined initial governance arrangements, vertically integrated within Walsall Healthcare Trust (WHT) as Host Partner, bringing partners together under an Alliance Agreement:

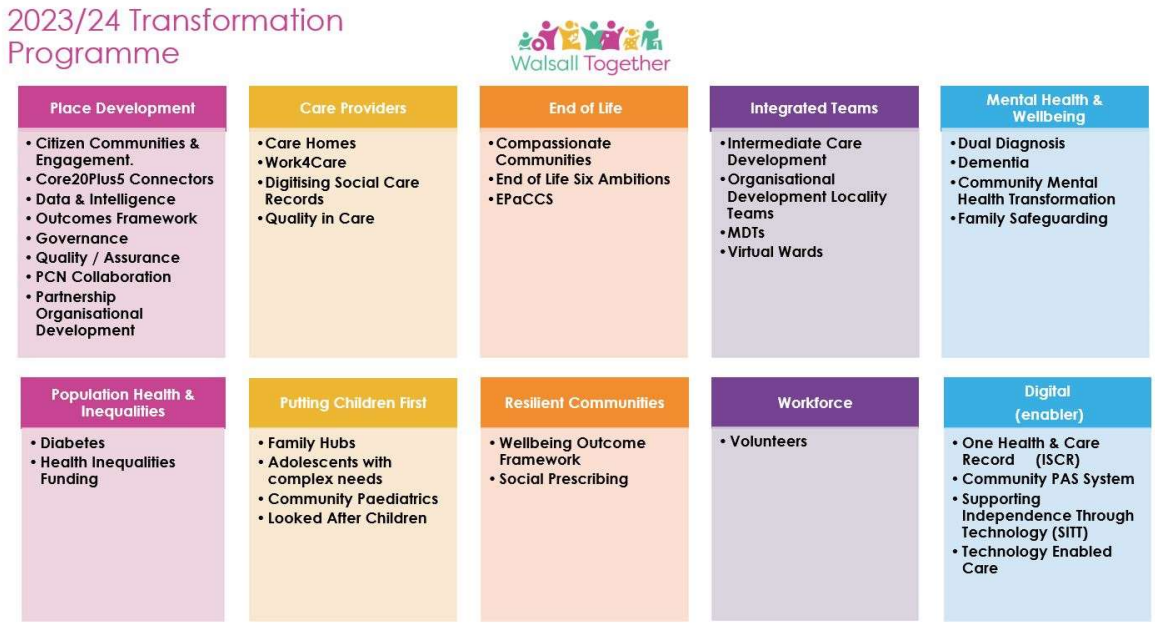
- WHT provides a vehicle for governance by establishing a Partnership Board and management structure within the framework of its existing corporate structure.
- The Walsall Together Partnership Board (WTPB) is a sub-committee of the WHT Board.
- The established governance and regulation for each of the providers is retained and used to underwrite any collaborative decisions.

3.3 In December 2022 the partnership refreshed its strategic aims:

4 Transformation and Place Development Overview

4.1 The next stage of our ambitions and plans for delivering services in a more integrated way are in development. They remain aligned to the original business case, updated to reflect the Heath & Care Act (2022), lessons learned through partnership working to date (including the Covid-19 pandemic), and other national policy documentation pertinent to health and wellbeing across our partner organisations.

Our ambition is to deliver integrated services in the community that focus on a data driven, proactive and preventative approach, by putting people at the centre and giving them more control over their own health and more personalised care when they need it. The following programme of change was approved in April 2023, to support delivery of this ambition during 2023/24:



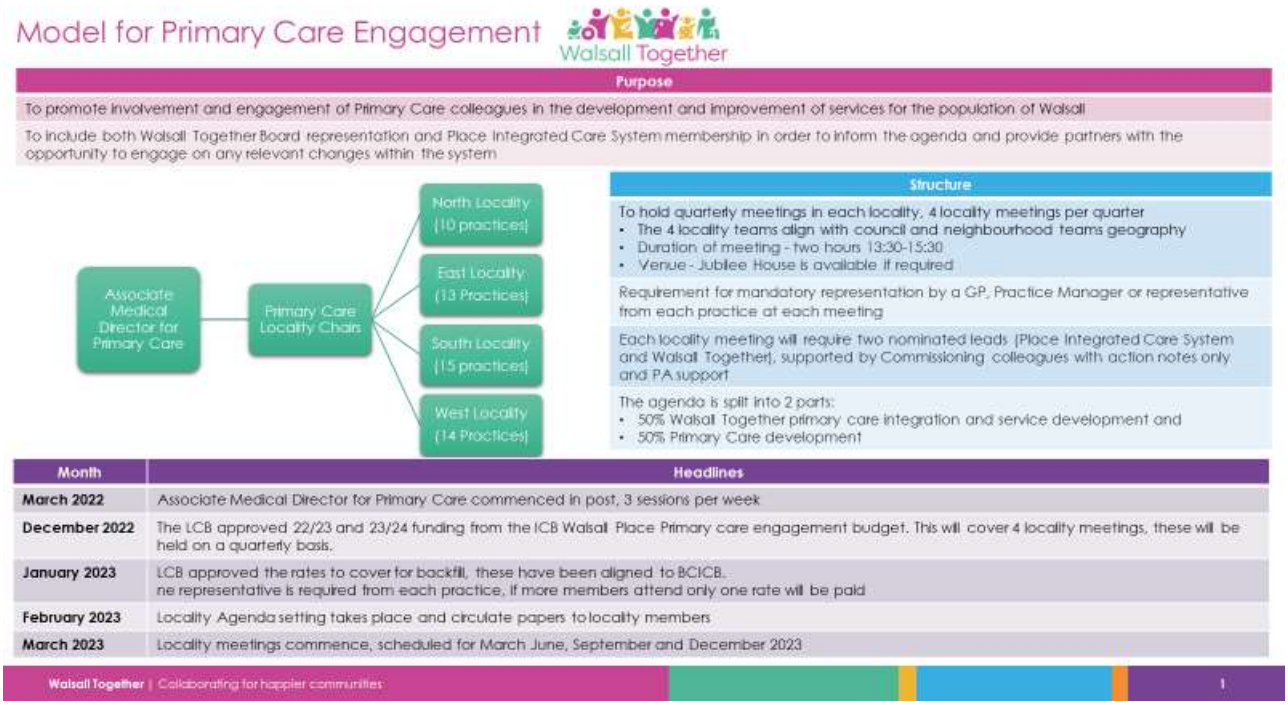
5 Transformation Highlights

5.1 Virtual wards (hospital-level care delivered safely at home) have been further expanded to include patients with heart failure, frailty diagnosis and palliative care, in addition to the already established services for patients with respiratory conditions and Chronic Obstructive Pulmonary Disease (COPD). Feedback from patients has been positive and the teams are now working on building closer relationships with referring teams across the community and hospital.

Virtual wards are coordinated by the Care Navigation Centre. There was a total of 1,138 patients treated up to July 2023 (see table).

Virtual Wards	Go-Live Date	Total Patients
Acute Respiratory Infections	Jul-22	437
Heart Failure	Sep-22	182
Palliative Care	Nov-22	216
Hospital & Home	Dec-22	200
Frailty	Jan-23	103

5.2 In November 2022 we hosted a WT led Primary Care event to look at how we can better support Primary Care Networks and improve population health by strengthening working relationships and working more collaboratively. The event was well attended, by over 100 primary care colleagues. Their recommendations and contribution during the session informed the future model for primary care engagement, illustrated below:



5.3 The governance for the Family Hubs programme sits within the partnership. The Clinical & Professional Leadership Group, chaired by the Director of Public Health, has oversight of implementation, with clear escalation routes through the partnership and into the Council. A network of family hubs offers help and support for a range of children's services including infant feeding, mental health support, health visiting and parenting classes. The hubs launched in July 2023 and will integrate services and support for children aged 0-19 (0 to 24 for children with special educational needs and disabilities), their parents and carers. This will include physical places, a virtual offer and outreach services.

5.4 In November 2022 the partnership approved a new strength-based approach in the way we communicate and engage with our citizens, using their stories alongside the data we collect, to influence decision-making around services. This includes working with individuals and groups to understand what our community are best placed to do, what they need our help with and what they need us to do. A refresh of the communications and engagement strategy is currently underway to reflect this new approach.

6. Population Health and Inequalities

6.1 To ensure our work to reduce health and social inequalities is coordinated, and embedded within our approach to population health management, we have a well-established Population Health and Inequalities Steering Group, Chaired by a Consultant in Public Health. The Group has drafted a partnership Population Health & Inequalities Strategy aligned to the Joint Health and Wellbeing Strategy and ICB Health Inequalities and Prevention objectives. The strategy describes the partnership approach to reducing inequalities and local Population Health Management delivery model.

6.2 Several partner organisations are anchor institutions and by definition have responsibilities to consider their influence on the wider determinants of health. The partnership is currently compiling a collaborative response to the national cost of living crisis, recognising the growing evidence base linking such circumstances as fuel poverty on health outcomes, particularly excess winter deaths. The partnership has identified several initiatives that can be rapidly implemented without additional investment, working with our housing and third sector partners. The partnership will also consider how a more strategic response could support coordination of the limited resources available across our partnership, particularly in advance of Winter.

6.3 whg was announced winner of the Resident Employment and Training award in the UK Housing Awards 2022 for its Work4Health programme, which has helped more than 145 local people to secure jobs in healthcare. The scheme was created in partnership with Walsall Healthcare NHS Trust, Walsall College and the DWP. Judges praised the "unique and innovative programme" stating, "its outcomes are impressive, especially in terms of the diversity of residents recruited to NHS jobs from the most deprived communities". We are now

working across the partnership to expand this approach to support people into roles within the care provider sector.

6.4 The following slide gives an overview of several other areas of work between whg and health partners.

Kindness Counts

- ***Power of 6 : 3,000*** = **18,000**
- **6** Kindness events held
- **3** Kindness Pop Up Shops– **Circular Economy**
- Connected **605** people via the Kindness Rocks Initiative**90,000** reached via social media
- **1500** Kindness Bags
- **12 Days of Kindness**in December **350** families
- **Kindness Counts** cited in Walsall's Mental Wellbeing Strategy as an example of**good practice**
- **Kindness in action**

NHS Black Country Integrated Care Board

whg

6.5 In February 2023, sixteen projects were granted a share of almost £455k in the second wave of funding from NHS England's Health Inequalities Programme. The funding aims to support the work being done by the Walsall Together Partnership, to build resilient communities and tackle health inequalities across the area, through delivering grassroots help to those people most at risk or experiencing poor health outcomes and reduced life expectancy. It builds on the success of existing projects that have a positive impact on health outcomes for the people of Walsall.

6.6 A senior midwife has been spending time with families building relationships and breaking down myths as part of work to improve the experiences and outcomes of maternity services for Black, Asian and minority ethnic women. Using the feedback she receives, as well as data collected through audits, she holds 'did you know?' sessions to raise awareness with staff on some of the issues women are facing and makes recommendations for change based on this. Some of these recommendations include the development of educational animation videos in different languages.

6.7 As part of building on this work, a team of outreach workers have been recruited using health inequalities funding from the partnership, and a Maternity Outreach Project at the Nash Dom Community Hub in Sun Street, Walsall, has been set up to support mums and dads-to-be. The team works alongside the senior midwife to provide advice and/or support with infant feeding, mental health, transition to fatherhood, parenting, birth and beyond, gestational diabetes, health (including child health) and social.

6.8 An experienced community engagement facilitator, with lived experience and an active part within local communities, was recruited as the lead on our Core20Plus5 Connectors approach to reducing health inequalities. Their role is to advise, challenge and support us in reaching some of our more vulnerable communities, in particular homeless individuals, refugees and asylum seekers, victims of domestic abuse, LGBT+ communities and Roma, Gypsy Travellers.

6.9 A primary focus of this work has been to develop trust with communities and community activists and through the lead develop a team of up to 20 community connectors all with lived experience to work with our most vulnerable communities to help co-produce health and well-being services based on what matters most to them and their community. Some early successes include:

- Improved cervical screening for homeless women.
- Improved sexual health for gay men.
- Increased activity through football for asylum seekers.
- Engagement with Roma communities to improve access to GP services.
- Establishment of a working group which links the End-of-Life steering group and Walsall's housing forum to support homeless people whose tenancies were under threat with landlords unwilling or unable to support adaptations or hospital beds in a property.

7. Outcomes Framework

7.1 To help residents to stay well for longer the partnership has developed a Walsall-wide Wellbeing Outcomes Framework (WWOF). The framework will enable services to be commissioned, designed and delivered based on the needs of the population. It will support the strengthening of communities and provide a framework against which success can be measured. The WWOF was recently awarded 2nd runner up in the West Midlands Community Inspiration award, in the health and wellbeing category.

7.2 As part of this work, an online wellbeing directory of services – the 'Walsall Wellbeing Offer' is also being developed. This will allow citizens and professionals to find out about wellbeing support opportunities available across Walsall, and how they can access these to help manage, and support their own needs.

7.3 The WWOF is part of a broader partnership Outcomes Framework; a set of tools that have been specifically designed to enable several key things:

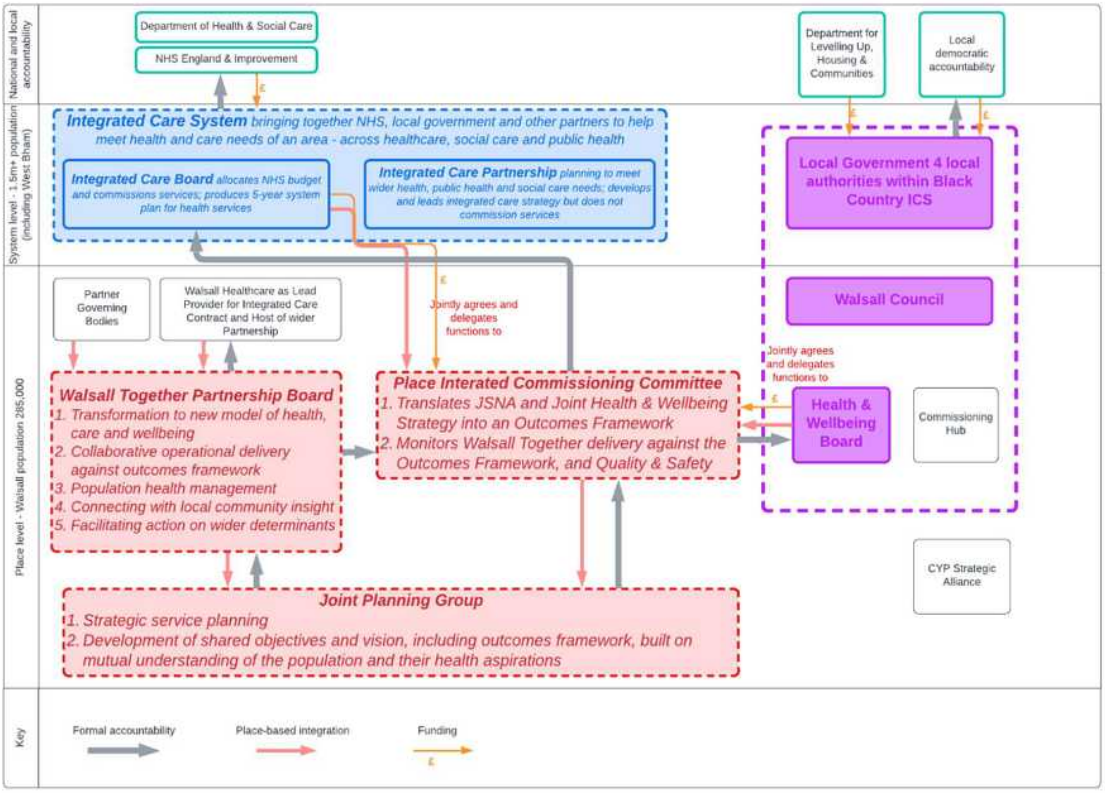
- Assist strategic decisions in a far simpler but more powerful way.
- Deliver freedom for the partnership to deliver local solutions but commissioners (Health and Well Being Board and ICB) to assure the process.
- Deliver and report against the Core20Plus5 agenda.
- Carry out risk stratification in population health and provider landscapes.
- Support the WWOF and clearly map and demonstrate the value of the VCSE sector.
- Evaluate impact of services and initiatives.

- Support a transition to outcomes-based commissioning.

7.4 Having established the foundations of the framework, with a focus on diabetes, end of life and wellbeing initially, this will be further developed in partnership with colleagues across the Black Country. We are establishing wellbeing assets through the framework, making providers clear of their contribution to improving health inequalities and well-being, and looking to demonstrate how operational performance targets align to citizen outcomes.

8. Place Based Partnership Governance

8.1 The Health & Care Act 2022 and associated policy guidance is designed to increase collaboration and integration across all health and care organisations in order that people can live healthy, independent and dignified lives, and improve outcomes for the population as a whole. It involves the integration of planning, commissioning and delivery, facilitated by the aligning and pooling of resources, digital transformation and changes to regulation. In response to this, the following model has been coproduced by partners in Walsall and across the Black Country. Development sessions and formal papers have been presented to the Health & Wellbeing Board, providing more detail and assurances to members about the implications of this model.



8.2 The intention is to build on existing joint commissioning arrangements by establishing a Place Integrated Commissioning Committee (PICC), for services agreed to be in scope for 'control' ('control' defined as shaping service models, managing delivery, and redistributing system-allocated resource) at place.

PICC was established in April 2023, replacing the Joint Commissioning Committee and adopting its responsibilities. Additional areas of responsibility are operational in shadow form for 2023/24.

8.3 Decision-making pertinent to the statutory responsibilities of the ICB and Council will be retained by the PICC, which will report jointly into the ICB for NHS expenditure and the HWB/Cabinet for the Council elements. However, greater collaboration on several processes traditionally associated with and undertaken solely by commissioning will be transferred to the Walsall Together partnership, to increase the level of collaboration across all partners including providers. For example, service planning and redesign. Membership of the Joint Planning Group will include representatives from all Walsall Together partners and will undertake the processes identified within the commissioning cycle as suitable for collaboration.

8.4 Walsall is considered to be comparatively advanced in respect of establishing the relationships and structures that comprise a place-based partnership. Several discussions have taken place to influence the current Black Country ICB operating model, and to secure delegation of ICB responsibilities (and associated resource) in advance of April 2024. Walsall Together is also gaining recognition on a national scale and is supporting other places and systems through the sharing our learning and experience:

- Director of Place Development & Transformation is part of an advisory group to the NHS Confederation Place Leads Forum.
- Working with Chamber UK to present an overview of our partnership to Local Authority, NHS and national policy leads in Autumn 2023.
- Finalists in HSJ Awards 2023, Place Based Partnership & Integrated Care category.

9. Future Priorities

9.1 The Walsall Together business case was for 3 years from April 2019 up to March 2023, so it is now timely to refresh the model and describe the next phase of the ambition for the partnership. The following diagram proposes a high-level strategic direction for the core components of the Walsall Together model of health, care and wellbeing. This is being developed into a strategic discussion paper for the November Partnership Board building on the original business case, utilising local, regional and national learning around integration, place-based working, asset-based working at scale, and collaborative commissioning. The intention is to be fully aligned to the We Are Walsall 2040 borough plan.

9.2 2023-25 transformation priorities:

- Evaluate the effectiveness of the existing GP-led MDT arrangements and support better health and care outcomes for people with complex long-term conditions. The outcomes report will incorporate recommendations for future MDT model, that considers the needs of Walsall patients, best practice from elsewhere, and established models across national and international landscape.
- The development of a borough wide model to deliver an integrated offer to residents in a care provider setting. Specifically to deliver a proactive model of care that promotes interventions for preventative care; better support patient needs in a timely manner, proactively reviewing indicators that could lead to deterioration, and establish interventions to avoid decline in health; better support care providers through engagement and relationship building, and establishing a delivery model that is reflective of their needs.
- Following the local needs assessment against the 6 national priorities for end of life care, implementation of an improvement plan for Walsall.
- Black Country wide Dementia Strategy, with local needs analysis and delivery plan for Walsall.
- Integrated commissioner and provider review of intermediate care to secure the future sustainability of the service and continued delivery of improved outcomes for citizens through timely discharge from hospital.
- Continued focus on improving the experience and outcomes for children and families in Walsall, though delivery of Family Hubs, supporting the sustainability of family safeguarding, delivering improvements for adolescents with complex needs, and implementation of our Winter RSV ((Respiratory Syncytial Virus) hub.
- Delivering end to end pathway development for people with diabetes, incorporating weight management and prevention as well as high quality

treatment and management across Primary Care and community services.
- Secure implementation of the WWOF and connect to wider borough work on anchor networks.

Appendices

None

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