Agenda item 21

Cabinet – 21 March 2018

Walsall Together Provider Board: Case for Change Outline Business Case

Portfolio: Councillor Diane Coughlan – Social Care

Councillor Ian Robertson - Health

Related portfolios: None

Service: Adult Social Care

Wards: All

Key decision: No

Forward plan: No

1. Summary

1.1 To update on the work programme of the Walsall Together Provider Board – to integrate health and social care delivery to improve people's health and wellbeing.

1.2 To gain feedback on the proposals.

1.3 To endorse the continuation of the direction of travel toward a "Host Provider" arrangement.

2. Recommendations

2.1 That Cabinet approve the next steps to create a full business case for a "Host Provider" arrangement in Walsall as set out in paragraph 6 of the report.

2.2 The Council co-commission the 'Host Provider' jointly with the Walsall CCG.

3. Report Background

3.1 In 2016, Walsall health and care partners established the Walsall Together Board to integrate and improve health and social care to the population.

3.2 It is chaired by Paul Sheehan and attended by Council officers: Executive Directors of Adult Social Care, Children's and Director of Public Health.

3.3 Councillors Ian Robertson, Chair of the Health and Wellbeing Board, and Diane Coughlan, Portfolio Holder for Social Care, are also members of the Board.

3.4 The partners of the Board include:

- Walsall CCG
- Walsall Healthcare NHS Trust
- Dudley and Walsall Mental Health NHS Trust
- Walsall Council Adult Social Care
- Walsall Council Public Health
- One Walsall (voluntary sector)
- GP Federation Groups:
- Walsall Alliance
- Palmaris
- Umbrella
- TPG
- Modality

3.5 Cabinet members, Health and Care Overview and Scrutiny Committee and Health and Wellbeing Board have received reports in the past on the work programme of the Walsall Together Board.

3.6 This in summary is a new operating model comprised of:

- Resilient Communities
- Single Point of Access
- Integrated Intermediate Care
- Locality Team that are multi-disciplinary and based in primary care.

3.7 In October 2016, the Executive Director of Adult Social Care and Accountable Officer of the CCG (Paul Maubach) proposed that a subgroup of the Board should be established: the Walsall Together Provider Board.

3.8 This has been established to develop a vision and business case for the integration of cross organisational delivery centred around patient population/natural communities.

3.9 In late 2017, the Provider Board commissioned KPMG as a partner to develop an outline business case for integrated health and care delivery.

3.10 This report outlines the case for change attached [**Appendix 1**] and asks for consideration to continue the work towards a shadow arrangement and full business case.

3.11 The CCG requirement is that by April 2019 there will be a new model agreed and under contract.

4. Report Detail

4.1 Why Integrate Health and Care Delivery?

4.1.2 There are national policy requirements to upgrade health and social care e.g. Five Year Forward View; Sustainability and Transformation Plans/Partnerships and Better Care Fund plans.

4.1.3 Financial imperatives. The high level profile of the health and care financial gap for continuing in the current model of delivery, projects a £50m gap per annum by 2027/28.

4.1.4 People who work in the health and care sector know they can improve delivery to people if they join up and work closer together. The Board is of the view that whilst the policy and financial imperatives are key, it is the professionals' and population view that is the most compelling reason to achieve this. We can improve people's experiences of health and care which in turn could be more efficient.

4.1.5 Walsall Council's aspirations of working closer together will enable:

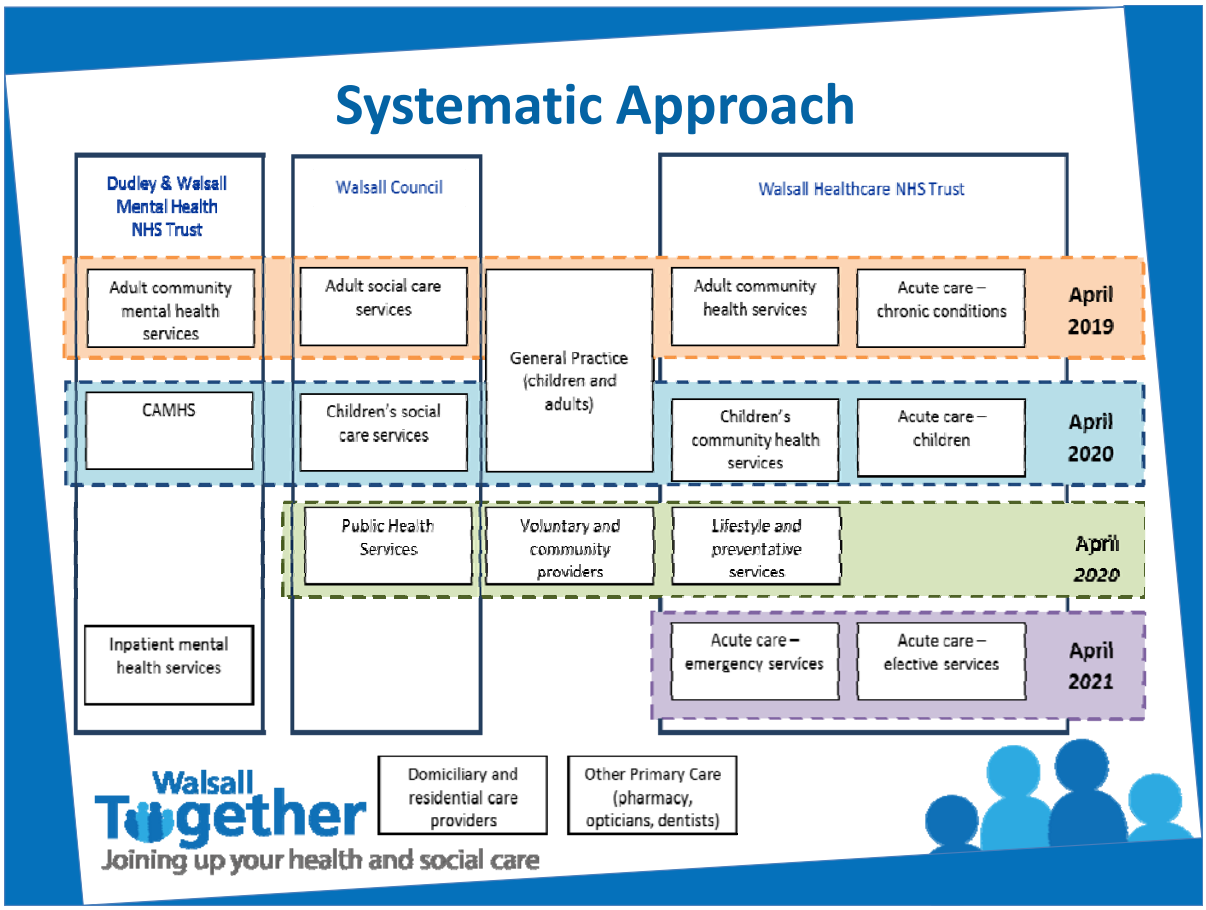
- The offer of a population, place based health and care system, that is person focused and based on the known needs of the population;
- The blend of different approaches of primary, secondary, community health and separate care; to one that is demand led, joint and centred on how best to respond to demand within the resources available;
- The Council to operate within the resources we have to improve the quality of care and support we offer across the whole health and care system;
- Clarity about the expectations and entitlements of access to care and support for our population;
- Empowerment of our practitioners, patients and clinicians to be the key decision makers in the design of new arrangements;
- Development of a system where prevention, early help and self-care are key, because people are well advised, confident and knowledgeable about their own health and wellbeing;
- Professionals in the health and care system to be connected, share responsibility and accountability for the health of the population;
- Care and support that is high quality, cost effective and the best value for money;
- Decisions about health and wellbeing that are evidence based and underpinned by good practice and knowledgeable staff;
- The Council to organise ourselves to achieve the above and much more.

4.2 **What Does Good Look Like?**

4.2.1 There are a multitude of transformation programmes at organisation level. In some cases these are bi-lateral, but few are across the whole system.

4.2.2 The Outline Business Case challenged the Board to look at how to "industrialise" change a) across the whole range of partners and b) across all operational delivery/services rather than in pockets. This is to maximise the impact of citizens and to improve quality and cost indicators.

4.2.3 The diagram below shows the intended cohorts and phases that could be upgraded over time. Walsall has some of these elements in place but not all; they are not across the whole system and therefore cannot be maximised for the full impact for all communities.



4.2.4 The benefit of gaining national and international expertise to develop the OBC is that it has enabled the current Walsall Together plan to be adapted.

For Walsall this will include a new development of a:

- Population Management Hub. This is where online wellness is offered; a support team is based who can offer advice and support to people; and the tools for self management are placed here and accessible.

There are already plans in place for locality teams, but these will be refined and expedited as the places where face to face access care and case management take place.

This leaves specialist and lower volume demand to be retained in more specialist centres e.g. acute and tertiary type care.

5. The Options for Integrating

5.1 The OBC outlines a range of options

5.1.1 **Alliance** - an Alliance provides a flexible but contractual agreement between providers and commissioners. The Alliance contract sets out the budget, terms and risk sharing agreements, while master service agreements govern the delivery of different transformation schemes. This flexible model allows for incremental growth, but can be at risk of unilateral decisions.

5.2.2 **Host Provider Model - Fulfilled by Council or one of the two NHS Trusts**

- Organisations that have inbuilt capacity to absorb some functions e.g strategy, contract monitoring, governance etc
- Able to take risk at scale
- Commissioner holds contract with Host Provider
- Host Provider establishes separate Partnership Board with own executive management team and governance arrangements
- Host provider will:
  - Provide a safe place for governance- providing confidence for commissioners and providers
  - Support the Board which is representative of all provider organisations
  - Agree delegated authority for services within scope
- To make this work GP's are integral to the development of the model and will play an important part in the governance arrangements

5.2.3 **Accountable Joint Venture (Corporate)** - this model involves the creation of a new legal entity between providers, which singularly contracts with the commissioners. Creation of a new entity does carry a longer timeframe and greater resource investment to implementation, however all providers are equitable; increasing alignment, contribution and collaboration. Alternatively, Joint Ventures can be purely contractual, which does not require formation of a legal entity. Financial and contractual arrangements can then be retained, flexed or delegated to the joint venture as required.

5.2.4 **Fully Incorporated Model** - an example of an Accountable Care Organisation (ACO) whereby all providers would merge into a single organisation (which could either be a new organisation or existing organisations could be absorbed into a single entity). There would be a single contract between providers and commissioners, however the new organisation may still subcontract services when necessary. This model streamlines decision making and management and simplifies risk sharing. Often an end state target, as difficult to implement initially and gain buy-in.

5.2.5 The board has evaluated the options and would recommend option 5.2.2 to Cabinet and Boards.

6. Next Steps

6.1 This case for change has moved the system to a point where it understands at an outline level the direction of travel for delivering more integrated health and care services in Walsall. However the work has also shown that there are critical gaps of knowledge within the Walsall system that will enable the Host Provider governance structure to become more accountable, deliver transformation at a system level and truly join up care – with the full buy-in of all stakeholders.

6.2 Adult Social Care are therefore recommending that the WTPB, must now undertake a more detailed business planning process (to include a business case for consideration with NHS Improvement that all stakeholders can sign-off on). Within this process we are recommending that the leadership structure agree three immediate actions:

1) Establishment of a programme team, with an interim programme structure akin to that shown below, with access to dedicated resources to run the detailed development process;

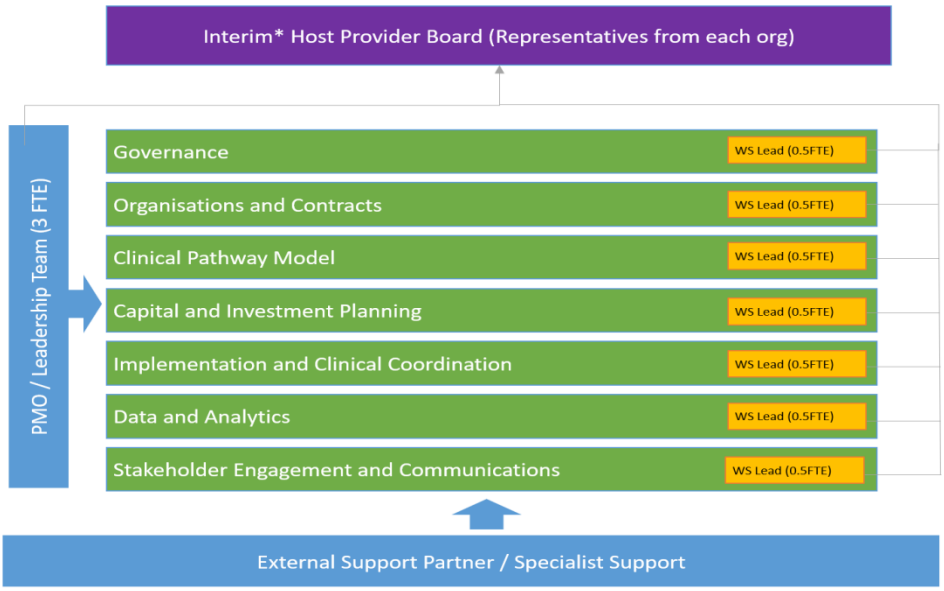
    a. Agreeing resource allocation and budget;

    b. Establishing a new senior tier of leadership;

    c. Establishing a dedicated PMO;

    d. Developing a stakeholder engagement and communications plan; including the public and regulators.

Proposed Interim Programme Team Structure



**The Walsall Together Provider Board to fulfil this role until Host Provider Arrangements agreed.*

2) Within this structure the development of a business case for consideration within the next six months, to include the following priorities:

   a. Clearly defining the governance structure of the host provider model, with roles and responsibilities well defined and clear lines of accountability between the host provider, commissioners and the provider supply chain;

      i. Understanding existing governance implications in consequence of adopting a new integration model;

      ii. Identifying and securing resource requirements to support proposals;

      iii. Agreeing how the different priorities of governance can enhance the improvements in wellbeing (such as political accountability);

   b. The development of a comprehensive, Walsall wide financial model for the system. This should include:

      i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the “do nothing scenario” for the future;

      ii. Strengthening relationships amongst stakeholders and building confidence in the system that change is both necessary but also possible;

      iii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific “do something” scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

      iv. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

   c. The development of a comprehensive, Walsall specific Clinical Operating Model (COM) for the future state system of health and care in Walsall. For Walsall Council, it is critical that a system wide Target Operating Model (TOM) in Walsall is clinically-led and developed in collaboration with existing service providers and users, with new experiences and knowledge embedded within the wider team. Furthermore the existing model and current service design projects should be challenged as part of this process in order to improve quality and achieve sustainability. To achieve this, we believe that a number of layers need to be collaboratively worked through, to achieve clarity in developing the TOM:

      i. What are your desired end user experiences across end to end health and care delivery?

      ii. How will these be delivered through an optimised clinical model/professional workflow?

      iii. How will service models support that workflow end-to-end?

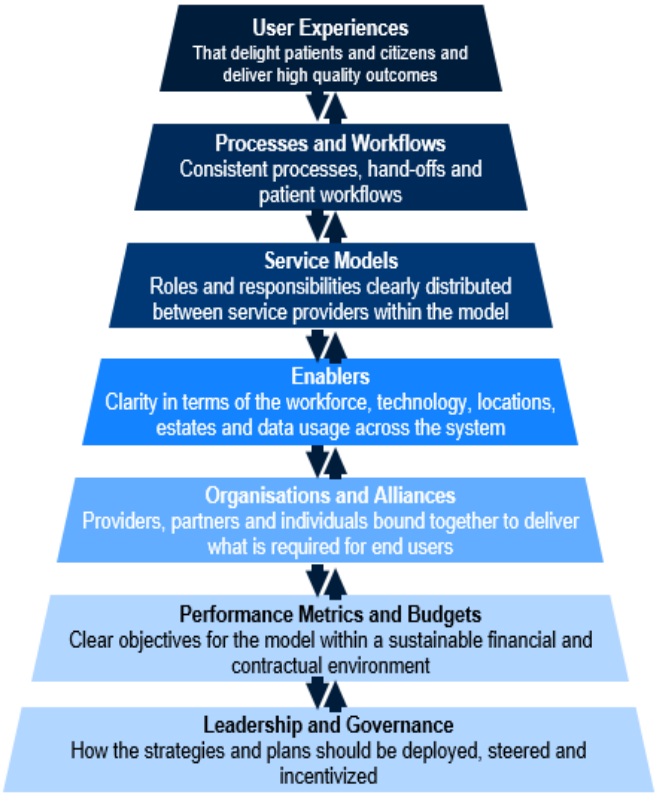
iv. Do you have the enablers, including workforce, in place to deliver on the future state service models?

v. How will the Host Provider Board/contractual arrangements ensure the commissioned services are delivered? What incentives and risk sharing options will facilitate the integrated working?

vi. How will these pathways grow? Can successful initiatives be "industrialised"? Can they be expanded to deliver to the whole population?

vii. How will you manage performance and ensure that the money works in the system – and can you transition to this future state?

Developing a Clinical Operating Model



d. Agreement on the commercial model for Walsall and the roadmap for transition. This will include:

i. How the provider organisations operate alongside the Host provider to deliver the TOM;

ii. Agreeing which commissioner hosted functions can be transferred to the Host Provider, such as IT and support functions;

iii. Agreeing an integrated place based commissioning arrangement across the CCG, Council, and Public Health;

iv. Creating an agreed outcomes framework and associated risk share arrangements;

v. Agreeing the allocation of financial resources to facilitate delivery of transformation phases.

And finally;

3) The creation of a budget and resource commitments to support both internal and external inputs to the process over the next six months. These are broken down as follows;

Internal requirements:

a. Dedicated director time (1FTE);
b. Support for the board meetings/governance;
c. PMO provision, including a Chief Officer;
d. Nominated Work Stream Leads (likely part time);
e. Communication and messaging support (0.5 FTE);
f. Clinical time for backfill for those tasked with delivery;
g. Circa £115k to facilitate Primary Care participation and clinical time release (figures based on a previous proposal to the CCG by the GP Leadership Group);
h. Commitment from organisations to free up resources to participate in the process during the next stage.

6.3 Whilst this represents a significant internal investment for the partners, it is fair to say that it builds on the significant commitments that have already been undertaken and the goodwill shown by all to participate in the process.

6.4 In addition, some external support is required to

a. Enable further definition to the governance structure, but to include legal advice that will ensure satisfaction of the regulatory environment;

b. Support to the development of a comprehensive, Walsall wide financial model for the system. This should include:

i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the “do nothing scenario” for the future;

ii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific “do something” scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

iii. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

c. Significant support to the development of a comprehensive, Walsall specific clinical operating model (COM) for the future state system of health and care in Walsall. This to be developed through the initial priority care areas that have been identified and likely working with a “model community” that could then become the early/first adopter of the model for their population. This process would need significant clinical/professional input, which is critical to agreeing a shift in care from higher cost to lower cost settings, as well as in designing the future workflows for example.

d. Significant support to agreeing the commercial model for Walsall and the roadmap for transition. This will include:

i. Scope of organisational or contractual integration;
ii. Organisational form for integrated provision;
iii. Contractual model(s);
iv. Payment model(s);
v. Approach to risk/reward sharing.

While a detailed budget is yet to be created, at this stage it is recommended that a ceiling budget for external support be set at £400k to support the requirements outlined above.

In terms of cost versus benefit analysis, it is clear that there is a significant opportunity to move towards a more integrated delivery model in Walsall. The analysis within this document (section 3.3.1) illustrates a potential for more integrated working to release annualised savings of between £49m and £153m at a system level.

This is a compelling rationale for continued development of the partnership approach as well as the necessary internal and external investment and commitment to shared progress.

7. Council Corporate Plan priorities

7.1 The integration of health and social care delivery is in line with the following Council corporate priorities:

- People: have increased independence, improved health and can positively contribute to their communities.

- Communities: are prospering and resilient with all housing needs met in safe and healthy places that build a strong sense of belonging and cohesion.

8. Risk management

8.1 there are multiple risks in a change of this scale and size. There is a requirement initially to create an executive leadership team to drive the plan forward.

8.2 This will be supported by a Programme Management Team and a cross-sector transformation plan; underpinned by new governance arrangements.

8.3 Resources are needed to create a pooled fund to resource these teams (Executive and PMO) to deliver the shadow arrangements and a Full Business Case (FBC).

8.4 The activities of developing the FBC include gathering data and analysis; designing the contractual approach; preparing and overseeing stakeholder and public engagement.

8.5 The PMO will devise and run a full risk register to monitor and oversee the risks outlined.

9. Financial implications

Walsall Health and Care System

9.1 Using available data, Walsall's predicted total health and care system spend for 2017/18 is £557.33m. This is comprised of £428.48m and £128.85m spend between Walsall CCG and Social Care (including Adult Social Care and Children's Services) respectively. For the purpose of this document, elements of Public Health spend have been excluded, however there will be opportunities to include that.

9.2 This spend is forecast to rise by 2.8% by 2019/20 to £563.15m. On this trajectory, the whole health and care system spend for Walsall by 2027/28 is forecast at over £628m. This may be a conservative estimate of the total cost, as Social Care and health budgets been reduced substantively over the last few years and this has reduced the trend of growth used to forecast future spend. These reductions are unlikely to be replicated as the existing savings were, in part, delivered by reducing the level of services available. Consequently the remaining services are broadly minimum statutory duties and any further reductions will not be possible.

Breakdown of total spend by service for Walsall Health and Care System

SERVICE	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)
Acute Services	182,330	187,387	195,672	205,051	206,388	212,780	217,246
Mental Health Services	43,907	44,454	46,393	47,925	40,796	41,852	42,915
Primary Care	9,964	9,848	11,908	10,538	10,301	11,446	11,230
Prescribing	45,714	48,118	49,978	50,499	50,969	52,740	54,955
Intermediate and Continuing Healthcare	20,369	20,726	21,150	21,991	24,302	26,483	28,386
Community	28,415	28,809	29,044	30,310	30,551	30,910	31,408

Services							
Other (including Estates, BCF)	15,229	17,135	15,378	11,629	17,282	9,619	4,051
Delegated Primary Care				36,312	38,280	40,068	41,233
Running Costs	6,317	6,575	6,507	5,787	5,754	5,620	5,679
Surplus	3,635	5,504	5,054	3,843	3,857	3,890	3,959
TOTAL	**355,880**	**368,556**	**381,084**	**423,885**	**428,480**	**435,408**	**441,062**
Adult Social Care			59,773	65,935	66,323	62,760	59,170
Children's Services			56,268	56,552	62,527	64,990	63,530
TOTAL			**497,125**	**546,372**	**557,330**	**563,158**	**563,762**

Sources: CCG Comparative Data (Nov 2017), Social Care data provided by Senior Finance Manager, Walsall Council (Jan 2019).

9.3 It is clear that continuing without improving the system will threaten the financial sustainability of all elements.

10. Legal implications

10.1 There will be a number of legal advice requirements to produce the Host Provider arrangement:

i. The Provider Board will commission legal advice to develop the collaborative position on the host and sub contractual arrangements.

ii. Each organisation will require individual legal advice to be fully informed about the contracts and the implications.

11. Property implications

11.1 Over the lifetime of the Host Provider, premises will be adapted for collocation and locality access.

12. Health and wellbeing implications

12.1 The main aim of this arrangement is to enhance the health and wellbeing of Walsall people.

13. Staffing implications

13.1 The full scope of the people involved, as the Council's workforce is yet to be finalised.

13.2 However, it is intended to bring into scope the four locality teams, all intermediate care and some of the business support teams. Implications may involve a redesign of services as well as redesigning the way in which we work so to increase collaboration and really put the service user at the heart of everything we do.

13.3 The commissioning resources will also be scoped in adult social care and public health.

13.4 Some Children's services will also be considered in due course.

14. Reducing inequalities

14.1 The main purpose of this 'Host Provider' is to reduce the health and life opportunity inequalities of Walsall residents.

14.2 The specific health and wellbeing issues (and their measures) will be outlined in the full business case using the data gathered in the next stage.

14.3 A comprehensive EQiA will be produced to inform the impact of this development; and be further informed by the public engagement and consultation phase.

15. Consultation

15.1 The next steps identify a full citizen consultation on the plan and the programme office will oversee the delivery of that.

15.2 Staff (as and when clarified) will be engaged and enabled to support the improvements planned.

Background papers

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Appendix 1 – Case for Change

Adobe Acrobat Document

Paula Furnival
Executive Director

12 March 2018

Councillor Diane Coughlan
Portfolio Holder

12 March 2018

Walsall Together Provider Board

Case for Change and Next Steps

January 2018

NHS Walsall Clinical Commissioning Group

Walsall Council

Walsall Healthcare NHS Trust

GP Groups

One Walsall
Inspiring and supporting social action

NHS Dudley and Walsall Mental Health Partnership NHS Trust

Version 3.0 – 12th February 2018
Release Copy

Disclaimer

This report has been prepared on the basis set out in the scope agreed with KPMG and addressed to Walsall Together Provider Board (WTPB) in accordance with the agreed written terms of engagement dated 21 November 2017 (the 'Engagement Letter'), and should be read in conjunction the Engagement Letter.

This document is for the benefit of the Walsall Together Provider Board only and only to enable the WTPB to give preliminary considerations to the findings available based on fieldwork carried out up to the date set out in the document and for no other purpose. This document has not been designed to be of benefit to anyone except the WTPB.

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Foreword

So why integrate different organisations to improve people's health and wellbeing? There are now significant reports and publications that help us answer this question, and we have referred to those. However, our starting point has been very straight forward: as leaders in the health and care system we know we cannot continue as we are currently working. Our system is disparate and offers care on an episodic basis, rather than in a coordinated efficient way.

The public tell us regularly that they cannot access the support and services they need quickly enough or locally enough. We know that as the population grows, lives longer and with more complex and inter-related illnesses that the need for coordinated care is increasing.

Professionals want to provide good quality and responsive services, but often they end up handing patients off to other colleagues and organisations without having influence or an ability to coordinate a full oversight of care.

We know that if we don't stem the increase in lifestyle related illness (obesity, diabetes, and substance misuse) then the current resources we have will not meet the needs of our population. We also know that in many areas where we spend significant amounts of money, that the outcomes for people are not always satisfactory.

Our aims in this work are multiple but in summary we aspire to:

- Offer a population, place based health and care system, that is person focused and based on the known needs of the population;
- Lose the different approaches of primary, secondary, community health and separate care; to one that is demand led, joint and centred on how best to respond to demand within the resources available;
- Operate within the resources we have to improve the quality of care and support we offer across the whole health and care system;
- Be clear about the expectations and entitlements of access to care and support for our population;
- Empower our practitioners, patients and clinicians to be the key decision makers in the design of new arrangements;
- Develop a system where prevention , early help and self-care are key, because people are well advised, confident and knowledgeable about their own health and wellbeing;
- Ensure that professionals in the health and care system are connected, share responsibility and accountability for the health of the population;
- Provide care and support that is high quality, cost effective and the best value for money;
- Ensure decisions about health and wellbeing are evidence based and underpinned by good practice and knowledgeable staff;
- Organise ourselves to achieve the above and much more.

This paper moves the Provider Board forward in its thinking and clearly outlines the next steps to transforming the Health and Care System in Walsall. We are looking at new, emerging care models

and innovative contractual arrangements which facilitate providers to work together in new ways to achieve a shared aim of improving patient outcomes.

In early 2018/19, we will have agreed a preferred model for delivering integrated care in Walsall and to drive the transformation we want to see. We have collectively identified and agreed population cohorts that will be incorporated into the model in a phased approach, starting with enabling effective support for the frail elderly and adult population. However the end-state vision is for the chosen model to serve the health and care needs of the whole Walsall population.

Each member of the Walsall Together Provider Board is committed to this vision and understands the considerable organisational and operational changes that will be required. However we as a group believe this will help to improve the delivery of services, address the health inequalities and provide long-term sustainability for the system; ensuring the people of Walsall receive high quality care as close to home as possible both now and in the future.

Mark Axcell

Chair of Walsall Together Provider Board

1 Executive Summary

Introduction and Context

The Walsall Together Provider Board was established to provide a forum for colleagues across the health and care system to design and deliver innovative, integrated care. The Board has a shared vision of improving the health and care of the people of Walsall, through providing more cohesive and person centred support that maximises independence and well-being.

The goal of the programme is to ensure, through effective collaboration, that health and care services in Walsall achieve the triple aim of:

- Improving health and wellbeing outcomes for the Walsall population;
- Improving care and quality standards in the provision of care;
- Meeting the statutory financial duties of all partner organisations.

In addition to developing new partnerships, the Board has co-designed the Walsall Model of Care, which describes how providers plan to work together; wrapping services around a patient to ensure they are seen by the right service, at the right time in the right place. We are now exploring how best to deliver this; including new governance arrangements as an initial step to strengthen joint decision making and accountability. This paper reviews the current system readiness and provides a clear roadmap to deliver system wide integration. A key element to delivering this will be strong clinical leadership and the support of individual providers; this paper aims to provide a starting point for these discussions.

Walsall's population of ~272,000, is currently served by a number of providers, including an integrated Acute and Community Provider, Mental Health Trust, 59 GP Practices, Local Authority and a third sector umbrella organisation 'One Walsall'. By following the recommendations set out below, the Walsall health and care system can address the challenges associated with delivering care across multiple providers and deliver improved health outcomes for local people alongside securing long-term financial sustainability for the system.

The providers within Walsall have already jointly developed a model of care for the local population and now need to develop a roadmap to fully deliver this in agreement with the local health and care economy. This paper recommends three immediate actions to move the current partnerships into contractual agreements; leveraging innovative payment reform and risk sharing options.

Strategic Case

When comparing Walsall's current health economy to national and local examples of successful integrated care, such as the Dudley Multispecialty Community Provider, Walsall shares many of the integral features of these systems. For example in Walsall there has been progress in the establishment of seven Place Based Teams across four localities and these will provide community, primary and social care services to populations of between 30-50,000 patients in the long-term.

Providers also already recognise the levels of duplication across the system that arises from silo working and the barriers to coordinated delivery when working across organisational boundaries. This is seen particularly in intermediate care pathways, both before and after a hospital admission. A shared vision has been borne out of these frustrations; to deliver more integrated care that saves time, resource and costs while providing a better service and outcome for patients. Thus a new integrated care model is being implemented.

The Walsall Together Provider Board has identified four priority work streams for delivery through the new model;

- Adult and Older Adult Community Services;
- Children's Services;
- Community Services and Prevention;
- Acute Service.

These have been selected as each area extends across multiple organisations and can build on the relationships and integrated working that is already in place. Adult and Older Adult Community Services in particular also addresses some of the most significant health challenges for Walsall; such as 1 in 5 older adults living with a mental health problem. Falls are also a significant clinical risk and area for improvement; in addition to the £11.3m cost incurred as a result of treating fall injuries, falls destroy confidence and reduce individuals' independence (The Annual Report of the Director of Public Health for Walsall, 2014).

Following consultation with the CCG, a phased roll out approach has been agreed and a timetable for delivery has been developed, with an intention to have the 'Adult and Older Adult Community Services' work stream live by April 2019.

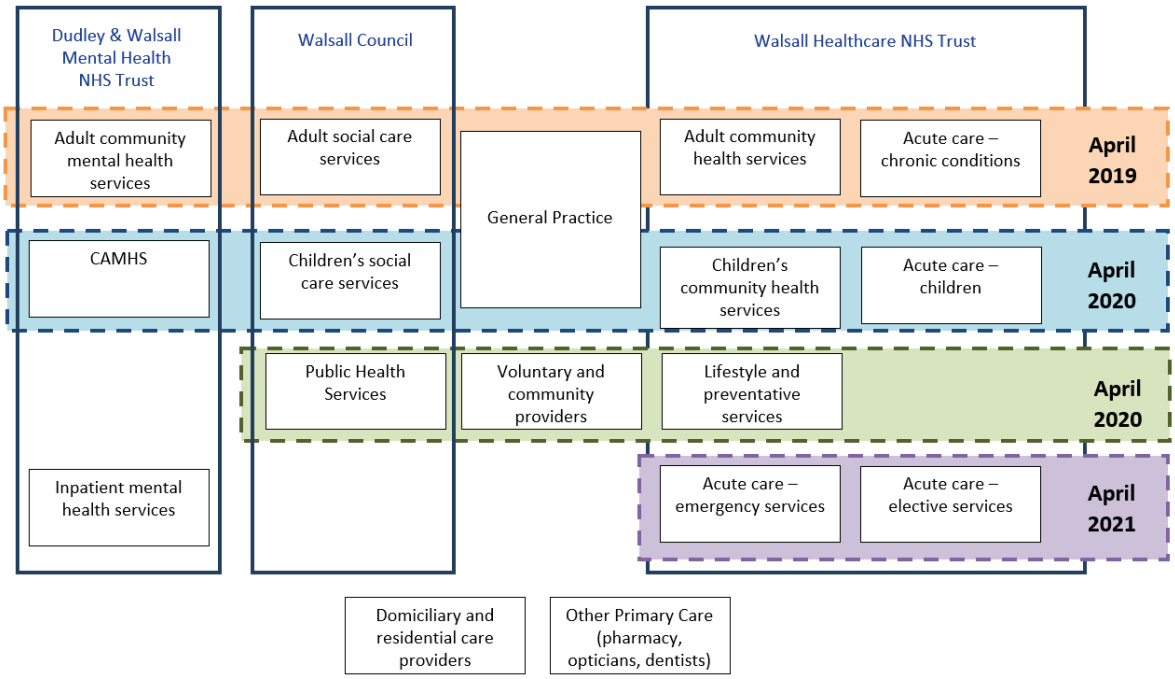


Figure 1 Proposed phased roll out of transformation work streams

While there is alignment amongst providers on the transformation required and a history of cooperative partnership working, the programme requires dedicated programme resource to ensure these work streams are delivered. A particular focus is being kept on Primary Care, as their ability to be involved and actively steering this is more challenged, due to capacity issues and a shortage of funding being made available for Primary Care engagement. This is in part due to endeavours of the Board sitting alongside Business As Usual (BAU) activities; pulling resource away from individuals' primary roles.

Additionally while partnership working is well intentioned, current contractual arrangements don't always reflect or incentivise this and in some cases providers are in fact penalised for acting as partners in the same system. For example disincentives to invest in social care to reduce unnecessary hospitalisation, disincentives for hospitals to avoid admissions through A&E and disincentives for hospitals to provide advice and guidance as alternatives to outpatient appointments. The aim of reforming contract and payment models is to better align incentives so that individual providers don't lose out from playing their part in transformation and are rewarded when the system as a whole is better off.

It should be noted that a number of these work streams are already underway and demonstrating progress towards a future state model. However the current arrangements lack the clear governance, accountability and contractual models to underpin and incentivise the pace required for the future sustainability.

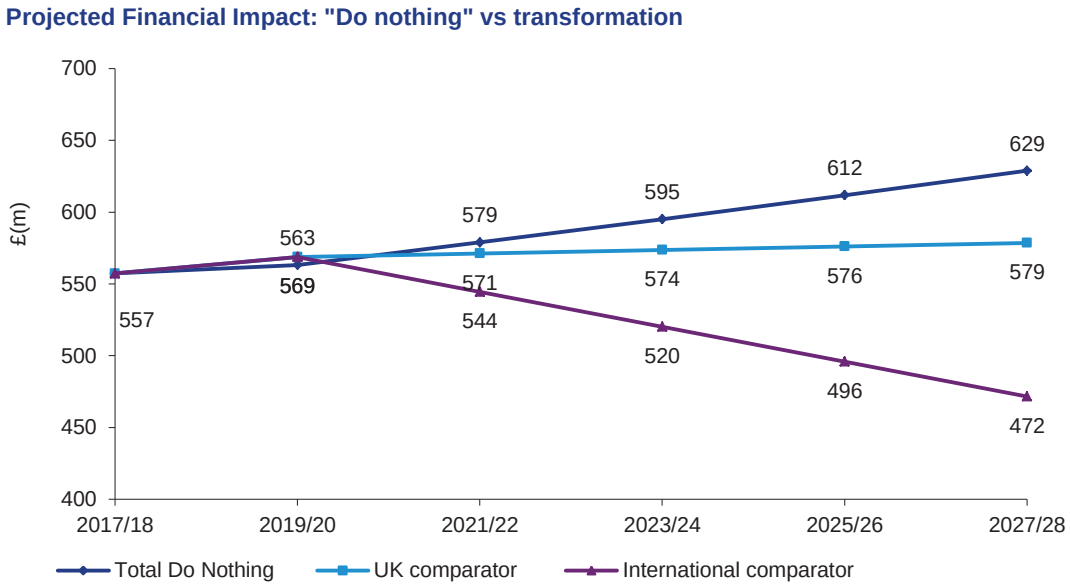
Projected Financial Impact

Whilst data on the forecast commissioner spend is available this does not provide the granular detail required to understand spend by individual providers or the activity and cost impact of different initiatives. As such, financial impact data provided below is for illustrative purposes only and whole system modelling is strongly recommended.

Using the data available, the predicted health and care commissioner spend for Walsall in 2017/18 is £557.33m. This is a cumulative total of the health spend and social care commissioner spend; £428.48m and £128.85m respectively.

Using data trends from previous years, the total system commissioner spend 2027/28 is forecast to rise to almost £629m by 2027/28; however this may be a conservative estimate, falsely lowered due to the forecast decrease in spend on Adult Social Care between 2017/18 and 2019/20. In order to provide a view on how the cost curve can be impacted, two alternative scenarios were mapped using UK and International examples of integrated system transformation. These alternative scenarios illustrate the potential for significant financial savings against the Walsall 'do nothing' scenario.

Figure 2 Walsall Health and Care Economy financial projections



Contractual and Governance Arrangements

In addition to a Care Models and Benefits workshop, two half-day workshops focussed purely on exploring payment reform, contractual arrangements and system governance has enabled providers and commissioners to develop a shared understanding of the commercial and governance arrangements available.

The WTPB considered both the options available and most importantly the impact of each of these on individual organisations. A supplementary report, *Walsall Alliance Organisational Model Appraisal*, was supplied to the WTPB on January 8 2018, providing a breakdown of four potential options, which will support discussions with the wider members of the WTPB and commissioners in agreeing a preferred route. The four options included were as follows:

- Host Provider Model (as a variant of the traditional Lead Provider model, with decision making authority delegated to a Board with equal representation from provider organisations);
- Accountable Joint Venture;
- Fully Incorporated Model;
- Alliance.

At this stage, the Host Provider model has been identified as the preferred commercial model to move forward with; although the host provider is yet to be identified. This touches on the significant amount of work required prior to both the transitional phase beginning April 2018/19, delivery of a business case and beyond into delivery of the first work stream under the new arrangement by 2019/20. Further details of transitional governance arrangements and beyond can be found in section 4.

Leadership & Programme Management

The delivery of system wide change of this scale is a significant undertaking and it is expected that the design phase will run from February 2018 to April 2019. In order for the programme to be jointly owned, Leadership & Programme Management resource should be provided/supported by the WTPB and local commissioners. This paper recommends a full time Leadership & PMO function is provided to drive the programme management, while work stream teams, led by subject matter experts ensure the delivery of the following work streams;

- Governance;
- Organisations and Contracts;
- Clinical Operating Model;
- Capital and Investment Planning;
- Implementation and Transformation;
- Data and Analytics;
- Stakeholder Engagement and Communications.

A lead from each work stream and the PMO function will report directly to the Provider Board, with the Provider Board retaining ultimate decision making authority. It is expected that external support and specialist advisors will support delivery of the work streams where appropriate and necessary.

Recommended Next Steps

This process has advanced the level of alignment amongst the Walsall Together Provider Board and commissioners and developed a shared understanding of appropriate and available options for a new model. In order to drive the project forward from this position, we recommend the following three actions for immediate approval:

1. Establishing a Leadership & Programme Team with access to dedicated resource to run the development process;
2. Developing a business case for stakeholder sign-off (Including NHSI & NHSE) within the next six months to include the following priorities:
    a. Defining appropriate governance to facilitate collective leadership in transition and end state;
    b. The development of a comprehensive, Walsall wide financial model for the system;
    c. Developing a Clinical Operating Model;
    d. Developing an appropriate contractual model.
3. The creation of a budget and resource commitments to support both internal and external inputs to the process over the next 6 months. These are broken down as follows;

Internal requirements:

a. Dedicated director time (1FTE);
b. Support for the board meetings/governance;
c. Leadership & PMO provision, including a Chief Officer;
d. Nominated Work Stream Leads (likely part time);
e. Communication and messaging support (0.5 FTE);
f. Clinical time for backfill for those tasked with delivery;
g. Circa £115k to facilitate Primary Care participation and clinical time release (figures based on a previous proposal to the CCG by the GP Leadership Group);
h. Commitment from organisations to free up resources to participate in the process during the next stage.

Whilst this represents a significant internal investment for the partners, it is fair to say that it builds on the significant commitments that have already been undertaken and the goodwill shown by all to participate in the process.

External requirements:

a. Light touch external support around further definition to the governance structure, but to include legal advice that will ensure satisfaction of the regulatory environment;

b. Significant support to the development of a comprehensive, Walsall wide financial model for the system;

c. Significant support to the development of a comprehensive, Walsall specific target operating model (TOM) for the future state system of health and care in Walsall. This to be developed through the initial priority care areas that have been identified and likely working with a “model community”.

d. Significant support to agreeing the commercial model for Walsall and the roadmap for transition.

While a detailed budget is yet to be created, at this stage it is recommended that a ceiling budget for external support be set at £400k to support the requirements outlined above.

In terms of cost versus benefit analysis, it is clear that there is a significant opportunity to move towards a more integrated delivery model in Walsall. The analysis within this document (section 3.3.1) illustrates a potential for more integrated working to release annualised savings of between £49m and £153m at a system level.

This is a compelling rationale for continued development of the partnership approach as well as the necessary internal and external investment and commitment to shared progress.

As part of the Walsall Together Programme, a branch of the Black Country and Birmingham STP, the Walsall Together Provider Board have developed a model of care to address some of the health inequalities unique to Walsall. These include an average health life expectancy 3.4 years lower than the national average and an increasingly dependent and ethnically diverse population all while sitting in one of the most deprived areas in the country (33rd out of 326). Following insights from across the UK and internationally, the WTPB have identified initiatives such as Population Management Hubs, as key to delivering the transformation and long-term sustainability required for the future.

2 Strategic case

2.1 Introduction

The Walsall Together Provider Board (WTPB) is seeking to facilitate improved wellbeing and enhanced delivery of health and social care to the people of Walsall. This deepens its integration across health and care and forms part of the wider Walsall Together agenda to deliver integrated care to the local population that supports individuals to develop proactive self-care behaviours and maximises the potential of existing teams and the broader Walsall health and care system.

The Walsall Together programme set out to deliver three key objectives:

- Improved outcomes;
- Better quality / safety / experiences;
- Financial sustainability of health and care sector.

The existence of the Walsall Together Programme and its progress to date in unifying providers, including ~151 GPs across 59 practices and the implementation of place-based care teams, signifies the appetite for more integrated working in the area. However the traditional barriers to collaboration, including ambiguous accountability and varying payment models, continue to impede realisation of significant system change. As such, WTPB is seeking to agree a new contractual model to deliver its agreed Model of Care, focusing initially on key priority areas but with the capacity for expansion over time to meet ongoing transformation programmes and provider flexibility.

2.2 Member organisations and ambitions

Walsall Healthcare NHS Trust (WHNT) - Walsall Healthcare NHS Trust is an integrated provider across Acute and Community services. They deliver a full range of acute hospital services including A&E, outpatients, and diagnostics, elective and non-elective admissions, in addition to Community services.

Motivations – As current provider of the Community Services contract in Walsall, WHT strategic direction is set to continue to build on the integration already embedded in their service offering. This would form the foundations of a jointly managed contract. Following on from the identified target patient cohort of frail elderly, WHT has identified Adult Community Services as the initial first phase to transition. This would be followed by Children' Community Services and finally LTC management in the Community. This final element would provide opportunity to involve secondary

and intermediate care, once new ways of working and pathways have been established and strengthened.

Walsall Metropolitan Borough Council – Walsall Metropolitan Borough Council provide Adult Social Care and Children's Services, and Public Health. This includes but is not limited to; safeguarding, supporting those with mental health needs, those with physical or learning disabilities and those acting as a carer. There are statutory responsibilities to safeguard those at risk of abuse, to look after children who cannot live within their own immediate family and to offer early help and support to children in the most need.

Motivations –There are distinct segments of services provided by the Council that would be eligible for management under a new integrated model; for example some Adult Social Care and some Children's Services and some elements of Public Health, however some statutory requirements are likely to remain within control of the Local Authority. The Council is also a commissioner and those responsibilities will be separated between strategic commissioning and the potential operational functions which can be transferred to this new arrangement.

Dudley and Walsall Mental Health Partnership Trust - Dudley and Walsall Mental Health Partnership Trust (DWMHPT) provide a full range of mental health services under contract with the CCG to the people of Dudley and Walsall. This includes community mental health services for children, adults and older people, in addition to inpatient facilities for adult and older people. Some mental health Social Care services are also provided via partnerships with Walsall Council. It is a one of only four national hubs for Specialist Deaf CAMHS and was given a CQC rating of "Good" in November 2016.

Motivations – The Trust has been a key partner in the Dudley Multispecialty Care Provider (MCP) Vanguard and are keen to further develop the locality based model in Walsall. Furthermore the opportunity to integrate physical and mental health is paramount to addressing issues such as; the high rates of mental health conditions among people with long-term physical health problems, the reduced life expectancy of those with the most severe forms of mental illness(largely attributable to poor physical health), poor management of 'medically unexplained symptoms' lacking an identifiable organic cause and the limited support for the wider psychological aspects of physical health.

GP Groups – Walsall CCG commissions 59 GP practices, covering approximately 281,000 patients. The GP landscape in Walsall is typically broad, consisting of two federations, two partnerships, one private provider and a small number of individual practices. The largest of these is the 'Alliance' federation, covering over half the patient population with 27 practices. The distribution of GP groups is shown below:

Table 1 The distribution of Primary Care Providers groups across Walsall

Name	Organisation	Number of Practices	List Size
Alliance	Federation	27	106,107
Palmaris	Federation	7	65,567
Modality	Partnership	7	32,455
The Practice Group	Private Company	7	29,137
Umbrella	Partnership	5	27,978
No Group	N/A	6	19,906

Motivations – GPs in Walsall have formed a 'GP Leadership Group' to facilitate co-operative working within Primary Care, although they recognises that it is unable to represent every GP in Walsall. Furthermore while the GPs are supportive of new ways of working, they require sufficient resource and financial support to enable their ongoing participation in discussion and delivery moving forward.

2.3 Case for Change

2.3.1 Challenges/ issues in the local system

There are five specific population challenges that we face in our service delivery alongside the financial pressures: growth in activity (spells for emergency care, inpatients and outpatients); the deprivation levels of the population; the diversity of the population; the increasing healthcare needs of our population and the inequality of life expectancy across the area. The specific challenges and metrics are set out below.

2.3.1.1 Growth in Activity

Overall resident population is set to have increased by 4.5% over 10 years by 2021, growing from 269,500 in 2011 to 281,700. Furthermore, as is found across the country, Walsall has an increasingly aging population, with the number of residents over 65 set to rise by 13.8% over the same period. (Walsall CCG Strategic Plan 2014-2019, 2014).

2.3.1.2 Deprivation

Walsall is one of the most deprived boroughs in England; ranked 33rd out of 326 local authorities, with 27% of children living in poverty. We know deprivation is linked to high rates of infant mortality and at 8 per 1000 births this is significantly higher in Walsall than statistical neighbours. Likewise the incidence of preventable diseases is significantly higher than the national average, including; diabetes (8.7% against a national average of 6.4%), coronary heart disease (4.0% against a national average of 3.2%) and chronic kidney disease (5.2% against a national average of 4.1%).

Also correlated is the impact on substance misuse and smoking; Walsall has a significantly higher rate of problematic drug users and the estimated prevalence for smoking 22.7% (c.45,000 adults) and smoking related deaths are significantly higher than national averages.

2.3.1.3 Diversity

Almost 1 in 4 residents are from a minority ethnic group, compared to the England average of 1 in 5. The largest increase has been from people with an Asian background. This is likely to impact the birth rate, as residents from minority ethnic groups tend to have higher birth rates. This also impacts on community cohesion as the areas ethnic composition has changed quite rapidly. This can actually contribute to areas becoming less diverse and some ethnic minority groups can be highly concentrated in a particular area (up to 90%).

English language proficiency is very good in Walsall and in line with the English and Welsh averages. However 3.3% of households have no occupants that speak English as their main language, 6,200 residents cannot speak English well and 1,200 who cannot speak the language at all. This can make delivering healthcare and health information challenging and can be a barrier to accessing services.

2.3.1.4 Increasing healthcare needs

Walsall has an increasingly dependent population, with an above average proportion of the resident population made up of children and older people, with a correspondingly low proportion of working

age adults. Furthermore, 1 in 5 residents have a health condition that limits their day to day activities, increasing the number of people who are unable to work (DWMH Clinical and Social Care Strategic Vision 2015-20, 2015). An ageing population also increases the occurrence of age-linked diseases and incidents; the number of residents with Dementia is, likely to increase by 22.5% over the next eight years, putting extra pressure on all health services (Five year Strategic Plan for Walsall, 2014), while falls cost Walsall £11.3million per year (The Annual Report of the Director of Public Health for Walsall, 2014). These aspects put additional strain on the health and care system, but also on Walsall residents as the number of individuals caring for someone with a long-term condition is increasing, from 10.6% in 2001 to 11.6% in 2011 (Walsall Strategic Needs Assessment May, 2014).

2.3.1.5 Health Inequality

The average healthy life expectancy in Walsall is just 60.3 years; 2.3 years less than the West Midlands average and 3.4 years lower than the England average. Male life expectancy is particularly poor at just over 77 years, compared to 79 years nationally. Walsall also performs poorly on the number of unplanned admissions for ambulatory care sensitive admissions and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.

A range of measures demonstrate that older people in Walsall are high users of institutional care, an approach that neither promotes efficient use of limited resources, nor meets the individually identified needs of older people and their carers. We also know that while 1 in 5 community dwelling older people have a mental health problem, 2 in 5 of those living in care homes are suffering from depression (The Annual Report of the Director of Public Health for Walsall, 2014).

2.3.2 Regional and national strategic alignment

The Walsall Model of Care sits alongside both regional and national strategies and has been designed to contribute to the broader health and care objectives, as shown below.

Black Country and West Birmingham STP

The Black Country and West Birmingham Sustainability and Transformation Plan (STP) was published on November 21 2016. The STP is a blueprint for the future development of healthcare and wellbeing services across 18 organisations in the Black Country and the West of Birmingham including primary care, community services, social care, mental health and acute and specialised services. STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by local organisational boundaries. The aims are to:

- Improve the health and wellbeing of local people;
- Improve the quality of local health and care services;
- Deliver financial stability and efficiencies throughout the local health care system.

Walsall is identified in the STP as one of the four established place based care models and will continue to deliver services to its population as part of this broader programme. The Walsall model's continuing alignment with the STP will be monitored throughout and facilitated through regular communication from the STP programme group and CCG. Likewise local developments will be shared between the WTPB, CCG and STP programme group to ensure learning is shared and built upon.

Five Year Forward View and adherence to contracting guidance

The NHS 'Five Year Forward View' (FYFV) published in 2014, and the follow up report 'FYFV Next Steps' in 2016 describe the high level of fragmentation that has arisen in the NHS and explains how the divisions between primary and secondary care are increasingly barriers to personalised and coordinated health services. They also assert that out of hospital care needs to become a much larger part of what the NHS does, and that services need to be integrated around the patient.

The recommendations set out in the FYFV include:

- Developing new models of care – based around partnership, integration and joining up organisations and funding streams. These may require the development of Accountable Care Partnerships/Organisations.
- A radical upgrade in prevention and public health;
- Increasing the control patients have over their care when they require access to services.

Out-of-hospital services are a vital part of the urgent and emergency care system. Yet for patients and staff they rarely feel as coherent and streamlined as they should be. Integrated Care models are intended to make it much easier to simplify the interactions between GP in-hours, GP extended access services, minor injury units, walk-in centres, community pharmacies, 111, GP out-of-hours, and A&E.

Accountable Care Partnerships/Organisations (ACPs or ACOs)

ACPs have emerged as a key strand of NHS policy as part of essential actions to manage quality and financial sustainability in health and social care, bringing health and social care organisations together creating a single health and care system in a specific geographical area organised around patient needs. They are accountable for the delivery and quality of that care. This requires a range of providers working together to develop new ways of integrated working.

These new forms do not replace the accountabilities of individual organisations, rather they supplement them. Nevertheless, to be successful these partnerships need a basic governance and implementation support – this is in line with the Black Country and West Birmingham STP, and the Walsall Together Programme.

ACPs involve:

- Shared decision making and population health management;
- Collective management of funding for the ACPs' defined population through a system control total;
- A system partnership that has clear plans – and the capacity and capability to execute those plans;
- ' Integration' of providers whether virtually or through actual merger or joint management;
- Simultaneous ' integration' with GP practices formed into primary care networks;
- A system that acts and behaves as though one single system, even though in law there are a number of distinct entities.

Walsall's proposals build on many of these key themes and provide a stable model fit for the future.

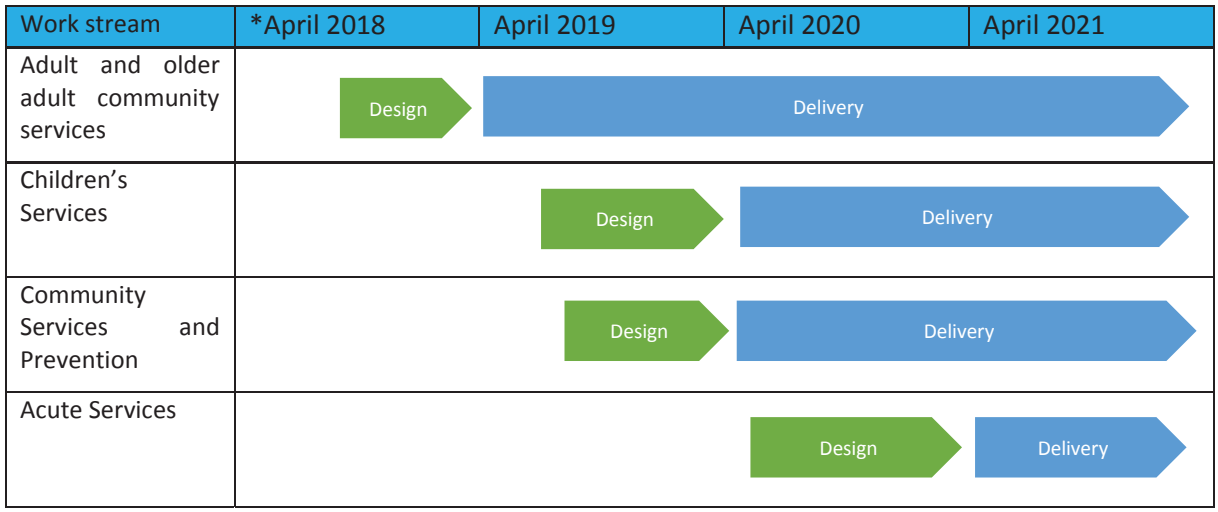
2.4 Scope

The proposed transformation and future model of care will help manage demand out of hospital and manage costs across health and social care. On 29 June 2017, WTPB held a workshop to discuss the high need, high cost users of their services and identified priority patient cohorts that would benefit from improved integrated services. This session highlighted the considerable overlap between organisations highest users and the specific patient cohorts these users belong to. These were

broadly identified as the frail elderly with co-morbidities, including mental health and additional social care needs.

The group recognised that in order to provide a manageable scope for an initial programme, elements of this pathway would be addressed alongside other priorities for the area in a phased approach.

Figure 3 Proposed phased delivery of transformation



**Each work stream builds on work already completed as part of the Walsall Model of Care (Section 2.5.1)*

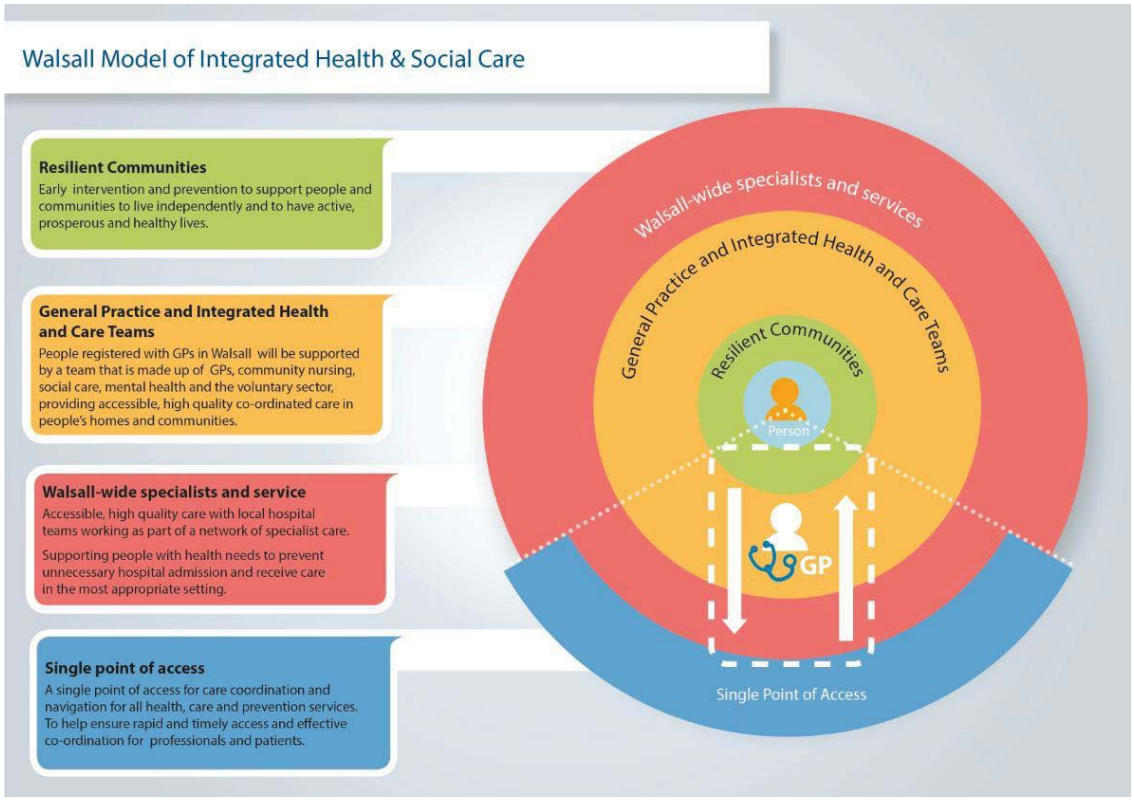
2.5 Service model and benefits summary

2.5.1 Current service model

The WTPB was established in 2016 to provide a forum for local providers to work collaboratively in designing and improving the health and social care received by the population of Walsall. All party members recognise the benefits of closer working; including reduced duplication, more streamlined pathways and high quality care being delivered more efficiently to the population.

The primary output of the WTPB to date had been the collaborative design of the Integrated Health and Social Care Model for Walsall, as shown in figure 3. This integrated model, which wraps services around a patient, based in a community setting, inclusive of Primary Care, includes the establishment of three key service areas with a Single Point of Access. These areas are outlined in greater detail below:

Figure 4 Walsall Model of Integrated Health & Social Care



Resilient Communities: Patients are first and foremost citizens of their immediate communities and as such this aspect of the model should be the first port of call for patients wishing to address their health and social care needs. This may include accessing preventative medicine or early intervention services; such as community activities and groups to prevent isolation and mental health issues or healthy lifestyle tools and services such as diet advice, exercise classes or support groups. Local and national public health Interventions have shown to be highly cost saving, with £14.30 saved for every £1 invested[2].

There has been significant progress made on this work stream, including the deployment of referral Hubs by Public Health. These Hubs support patients through the system and model the "Making Every Contact Count" scheme. This joins health care providers with voluntary sector agencies and other providers, such as the fire service, to deliver projects in the community; reducing isolation and supporting people to live independently in their own homes

General Practice and Integrated Health and Care Teams: General Practice remains the cornerstone of the NHS and patients registered with a GP in Walsall will continue to be supported by their practice. However the primary care team is becoming increasingly diverse to include community nursing, social care, mental health and voluntary workers. It is recognised that as the population ages, more people than ever are living longer with one or more long-term conditions; often accompanied by other mental health or social care needs. By continuing to grow and develop Integrated Health and Care Teams (IHCT), patients in Walsall will receive care from a variety of organisations to ensure care is being delivered by the most appropriate individual in the most appropriate setting. IHCT, or Multidisciplinary Care Teams, are recognised as an essential aspect of integrated care. By working in a more joined-up way, evidence suggests it is possible to reduce hospital admission rates by as much as 19% when compared traditional care[3], in addition to reducing duplication and referral waiting times. This will only be achievable if we transfer resource into the new model of are and build on the good work already started with these teams

Significant progress has been made here, with seven Place Based Teams working across the four localities in Walsall. Each provider is working to align their caseloads to identify the highest services users and high risk patients. Rolled out since June 2017, this is already reducing duplication and the number of unnecessary GP appointments.

Walsall-wide Specialists and Service: When patients require specialist care, this will be facilitated by an appropriate network, including neighbouring hospitals, to ensure patients receive the highest quality care available and unnecessary hospital admissions are avoided where possible. Walsall has begun to develop this service, beginning initially with the Integrated Diabetes Service, which allows clinicians working in Primary Care to seek clinical advice from Specialist Endocrinologists. There is a similar service in place for respiratory conditions, linking Specialist Respiratory nurses with a locality, providing support in the management of COPD and bronchiectasis.

Single Point of Access: Navigating the health and care system can be complicated and frustrating for patients. A lack of cross-organisation communication can mean patients are passed from one provider to another, while the demand pressures can mean referrals take weeks or months to be successful. A single point of access for patients means that they are directed to the right service at the right time and unnecessary steps can be avoided. However a single point of access can have even greater benefit for patients when used to facilitate care coordination and deliver preventative medicine. The potential for this tool will be covered in more detail under future service model opportunities. Due to the cross organisation and technological requirements to unlock the potential of this element, this is the least developed area of the model at present. It is expected that these barriers will be removed or lessened through the proposed model and that some of these expected benefits can be realised.

2.5.2 Future service model opportunities

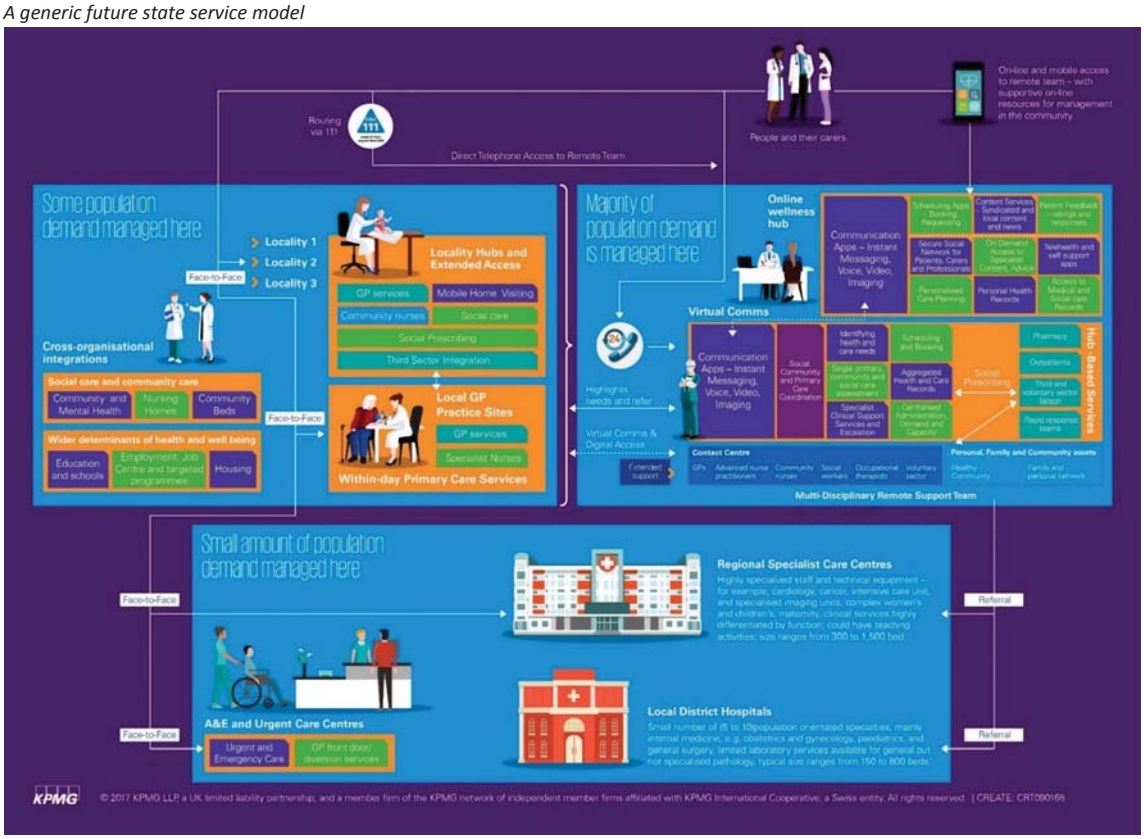
The WTPB decided to advance this work through a series of workshops; beginning with comparing the Walsall Model of Care with other UK and international examples and the associated benefits of these, to both patients and organisations. There are similarities found across all integrated systems; such as the "shift-left" of services, (from expensive secondary care settings to lower cost community settings), multidisciplinary teams wrapped around a patient and streamlined referral pathways to highlight a few. Other such initiatives that may run in parallel include;

- Population Management Hub;
- Established locality teams at the heart of population health
- Consultants in Community;
- Care Home in Reach Service;
- Outpatients in the Community;
- Specialist Skills in Community;
- Ambulatory Care Model;
- Condition Specific Rehabilitations (i.e. in Heart Failure and COPD);
- Implement GP Case Management;
- Social Prescribing;
- Implementation Mental Health & Substance Abuse Liaison Services;
- Implementation of Hospice at Home service;
- Implementation of care co-ordination centre;
- Fast Response Service / Integrated Rapid response service;
- Community bed provision;
- New approaches to urgent and emergency care centres;
- Extending access to Primary Care;
- Hospice at Home in the Care Home setting;
- Clinical referrals management;
- Reduce number of outpatient follow ups;
- Clinical Thresholds;

The Population Management Hub was highlighted as a particularly key initiative, building on the Single Point of Access work stream currently in development but evolving this in to a tool to manage and direct demand to the most appropriate setting. Initially this Hub would fulfil administrative functions across organisations, such as; scheduling and booking appointments, however by bringing clinical teams together "in-house" these Hubs would also provide clinical services, such as; outpatient appointments, pharmacy and social prescribing services through voluntary and third sector teams that are based here.

As data-sharing capabilities are improved across providers and also between patient and provider, it is envisioned that this facility will be able to prevent illness exacerbation and admissions by tracking patient activity in addition to real-time care-coordination. This is visualised at a generic level in the service model below:

Figure 5 A generic future state service model



Achieving this type of service model by implementing individual transformation projects, in separate provider organisations doesn't work - delivering this level of change in parallel requires a holistic approach to transformation, where all partners are signed up to a new Clinical Operating Model (COM) for the system.

This future Clinical Operating Model, must be supported by robust data and analytics in order to plan the transformation, monitor performance and move towards population management in real time.

2.6 Risks and Interdependencies

There are substantial risks associated with large scale projects involving multiple organisations, however identifying these early and developing solutions can reduce their likelihood and impact. A number of the risks and interdependencies identified so far are listed below and it is recommended that a similar process is maintained as appropriate throughout the development and implementation of the new commercial arrangements.

Table 2 Identified Risks and Interdependencies

Risk / Interdependencies	Description
New model financially destabilises one or more providers and therefore can't be agreed.	Without a clear system wide view of costs, it is possible that new ways of working reduce activity in certain areas, leading to destabilisation of these organisations. Working collaboratively with appropriate risk share arrangements will be key.
New model does not deliver a sustainable health economy for Walsall.	A new proposal must deliver an improved financial position when compared to the current financial forecast when taking a "Do-nothing" position.
The new clinical model does not align with wider work on sustainable clinical models for Walsall Healthcare NHS Trust service review and Dudley and Walsall Mental Health Trust Black Country wide Mental Health model development	Over the next 12 months two of the partners will be taking part in reviews of services and clinical models. Any development of clinical proposals during 18/19 should ensure alignment with these pieces of work and have full clinical engagement.
Lack of alignment between commissioners and providers in delivering the new model/integration programme.	As KPMG have seen in their work in Guernsey and STPs across the country, successful system transformation plans are those which harbour close working relationships between the provider and commissioners to develop a shared vision.
Sufficient focus on the new model and integration programme with other challenges.	Without building in dedicated time and resource, the project can become side-lined amongst BAU and other pressing challenges. Stakeholder engagement should be scheduled and maintained throughout as a priority.
Willingness of primary care to support proposals.	Walsall's diverse GP landscape, including 5 different groups alongside independent practices poses a challenge for a gaining a coherent and unified Primary Care Voice. As the cornerstone of the NHS, we how important support from Primary Care is for system change.
Understanding the voluntary sector	The unique but vital input from the third sector can

opportunity and perspective.	be complicated to facilitate due to financial restrictions. Our experience with charities will support identifying what are feasible “offers” for the voluntary sector and NHS.
Not fulfilling your statutory duties either financially or in terms of oversight.	Developing and designing new contracts takes place alongside an evolving and complex regulatory environment for providers. Statutory duties must be considered and fulfilled
Tax impacts.	The headline tax and VAT consequences associated with creating any new entities or quasi-entities should be considered prior to agreement, where the governance of such entities is not led by an NHS Trust prime provider.

The Walsall health and care system deficit is forecast to rise to £165.1m by 2020/21 if no action is taken to address this. While there is a lack of system wide financial data at sufficient granularity to enable modelling of initiatives against cost and activity impacts, it is possible to draw upon the impacts of comparators. Using this data, an indicative saving of between £49m and £153m per annum could be realised depending on the level and success of integration initiatives. In order to understand these figures more clearly, the system modelling capabilities must be strengthened and a full benefits analysis completed.

3 Projected Financial Impact

3.1 Introduction

A solid understanding of the baseline financial position and forecast future spending will provide a clear starting point for risk sharing arrangements and target savings. This will require an understanding of not just commissioner spending with individual providers but also a common understanding of the drivers of provider costs within each organisation (linked where possible to activity so that it is possible to see the impact of shifting care between settings). Using predicted spend data from the CCG, medium term financial plans from Walsall Council and applying external benchmarks, a high level, indicative interpretation has been prepared below for the purposes of considering what the impact could be on the financial sustainability of the health and care system, thereby enabling the best possible services across Walsall.

In order to move further in this process, it is recommended that full system modelling is completed to provide a clear view on expenditure across the system and allow for intelligent forecasting against "Do nothing" and new transformation scenarios. This will in turn inform proposed shared budgets and risk sharing options. Please note, due to scarcity of available and comparative data, all figures and forecasts shown below are indicative.

3.2 Financial context-by organisation

3.2.1 Walsall Healthcare NHS Trust

Following a series of recent challenges, The Trust has now commenced a credible recovery program which has started with the newly announced CQC ratings which highlight the Trust as Requires Improvement over all and importantly community services as Outstanding. Walsall Healthcare Trust's deficit stands at (£21m) but is currently producing a 3 year financial recovery plan to sustainability. The Trust is currently forecasting a reduction of £707,000 in their deficit position for 2018/19 and a further reduction of almost £7m by 2019/20 to bring their end year deficit to (£12.7m).

3.2.2 Primary Care

Primary Care is commissioned by Walsall CCG via both capitated GMS and Locally Enhanced Services (LES) contracts. Due to an ever increasing demand on Primary Care, practices are increasingly stretched to deliver patient care within budget. Although a breakdown of costs is unavailable, Walsall CCG spend on delegated Primary Care rose to £38.28m in 2017/18. A further £10.3m of Primary Care was delivered by the CCG, however this is a decrease of £0.2m from 2016/17.

3.2.3 Dudley and Walsall Mental Health Partnership NHS Trust

A piece of modelling work has been completed by the Trust that shows the split of costs and income between the Walsall and Dudley boroughs. Data from Walsall CCG suggests a decrease in spending for 2017/18 compared to the previous period, however spend is forecast to continue to be in line with budgets. For 2016/17 with was £45.42m while the 2017/18 budget is £44.19m with the forecast outturn in line with budget.

3.2.4 Walsall Council (Social Care only)

National Social Care budgets have been reduced by 26% in real terms over the last 4 years. Locally, Walsall Council savings requirement for Social Care stands at £15m over the period 2018-20; comprised of £9.3m for Adult Social Care and £5.7m for Children's Services. Consequently the provision for Adult Social Care in particular faces major reductions over this period, with the greatest cuts to be made during 2018/19. This reflects the cut backs on almost all but statutory care services. However as the graph below demonstrates, there is a difference in spending trends across these two services, with Children's Services spend increasing from £56.27m in 2015/16 to £64.7m in 2018/19, before forecast spend dipping to £63.53m in 2019/20.

The inclusion of Public Health commissioning and services has been discussed by the wider group and

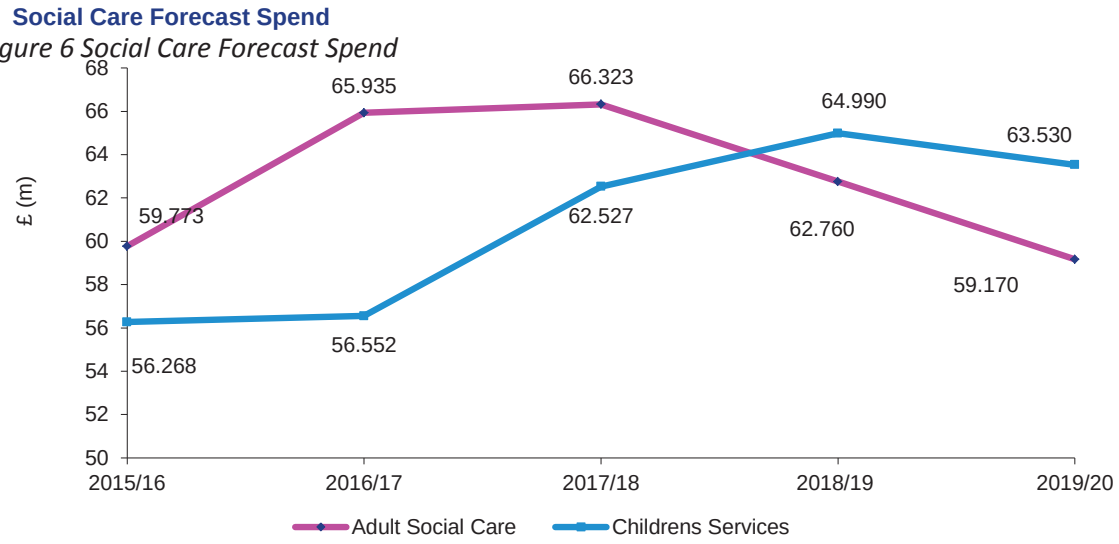


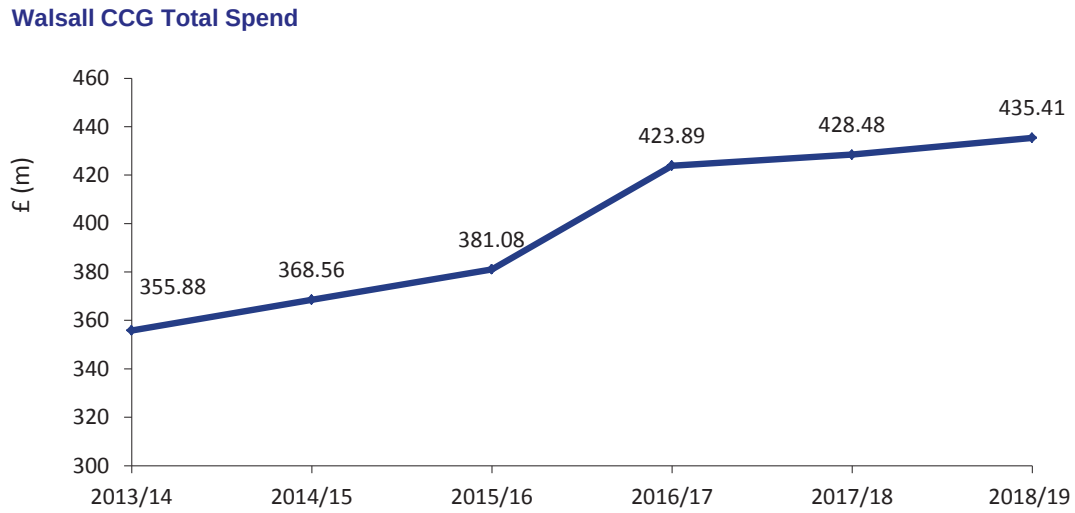
Figure 6 Social Care Forecast Spend

there is the intention that this may be delegated to a Host Provider as appropriate and when possible.

3.2.5 Walsall CCG

Walsall CCG is exiting a challenging period, having been placed in 'Special Measures' in July 2016 due to poor performance against NHS Constitutional standards but also a deteriorating financial position. The CCG has worked extensively to rectify the issues raised in the report and achieved a surplus of £3.8m in 2016/17. The 2017/18 budget currently stands at £426.1m for the commissioning of community, hospital, primary care and mental health services, with a forecast spend of costs of £428.48m, with this set to rise to £441.06m by 2021.

Figure 7 Walsall CCG Total Spend



3.3 Walsall Health and Care System

Using available data, Walsall's predicted total health and care system spend for 2017/18 is £557.33m. This is comprised of £428.48m and £128.85m spend between Walsall CCG and Social Care (including Adult Social Care and Children's Services) respectively. For the purpose of this document, elements of Public Health spend have been excluded, however there may be opportunities to broaden the scope in the future.

This is forecast to rise by 2.8% by 2019/20 to £563.15m. On this trajectory, the whole health and care system spend for Walsall by 2027/28 is forecast at over £628m. This may be a conservative estimate of the total cost, as Social Care and health budgets been reduced substantively over the last few years and this has reduced the trend of growth used to forecast future spend. These reductions are unlikely to be replicated as the existing savings were, in part, delivered by reducing the level of services available. Consequently the remaining services are broadly minimum statutory duties and any further reductions will not be possible.

Table 3 Breakdown of total spend by service for Walsall Health and Care System

SERVICE	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)
Acute Services	182,330	187,387	195,672	205,051	206,388	212,780	217,246
Mental Health Services	43,907	44,454	46,393	47,925	40,796	41,852	42,915
Primary Care	9,964	9,848	11,908	10,538	10,301	11,446	11,230
Prescribing	45,714	48,118	49,978	50,499	50,969	52,740	54,955

Intermediate and Continuing Healthcare	20,369	20,726	21,150	21,991	24,302	26,483	28,386
Community Services	28,415	28,809	29,044	30,310	30,551	30,910	31,408
Other (including Estates, BCF)	15,229	17,135	15,378	11,629	17,282	9,619	4,051
Delegated Primary Care				36,312	38,280	40,068	41,233
Running Costs	6,317	6,575	6,507	5,787	5,754	5,620	5,679
Surplus	3,635	5,504	5,054	3,843	3,857	3,890	3,959
TOTAL	**355,880**	**368,556**	**381,084**	**423,885**	**428,480**	**435,408**	**441,062**
Adult Social Care			59,773	65,935	66,323	62,760	59,170
Children's Services			56,268	56,552	62,527	64,990	63,530
TOTAL			**497,125**	**546,372**	**557,330**	**563,158**	**563,762**

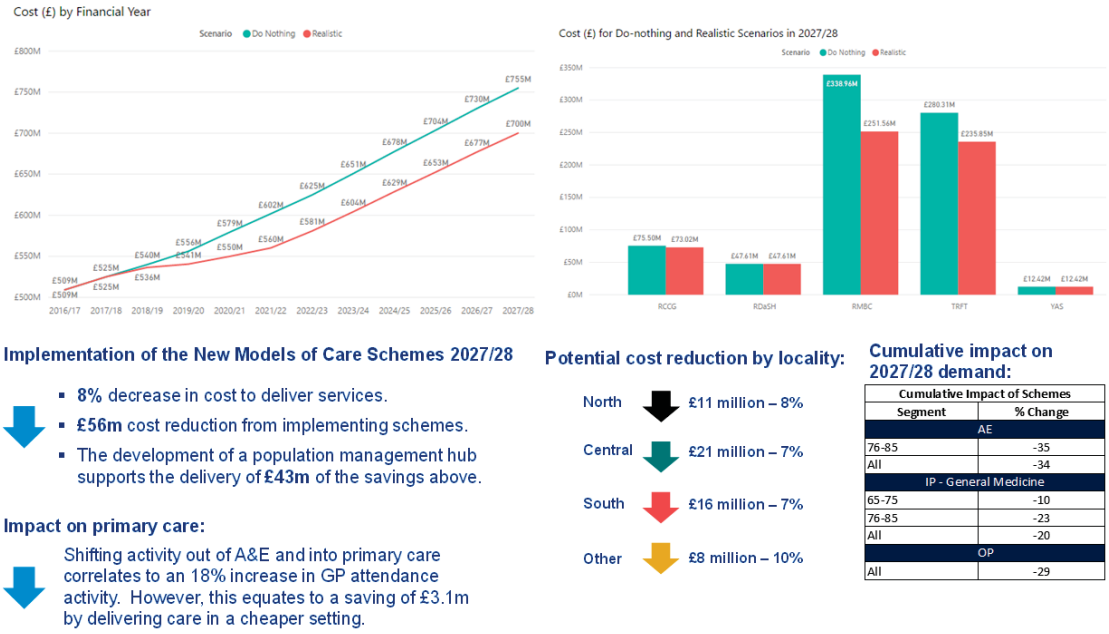
Sources: CCG Comparative Data (Nov 2017), Social Care data provided by Senior Finance Manager, Walsall Council (Jan 2019).

3.4 Comparable systems and benefits

To provide context to the proposed changes in Walsall and also to broaden understanding of the innovation taking place elsewhere, the WTPB held a 'Care Models and Benefits' workshop on 30 November 2017, inviting colleagues from across the health and care system (Appendix 2). This workshop drew on both UK and international comparators to illustrate the potential financial impact of transformation schemes where there has been a high level of collaboration between acute, community and primary care, alongside social care services. These two illustrative examples have been used to demonstrate the potential impact on Walsall. This is a very high-level approach but indicates the size of the opportunity in monetary terms.

The graphic below illustrates the impact of a new integrated service model within a comparable UK health and care economy:

Figure 8 UK Health and Care System Comparator



Implementation of the New Models of Care Schemes 2027/28

- **8%** decrease in cost to deliver services.
- **£56m** cost reduction from implementing schemes.
- The development of a population management hub supports the delivery of **£43m** of the savings above.

Impact on primary care:

Shifting activity out of A&E and into primary care correlates to an 18% increase in GP attendance activity. However, this equates to a saving of £3.1m by delivering care in a cheaper setting.

Potential cost reduction by locality:

North	£11 million – 8%
Central	£21 million – 7%
South	£16 million – 7%
Other	£8 million – 10%

Cumulative impact on 2027/28 demand:

Cumulative Impact of Schemes	
Segment	**% Change**
AE	
76-85	-35
All	-34
IP - General Medicine	
65-75	-10
76-85	-23
All	-20
OP	
All	-29

This modelling is a realistic UK proxy for Walsall and illustrates the potential for annual savings of £560m over 10 years for a similar sized population. (Note a comprehensive financial modelling exercise has not yet been conducted in Walsall specifically and this would need to be done prior to implementing a future service model).

Outside of the UK a comparable international benchmark for delivering joined up care within a National Insurance funded health and care economy would be the Israeli system. The data below illustrates the achievements of Clalit (the largest integrated care provider in Israel) over a 30 year period.

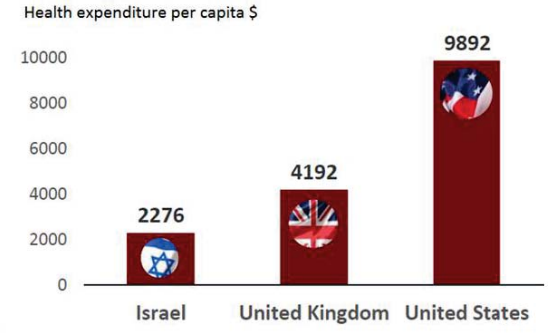
Figure 9 International Health and Care System Comparator

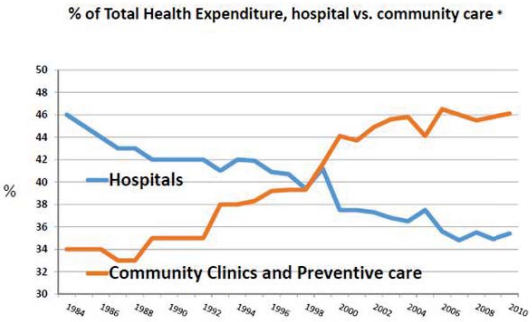
Background

The health care system in Israel was established by Clalit, a non-governmental, non-profit organisation. It has defined the health standards for the entire country for some 90 years. In January, 1995, in an effort to set health care on a more economically sound path, a national health insurance law went into effect. Every member pays in proportion to his or her income, and each is entitled to the same quality and range of medical services.

One of Clalit's unique features is its total involvement in the health services it offers. It employs as salaried personnel the nurses and doctors, teachers, researchers and administrators who staff its hospitals and GP clinics, including 7,500 physicians, 11,500 nurses, 1,300 pharmacists, 4,400 paramedics and laboratory/imaging technicians and 9,400 administrative personnel

Clalit has adopted a decentralized form of organisation, in which the country is divided into 8 districts. Each district has wide scope of independence in decision-making. The districts vary in size from some 340,000 patients to over 600,000 patients, and are responsible for a varying number of GP clinics, ranging from 60 to more than 180. Budgeting is based on a capitation system.





* By Ran Balicer, based on Israel Central Bureau of Statistics data

Clalit is probably the best international benchmark for the potential of delivering truly integrated services to a local population, within a publically funded system. They have radically reduced the costs of acute care per capita, whilst also increasing the expenditure on community and preventative care and are now an outlier internationally in terms of their health expenditure per capita.

In the UK example above, the financial impact of each proposed or currently operational initiative was modelled to generate a cumulative impact for the transformation delivered under the new commercial model. This level of modelling provides a system wide view on the individual impact of schemes across organisations; giving decision makers insight on the financial implications of "industrialising "or decommissioning schemes.

As a detailed transformation plan, including details of proposed initiatives, is not currently developed in Walsall, we have drawn upon these two comparators to provide an outline of the potential savings that could be achieved following implementation of the new model and associated transformation.

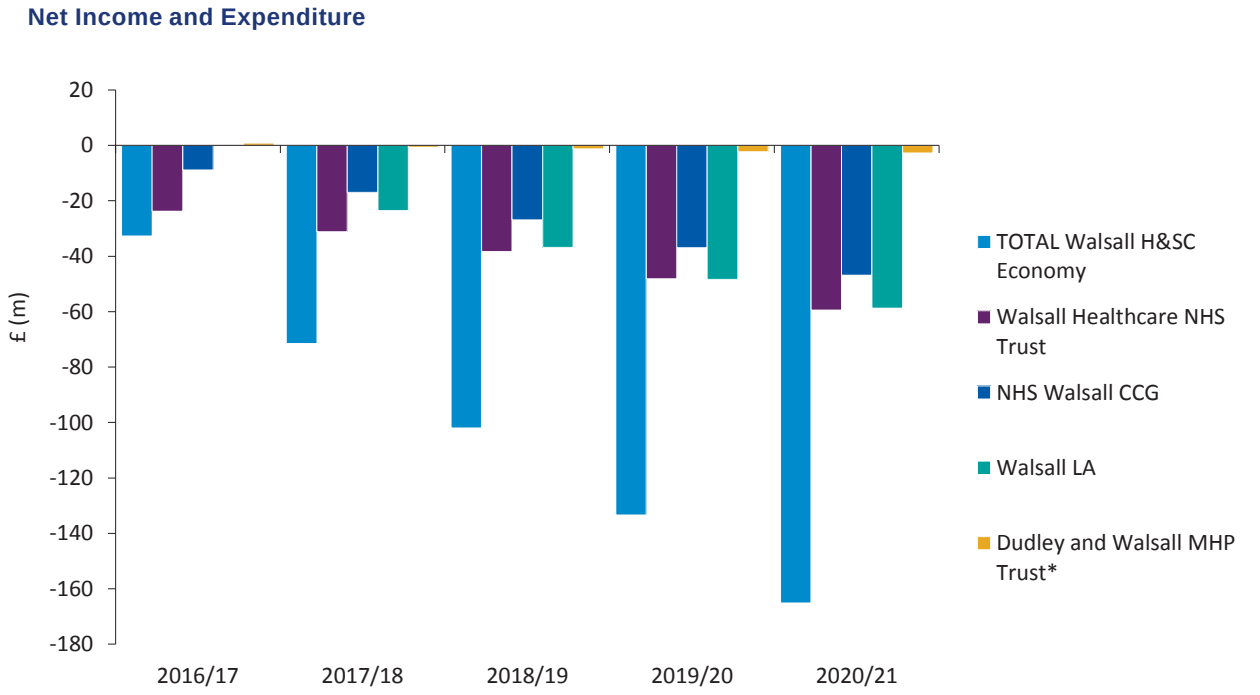
Table 4 Summary of UK and International comparators

System	Population	Acute	Community Services	Payment model	Outcomes
Walsall	272,000	Single acute provider; 2 alternative providers nearby.	Provided by the Acute and Mental Health Trust.	To be decided- Alliance model proposed	Potential outcomes yet to be mapped.
UK example	260,100	Single acute provider.	Provided by the Acute Trust.	Accountable Care Pilot.	Projected 8% decrease in cost to deliver services by 2027/28.
International example	8.6 million; split into 8 districts [Rob to confirm]	Facilities in each district; serving populations of between 340,000 and over 600,000.	Facilities in each district; serving populations of between 340,000 and over 600,000.	Beverage Model with capitated budgets.	Increased spend on Community Clinics and Preventative Care by 12%. Delivered a reduced Hospital spend by 20%. Almost 50% less expenditure per capita $ than the UK.

3.4.1 Projected financial impact

An initial "Do-Nothing" forecast made during 2016/17 predicted a Walsall health and care system deficit of £165.1m by 2020/21. This would increase Walsall's contribution to the Black Country STP deficit position from 17% to 20% and is illustrated below.

Figure 10 'Do-nothing' financial forecasts from 2016/17 for local providers and whole system. In each case organisations have implemented programmes to mitigate these projections



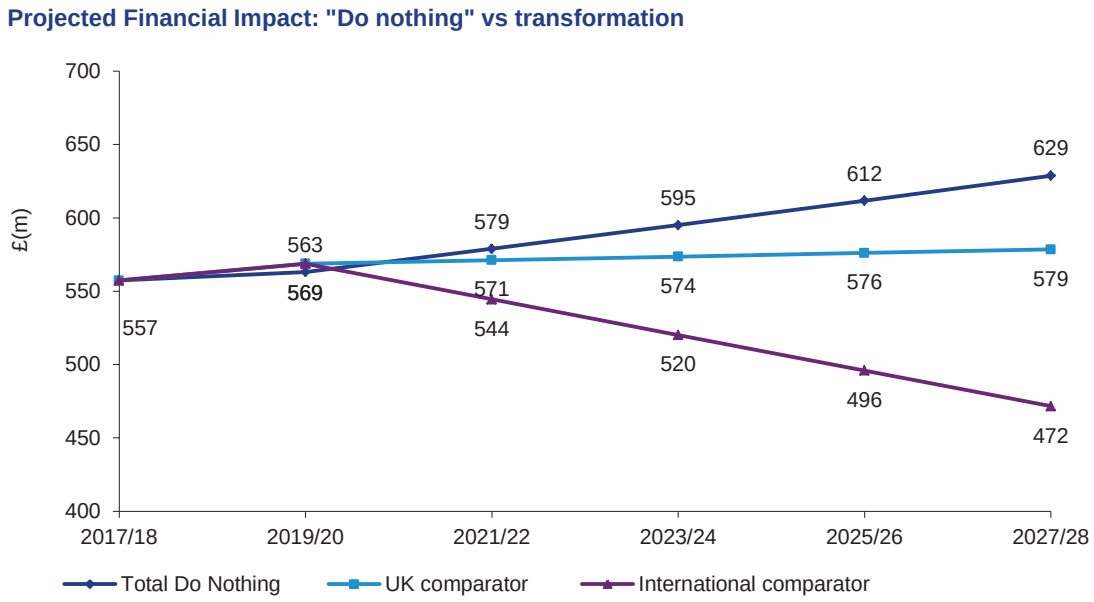
*Being 50% share of Trust's I&E plan

Using the high level data available for the periods 2017-2019 for the Walsall Health and Care system, an assumption can be made that spending increases by 2.8% over a 2 year period. This figure was used to forecast a whole system spend of £628.82m for the period 2027/28. This illustrative increase of 12.83% equates to an additional funding requirement of £71.49m over the next 10 years.

This high level example of increased spending is based solely on current forecasted spend and is likely to be a reserved estimation based on the extreme financial pressures and associated cutbacks being made by the Walsall health and care system.

In the absence of identified transformation initiatives to be implemented, modelling undertaken elsewhere was mapped on to the financial forecasts for Walsall. In the figure below, we use the two comparators given above to illustrate how system wide transformation can bend the cost curve. In the UK example a realistic reduction in overall spend of 8% was forecast based on the proposed transformation scheme, while the international system was able to successfully reduce their health and care spend by 25%. For Walsall, this would translate to an overall system saving of £50m and £157m respectively.

Figure 11 Walsall Health and Social Care Forecast spend against comparative systems



3.5 Assumptions applied

The data presented here has been provided by Walsall CCG and Walsall Council, however the calculations generated are purely illustrative and are not a substitute for Whole System Modelling. The projected forecast includes an indicative increase spend of 1% spend to cover additional investment requirements. This is to reflect the initial pump priming and ongoing costs associated with implementing and maintaining new schemes. Through full system modelling, it is expected cost of new transformation schemes would be fully costed to allow accurate analysis of overall system cost impact and return on investment.

A realistic reduction of 8% was forecast using the data from a comparable UK Health and Care System. In this scenario, data was gathered across the spectrum of care including activity and financial. This health economy, taking the baseline figures an increase of 40% total cost was forecast by 2027/28. This included activity increases of; 10% in acute, 8% in Primary Care, 30% in Adult Social Care activity and 5% in mental health.

By identifying initiatives to be deployed, such as social prescribing, community bed provision and population management hubs, it was possible to map the impacts of these over a period of 10 years; taking into account the cost of implementation. Taken as a whole, this programme of transformation was shown to decrease the overall system cost by 8% by the year 2027/28. Due to the similarities with Walsall, including population and distribution of providers, this is a good benchmark for the impact that could be seen locally.

In the international example, which has seen a reduction in total spend of 25%, data has also formed a large part of the success. Alongside the provision of health and social care they have established a research institute, which uses the population data for research and the development of new drugs, techniques and tools. This has enabled them to not only track the effectiveness of interventions and

policies and act accordingly, but also refine diagnostics and preventative medicine based on the evidence of their efficacy.

Following an appraisal of four contractual models, the WTPB have selected "Host Provider" as their preferred model. In this model the Host Provider is contracted by the commissioner to deliver a range of health and care services. The Host Provider then subcontracts with other providers in order to deliver the services beyond their sphere of activity. The Host Provider is accountable to the commissioner and bears all risk; allowing gains/losses to be distributed to other providers via the contractual arrangements.

4 contractual and Governance Arrangements

4.1 Introduction

Two further workshops were held focusing specifically on the contractual issues, risk sharing arrangements and governance. Following the later of these two workshops, there remained some uncertainty on which model would best serve the needs of the population and also how these would impact local organisations. As such, a supplementary review was prepared called *Walsall Alliance Model Options Analysis* (Appendix 3), which was provided to the WTPB on the 8 January 2018. This report detailed four commercial models and the impact of these on each individual organisation in Walsall. The four options appraised are summarised below:

1) Alliance

An Alliance provides a flexible but contractual agreement between providers and commissioners. The Alliance contract sets out the budget, terms and risk sharing agreements, while master service agreements govern the delivery of different transformation schemes. This flexible model allows for incremental growth, but can be at risk of unilateral decisions.

2) Host Provider Model

In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale. In this model the commissioner holds a single contract with the Host Provider. The proposed arrangement for Walsall requires the Host Provider to establish a separate Partnership Board, with its own distinct executive management team and governance arrangements. Further work will be required to set out this arrangements.

3) Accountable Joint Venture (Corporate)

This model involves the creation of a new legal entity between providers, which singularly contracts with the commissioners. Creation of a new entity does carry a longer timeframe and greater resource investment to implementation, however all providers are equitable; increasing alignment, contribution and collaboration. Alternatively. Joint Ventures can be purely contractual, which does not require

formation of a legal entity. Financial and contractual arrangements can then be retained, flexed or delegated to the joint venture as required.

4) Fully Incorporated Model

An example of an Accountable Care Organisation (ACO) whereby all providers would merge into a single organisation (which could either be a new organisation or existing organisations could be absorbed into a single entity). There would be a single contract between providers and commissioners, however the new organisation may still subcontract services when necessary. This model streamlines decision making and management and simplifies risk sharing. Often an end state target, as difficult to implement initially and gain buy-in.

4.2 Impact on Commissioners

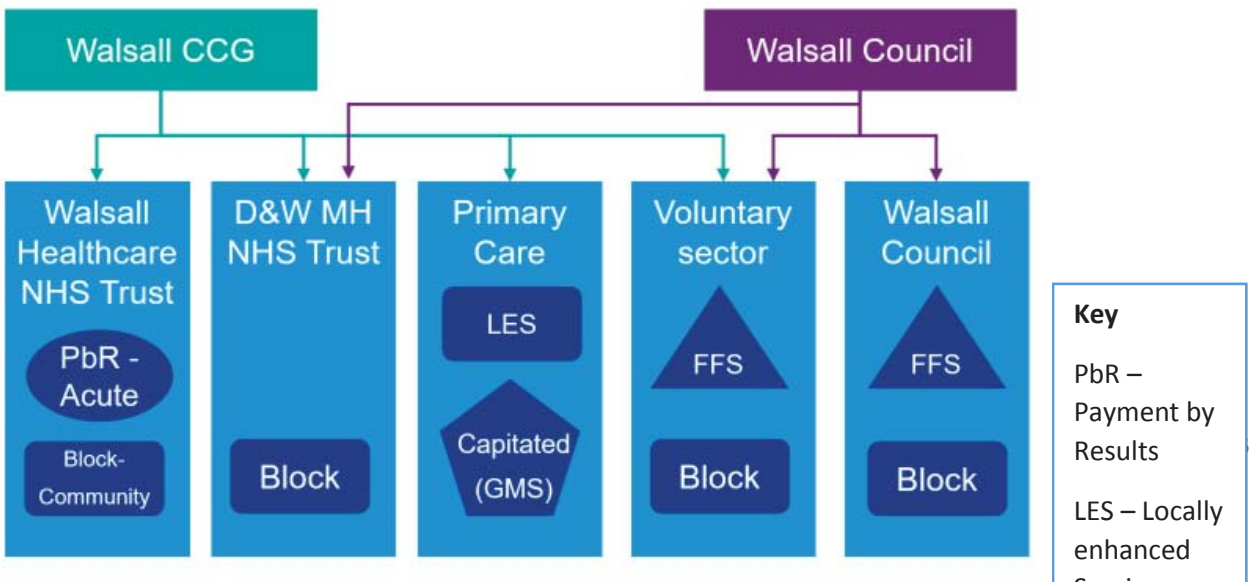
The development of a new commercial model will facilitate innovative new ways of provider working however it also provides a unique opportunity to simplify and streamline commissioning processes. As seen in Figure 13 below, currently both Walsall CCG and Walsall Council hold a range of contracts with multiple providers. The devolution of some commissioning functions from the CCG and Council (Social Care) into a new provider model is supported by local commissioners and will allow those providing patient care to have much greater control over how it is delivered. It also reduces duplication in the system and can increase the pace at which new initiatives are implemented. There are two key next steps in relation to commissioners:

- Commissioning functions that would be appropriate for transferring into a provider model will be identified and agreed as part of the ongoing programme development.
- Agreeing the form of commissioning between the commissioner and the providers (with their increased functions).

This leaves an important and residual set of strategic commissioning functions which could operate across Walsall, but are unified from currently disparate organisational arrangements. This means there are opportunities for the Council and CCG to join up their commissioning intentions, to aggregate regional CCG commissioning and to ally with specialist commissioning. The incorporation of the existing governance arrangements to facilitate this joining up is an action form this paper; for example the oversight of the Health and Wellbeing Board.

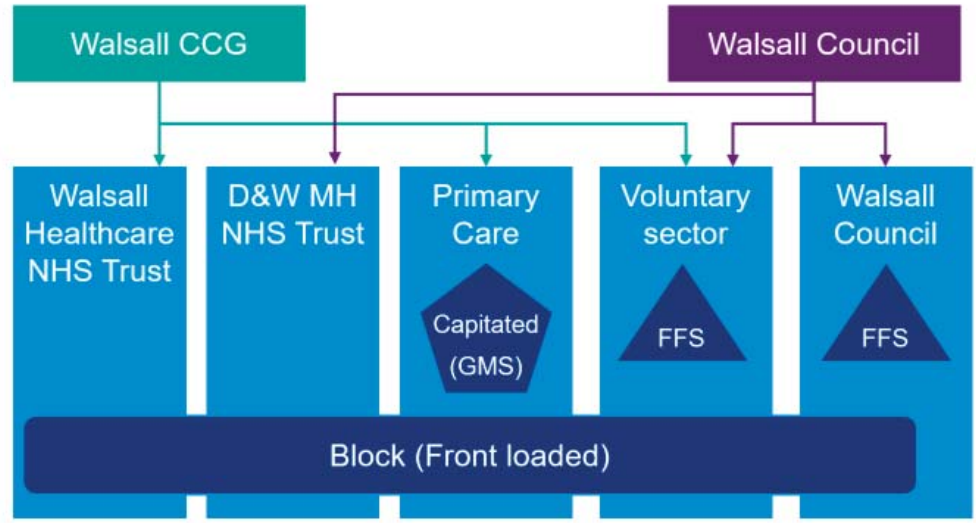
4.3 High level options for commercial arrangements

Based on similar work elsewhere, we expect that Walsall will have a period of transition between current state and the desired end state. This is likely to involve unique contracting arrangements to provide



assurance to the commissioners and allow providers to adapt to new ways of working before adopting more radical long-term, risk sharing contracts.

Figure 13 Payment models and contracting with partial integration



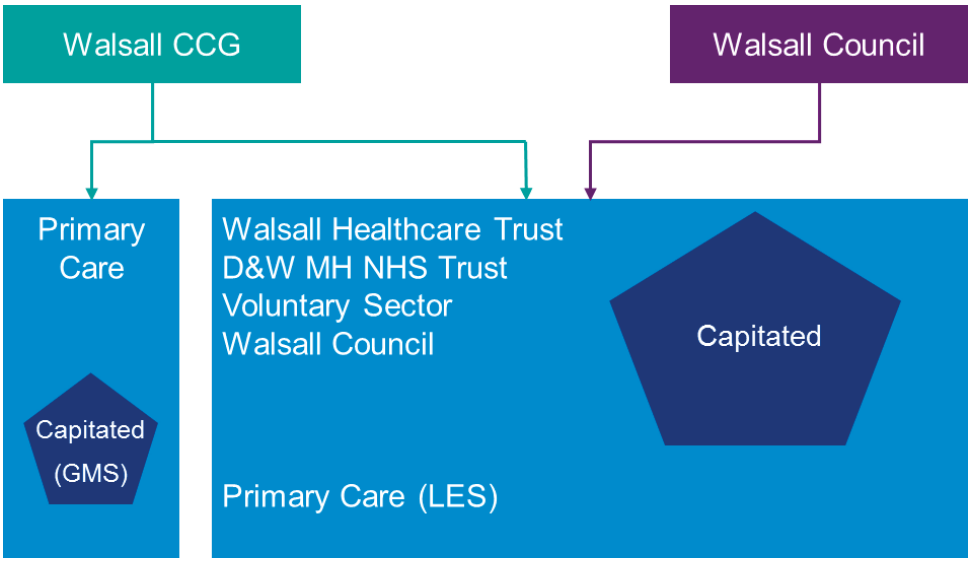


Figure 14 Payment models and contracting with full integration (excluding the GMS contract)

- Opportunity to increase the resource and allocation on LES as part of the new model

These system outlines are described in more detail below:

Option	Description	Benefits	Disadvantages	Alignment with ACO

				roadmap
No integration	Current state. Each organisation has multiple service contracts with differing payment mechanisms.	No amendments to existing arrangements required.	Does not incentivise collaborative or integrated working.	The current model is financially unsustainable and will have guidance imposed if a local solution is not proposed.
Partial integration	a) The WHT contracts (Including Community services) held by the CCG will be integrated in to a single block contract. b) The WHT and DWMHPT contracts will be integrated in to a single front loaded block contract. c) All contracts from the CCG (excluding GMS, but including LES) will be integrated into a single block contract. d) All contracts with the CCG (excluding GMS, but including LES) and those from Walsall Council (Adult Social Care, Children's Services, aspects of Public Health) will be integrated into a single block contract. In all above options, one year contracts will be signed with a binding risk share agreement and the block payments are payable in instalments.	a) WHT is incentivised to invest in Community Services. WHT is empowered to make decisions regarding their budgets and spending. b) Primary, Community and Acute incentivised to collaborate. Enables the journey towards full integration with capitated budgets.	There is less scope for all organisations to transform as some of the existing barriers to closer collaboration will remain in place (such as separate budgets and performance targets).	This contracting structure is an extension of the ACS structure where the commissioners integrate their service contracts under a single payment mechanism. The commissioners may operate a pooled budget.
Full integration	A single contract is implemented for all Walsall contracts, underpinned by a capitated budget. This contract structure supports the implementation of an ACO lead provider model.	Providers are incentivised to collaborate. Implementation of a capitated budget enables providers to make decisions on where they invest. Providers will be	Requires a long transition period to achieve full integration.	Full integration of contracts enables the implementation of an ACO. Some of the commissioning functions may be transferred to the ACO.

		incentivised to invest in low cost settings.		

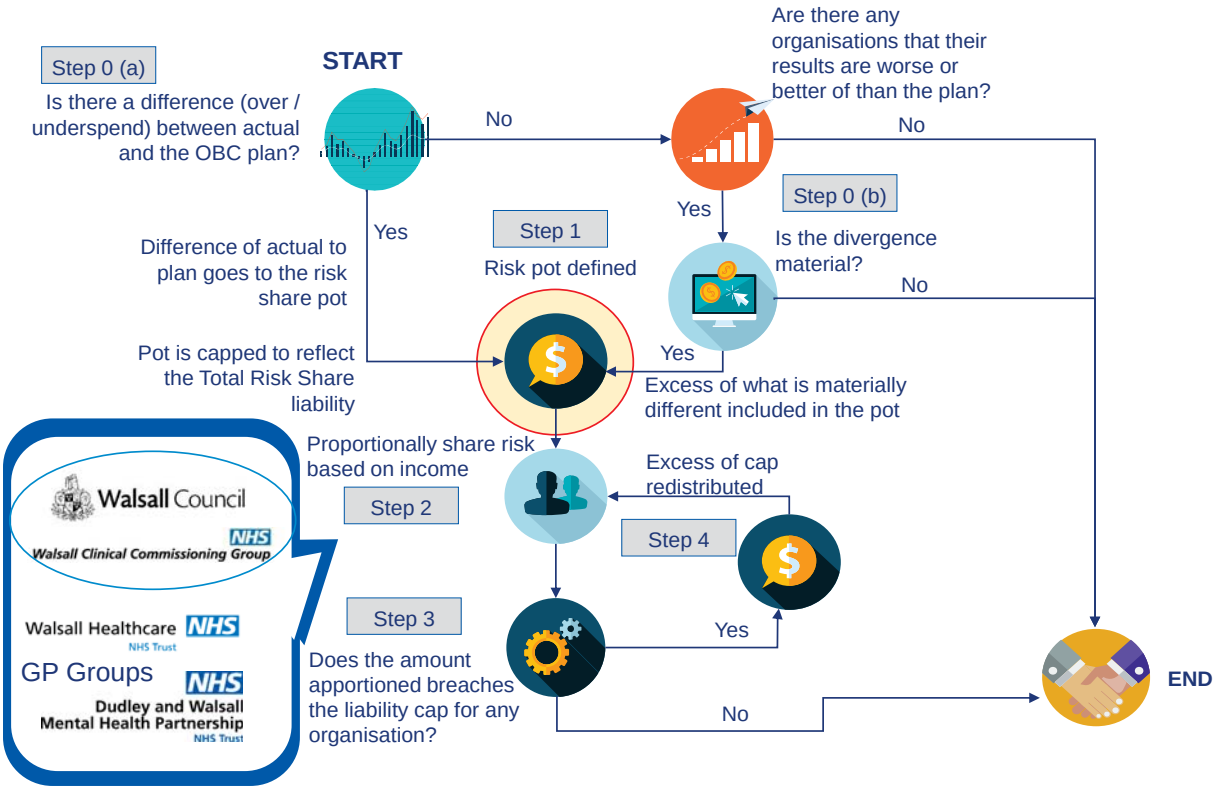
4.4 Agreed contractual principles

A workshop was held on 08 December 2017 to discuss the principles of a range of contractual arrangements that could be put in place between the providers; including the associated risk sharing arrangements. This workshop included a high level overview of the variety of payment models, many of which are used currently in Walsall, but demonstrated some of the innovative new ways these payment models are being deployed elsewhere. While contractual requirements are relatively inflexible, by utilising a range of payment models to deliver agreed outcomes, Walsall can dramatically alter how care is delivered.

In addition to this workshop and following the later circulation of the *Walsall Alliance Model Options Analysis* (Appendix 3) document, the WTPB have identified the 'Host Provider' model as the preferred route forward at this stage. There remains significant work to be completed prior to a new model being adopted, not least the identification of the Host Provider, and as such the details such as contractual arrangements, payment and risk sharing options remain to be discussed at a later date. However the WTPB reviewed and established design principles for risk sharing in Walsall and an example risk process has been circulated.

Figure 15 Design Principles for Risk Share

Figure 16 Example Risk Share Decision Making Process



The process flow detailed above demonstrates how gains and losses in the model can be shared proportionately amongst its members. Fundamentally, a risk share agreement should ensure that no individual member "loses out" and that the system benefits as a whole. This can be applied to a range of contractual arrangements, including a Host Provider model, with terms laid out in each contract.

4.5 Key contractual matters

Each of the health and care providers that participate in Walsall Together have a series of bi-lateral contracts between themselves and the commissioners of those services (including Walsall CCG, Walsall Council and NHSE). There is a long-term ambition to move to a simplified contractual structure and potentially to a contract based on capitation for the local population of Walsall. However, it was agreed that in the next 12-18 months it was unlikely that these contracts could feasibly be replaced and so the short to medium term aim is to reach a commercial agreement that will sit on top of the existing bi-lateral contracts as a separate contract (a 'wrapper' contract).

Figure 17 A new model will require a cultural shift from transactional to cooperative

Differences of worked risk sharing mechanisms		
Australian Alliance	**Walsall Together Alliance**	**PFI Style Contracting**
No cost/risk share, only gain share		Only risk allocation, gain remains with each organisation
No blame culture		Each organisation separately responsible for specific risks
Risk shared 50:50 between Commissioners and Providers		Risk is undertaken by the party best able to manage the risk
Overall system view		Organisational view
Open book accounting		Closed book accounting
Parties work together to solve issues		Organisations working separately and in some cases in competition (lead provider)
Principles based approach		Rules based approach

4.6 Proposed governance structure

A further workshop on the 4 January 2018 was held to provide opportunity for organisations to challenge a proposed governance structure, based on similar models elsewhere but with Walsall specific judgements remaining to be made. These included the role of the CCG as commissioner, Walsall Council as a provider/commissioner and also the involvement of One Walsall, the third sector body.

Until this point and as requested by Walsall CCG, Walsall CCG had been indirectly involved in discussions, with these instead being led by the members of the Provider Board. Walsall Council and Public Health parties were therefore involved in their provider capacity, rather than as commissioners. However, over the course of the consultation period, there was a reflection from the group that commissioner

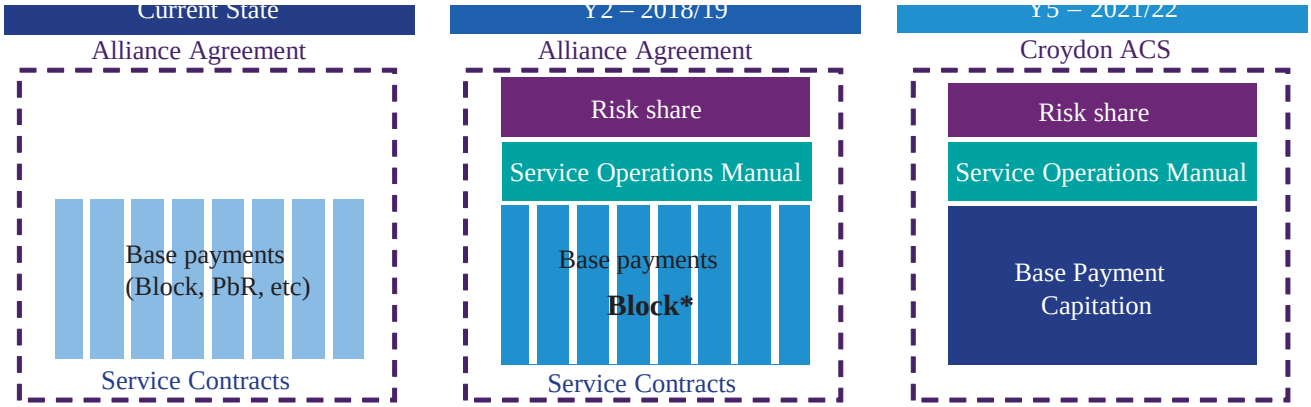
involvement would increase momentum and also ensure greater alignment between providers and commissioners when a proposal was to be made to regulatory bodies. Consequently this workshop had greater commissioner representation than previous workshops, which provided the opportunity to challenge the viability of options directly.

Some of the options explored included:

- Developing the commercial model(s) for Walsall including the organisational form for provision and the contractual framework, payment model and approach to risk sharing. The broad expectation is that transition this will involve integration of current contracts under a new commercial structure with consolidation of funding streams under a capitated budget. However, there are key questions still to be resolved are about scope and phasing of integration and the implications for individual commissioners and providers.
- Strengthening system governance in Walsall to formalise partnership working between commissioners and providers and to facilitate collective system leadership. This was seen as particularly important during transition to the new commercial model(s) although it may continue to play an important role in facilitating partnership working in the end state.

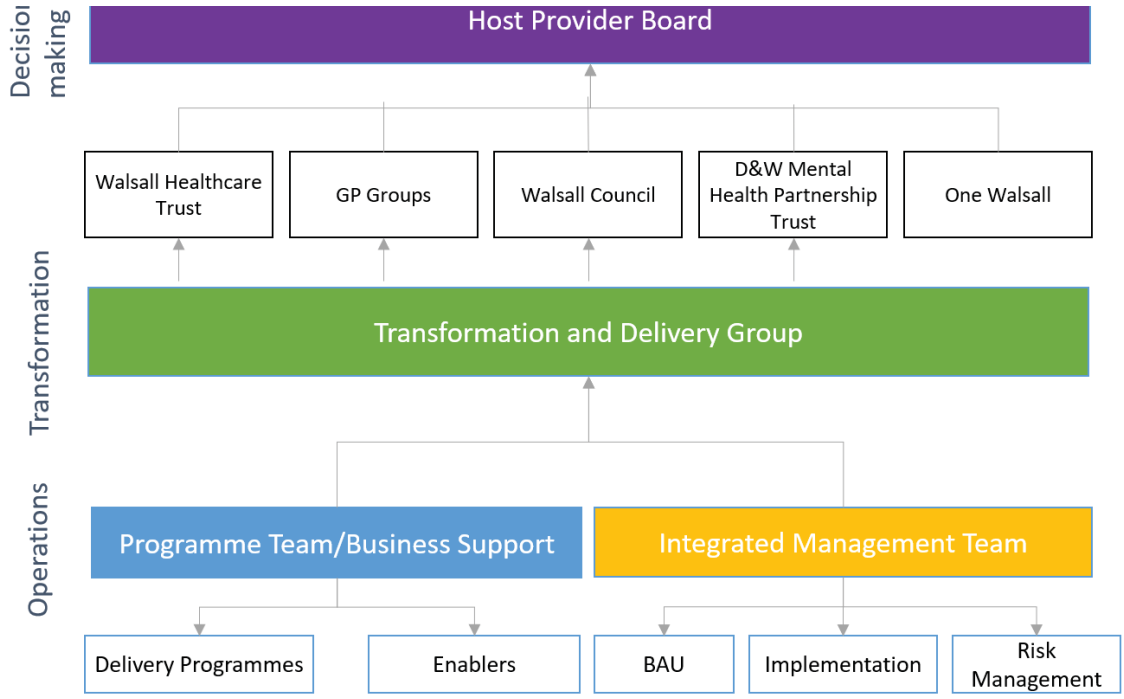
A key conclusion from the workshop was that further work is needed to agree a shared vision for the end state commercial model and the roadmap for transition. This will require appraisal of options for the end state and transition for the system as a whole and from the perspective of individual partners. The diagram below sets out an overview of the transition path for establishing an Accountable Care System in Croydon where the transition is being facilitated through a Commissioner/Provider Alliance.

Figure 18 Transition path for developing the commercial model for the Croydon Accountable Care System (ACS)



In the interim there is support for taking immediate action to strengthen the existing programme governance for Walsall Together, drawing learning from the Croydon model of a Commissioner/Provider Alliance. This approach is illustrated in the diagram below. The role and functions of a Commissioner/Provider Alliance would be expected to evolve over the transition period and some functions may transfer to the provider organisation(s) over time as the new commercial model is implemented. The case for continuing with any form of Commissioner/Provider Alliance would need to be reviewed for the end state.

Figure 19 Option of establishing a Walsall Commissioner/Provider Alliance to strengthen system governance and facilitate collective leadership of the transition programme



4.6.1 Host Provider Governance

The following principles have been agreed for the governance of a proposed Host Provider:

- The Host Provider should provide a safe place for governance – providing confidence for commissioners and providers;
- The Host Provider will support a Board which is representative of all of the provider organisations*;
- The Host Provider will agree an approach to delegated authority for services within scope as part of the development of the Host Provider model.

*As the cornerstone and front door of the NHS, the WTPB has always recognised the importance of Primary Care involvement and GPs will continue to play a crucial role as the programme develops, for example providing clinical leadership during design of the Clinical Operating Model. It is also essential that a Primary Care representative continues to sit on the Board. However due to the unique nature in which Primary Care is delivered, there is a challenge for the Board in achieving a single 'Primary Care voice', as individuals GP practices will each continue to deliver their own GMS contract as commissioned by the CCG. The GP Leadership Group has started to bring together the different GP partnerships and Federations, however there are a number of GPs that remain outside of the GP Leadership Group.

The GP Leadership Group will need to consider what amendments to structure and process are necessary to strengthen the 'Primary Care voice' and to ensure the Primary Care community is represented at the Board. An enabler to this will be adequate resourcing as referenced in section 5, however the expected

outcomes and deliverables from this arrangement must be identified in order to keep pace. It should also be acknowledged that the task of 'unifying' 59 practices into a single perspective is not a small ask and that while significant resources will be invested in achieving this, there may still remain some outliers.

A dedicated PMO and accompanying budget to support its functions is to be identified and effected by April 2018 to build on the momentum generated throughout this process. The PMO Lead will report in to a Board with equal representation from all organisations; likely to be the WTPB in the interim, prior to the Host Provider being identified. Once established, the Host Provider will continue to defer decision making responsibility to the Board, who will oversee 7 identified work streams. Each work stream will have a dedicated team and include where necessary specialist/external support; managed by a Works Stream Lead, who report will report directly in to the Board.

5 Leadership & Programme Management

5.1 Introduction

This paper provides a clear starting point and direction for future progress, with identified next steps to deliver system level transformation. In order capitalise on the momentum, strong alignment and shared ownership developed thus far, it is essential that dedicated resource is made available to the programme. This has support from both the WTPB and local commissioners; demonstrating the commitment to this vision from a system perspective.

Nevertheless, the support of individual organisations and individual providers of health and care is integral to the success of the programme, and as such, there remains considerable internal discussions to be had by the partner organisations and with our Primary Care colleagues. The benefits case must be clear why the proposal presented here is the right one for Walsall and the input from colleagues will be invaluable in shaping the programme design and delivery.

In reflection of this, the proposals for programme management presented here are approximate based on the current understanding of requirements and may change in response to changing needs.

5.2 Programme Management Arrangements

5.2.1 Board

The proposed Host Provider Model reflects the partnership mind-set held by the WTPB and the commitment to continuing to build on the strong relationships developed between providers of health and care in Walsall as part of the WTPB. This will be leveraged immediately with the current WTPB members assuming the Executive Board role from February 2018 in the interim. One of the first tasks of the Board will be to identify the Host Provider; which will provide a “safe-home” for governance. The Board will then move across to sit within the Host Provider; however the membership will continue to reflect the partner organisations, with equal representation and most importantly retain its decision making authority over the programme.

It is expected that continued Primary Care representation at Board level will be supported and facilitated by the CCG in relation to agreed outcomes and deliverables, however the terms of these arrangements are yet to be discussed.

5.2.2 Project Management

A dedicated, full-time Leadership & Project Management Office (PMO) will provide the necessary project management support over the next 12 months to ensure the programme moves into delivery by April 2019. It is expected that this would be resourced by at least 3 Full Time Equivalents; with one FTE assuming the Chief Office role for the PMO and the delivery of this programme.

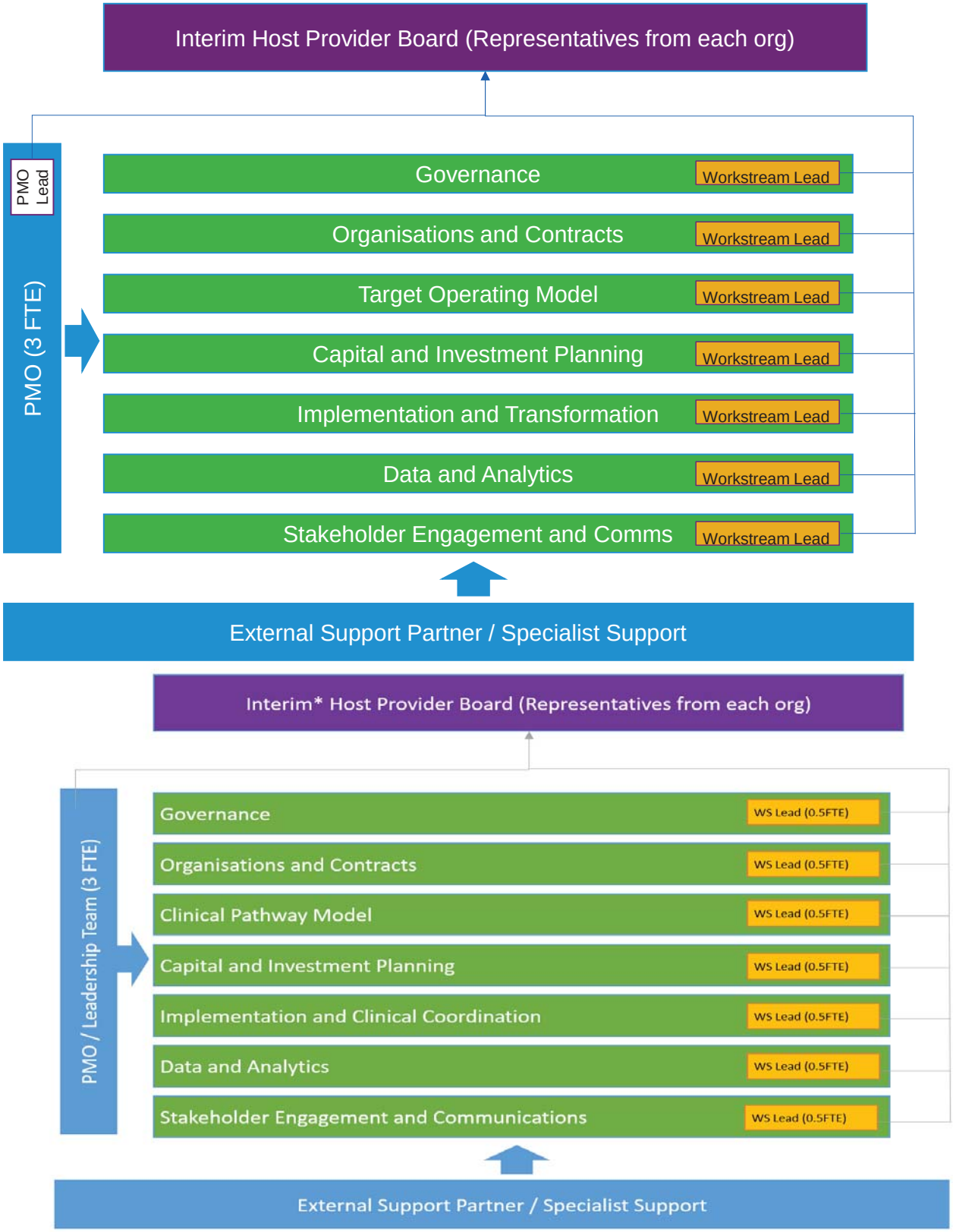
5.2.3 Work Streams

The next steps laid out in this document reflect the level of ambition of the proposal and also go some way to outlining the amount of work required to deliver the programmes' aims. As such the next phase is crucial and requires strong leadership. We have identified seven work streams which will be driven by team, with an identified lead who will have experience in that particular field, to move into delivery by April 2019. These teams will require support and steer from the PMO throughout and will draw upon specialist advice and/or external services as necessary. The work streams are as follows;

- Governance;
- Organisations and Contracts;
- Clinical Operating Model;
- Capital and Investment Planning;
- Implementation and Transformation;
- Data and Analytics;
- Stakeholder Engagement and Communications.

The diagram below provides a high level outline of how these work streams will be managed and the reporting structure for the interim arrangements.

Figure 20 Programme Management Arrangements for 2018-2019


Interim Host Provider Board (Representatives from each org)
PMO Lead
PMO (3 FTE)
Governance
Workstream Lead
Organisations and Contracts
Workstream Lead
Target Operating Model
Workstream Lead
Capital and Investment Planning
Workstream Lead
Implementation and Transformation
Workstream Lead
Data and Analytics
Workstream Lead
Stakeholder Engagement and Comms
Workstream Lead
External Support Partner / Specialist Support
Interim* Host Provider Board (Representatives from each org)
PMO / Leadership Team (3 FTE)
Governance
WS Lead (0.5FTE)
Organisations and Contracts
WS Lead (0.5FTE)
Clinical Pathway Model
WS Lead (0.5FTE)
Capital and Investment Planning
WS Lead (0.5FTE)
Implementation and Clinical Coordination
WS Lead (0.5FTE)
Data and Analytics
WS Lead (0.5FTE)
Stakeholder Engagement and Communications
WS Lead (0.5FTE)
External Support Partner / Specialist Support

5.2.4 Roles and Functions

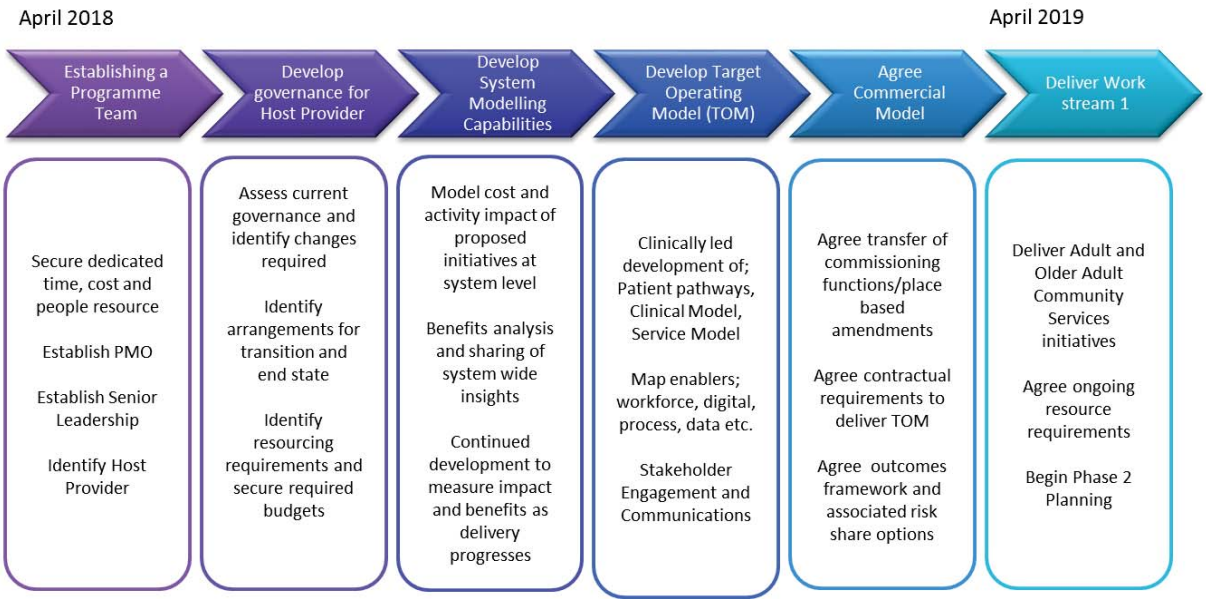
The table below describes in further detail the roles and functions of the groups outlined above. The continuation of some of these roles, such as the Work Stream Teams, beyond April 2019 will be decided as part of the ongoing programme management.

Role	Description
Host Provider Board	In the interim, the WTPB will fulfil this role. As part of the Governance and Organisations work stream, a Host Provider is to be identified and the Board will then sit within the Host Provider, while retaining the equal representation membership from each provider organisation. The Board will provide strategic direction and have ultimate decision making responsibility. The Board will receive regular updates from the Chief Officer and Work Stream Leads.
PMO (3 FTE)	3 Full Time Equivalent. The PMO team will oversee all 7 work streams and work alongside the Work Stream Leads and any External/Specialist advisors.
Chief Officer (1 FTE from PMO)	As part of the PMO function, the Chief Officer will have responsibility for managing overall delivery of the work streams. They will report directly into the Board.
Work Stream Teams	Work Stream Teams are subject to flex and adapt as necessary to reflect the non-concurrent delivery. Each Work stream is managed by a Work Stream Lead with support from the PMO and External/Specialist advisors where necessary.
Work Stream Lead (0.5 FTE)	Each of the 7 Work Stream Leads will have overall responsibility for delivery of their work stream. Each WS Lead will report directly into the Board.
External Support Partner/Specialist Advisors	External and/or specialist advisors will work alongside the PMO and Work Stream Leads as necessary, providing support where internal resource cannot be allocated.

5.3 Project Implementation Proposal

A high level timeline for project implementation and associated tasks is shown below. Development of a detailed timeline will be completed by the PMO function.

Figure 21 Project Implementation Plan



5.4 Stakeholder Communications Plan

A communications plan for the Walsall Together Partnership has been created alongside plans for each organisation to ensure the propositions in this paper are circulated amongst all stakeholders for discussion. Sufficient time should also be allocated to provide stakeholders with a consideration period within which to respond to the Walsall Together Provider Board.

* Denotes formal decision making bodies

5.4.1 Walsall Together Partnership

Group	Date	Lead	Status
Walsall Together Board	31/1/18	Mark Axcell	Listed as an agenda item for verbal update.
Walsall Together Provider Board	7/2/18	Mark Axcell	Main agenda item which will commence approval process of partner organisations. Requires agreement of parties Not formal decision maker
Health and Wellbeing Board *	TBA – could be April Board or a Development session	Paula Furnival/Barbara Watts	Statutory duty to oversee integration at system level and receives /endorses commissioning intentions of CCG and Council
Strategic Partnership Group	TBA	Simon Brake/Paula Furnival	Coordinating group across system No formal decision making powers
Health and Care Overview and Scrutiny Committee	TBA – following Cabinet	Paula Furnival/Barbara Watts	Formal scrutiny of service change

5.4.2 GP Leadership Group

Group	Date	Lead	Status
Walsall Alliance Federation	TBC	Waheed Saleem/Dr Sohaib Siddiq	Briefing and engagement
Palmaris	TBC	Chris Blunt/Dr Bhupinder Sarai	Briefing and engagement
Modality	TBC	Dr Narinder Sohata	Briefing and Engagement
Umbrella	TBC	Greg Bloom/ Dr Ryan Hobson	Briefing and Engagement
TPG	TBC	Ian Rose	Briefing and Engagement

5.4.3 Walsall Healthcare Trust

Group	Date	Lead	Status
Board *	8/3/2018	Daren Fradgley	Decision maker To be phased in the same time period at Cabinet, DWMHT Board and CCG Governing Body
Executives	Underway	Daren Fradgley	For alignment and support
Performance, Finance and Investment Committee	23/2/2018	Daren Fradgley	Conversations underway to bring committee members up to speed
NED's - Board Development Session	29/01/2018	Daren Fradgley	Open briefing for all board members

5.4.4 Walsall CCG

Group	Date	Lead	Status
Governing Body (Private Session)	TBA with Simon	Simon Brake/Paul	Preparation and endorsement for the Governing Body
Governing Body (Public Session) *	TBA with Simon	Simon Brake/Paul Tulley	Decision maker To be phased in the same time period as other Boards
GP Leadership Forum	30/1/2018	Paula Furnival/Daren Fradgley	Is this too early?
LMC	TBA with Simon Brake		TBC
Locality Boards?	TBA with Simon Brake		TBC

5.4.5 Dudley and Walsall MH Trust

Group	Date	Lead	Status
Board *	1/3/2018	Mark Axcell	Decision maker To be phased in the same time period as other Boards
Board Familiarisation	19/2/2018	Mark Axcell	TBC
Executives	Underway and continuing throughout February 2018.	Mark Axcell	TBC
MEXT	February MEXT	Mark Axcell	TBC

5.4.6 Walsall Council

Group	Date	Lead	Status
Portfolio holder	Underway	Paula Furnival	TBC
CEO and ED's	30/1/2018	Paula Furnival	Booked
CMT	February 2018	Paula Furnival	TBC
Cabinet /CMT	March 2018	Paula Furnival	TBC
Cabinet *	TBA	Paula Furnival	Decision maker To be phased in the same time period as other Boards

This document consolidates the progress that has been made to date in both delivering the Walsall Model of Care and the development of an appropriate commercial model to incentivise and animate providers to deliver the phased transformation. There are now three recommended steps for immediate action following approval, to allow the development of a business case over the next six months and to prepare to deliver the first work stream by April 2018/19.

6 Recommended Next Steps

This case for change has moved the system to a point where it understands at an outline level the direction of travel for delivering more integrated health and care services in Walsall. However the work has also shown that there are critical gaps of knowledge within the Walsall system that will enable the Host Provider governance structure to become more accountable, deliver transformation at a system level and truly join up care – with the full buy-in of all stakeholders.

We are therefore recommending that the WTPB, must now undertake a more detailed business planning process (to include a business case for consideration with NHS Improvement that all stakeholders can sign-off on). Within this process we are recommending that the leadership structure agree three immediate actions:

1) Establishment of a programme team, with an interim programme structure akin to that shown below, with access to dedicated resources to run the detailed development process;

    a. Agreeing resource allocation and budget;

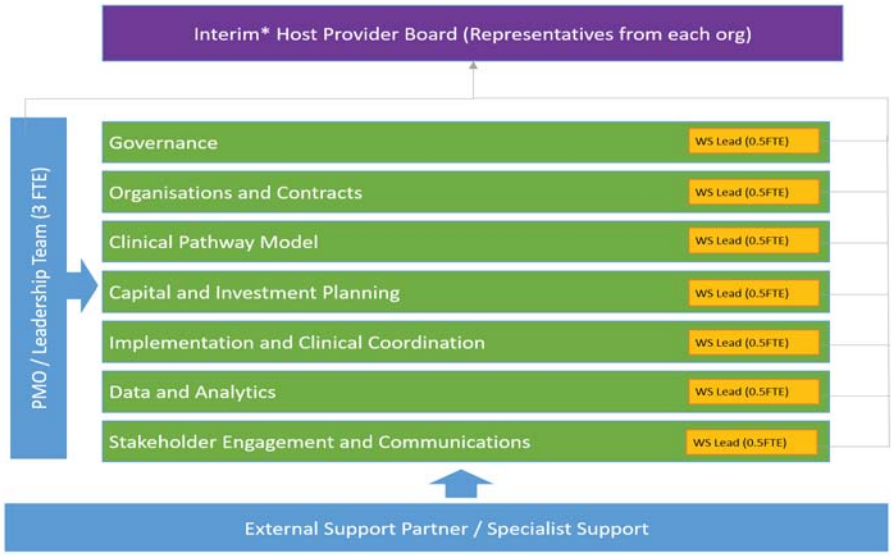
    b. Establishing a new senior tier of leadership;

    c. Establishing a dedicated PMO;

    d. Developing a stakeholder engagement and communications plan; including the public and

Figure 22 Proposed Interim Programme Team Structure

regulators.



**The Walsall Together Provider Board to fulfil this role until Host Provider Arrangements agreed.*

2) Within this structure the development of a business case for consideration with NHS Improvement within the next six months, to include the following priorities:

   a. Clearly defining the governance structure of the host provider model, with roles and responsibilities well defined and clear lines of accountability between the host provider, commissioners and the provider supply chain;

      i. Understanding existing governance implications in consequence of adopting a new integration model;

      ii. Identifying and securing resource requirements to support proposals;

      iii. Agreeing how the different priorities of governance can enhance the improvements in wellbeing (such as political accountability);

   b. The development of a comprehensive, Walsall wide financial model for the system. This should include:

      i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the "do nothing scenario" for the future;

      ii. Strengthening relationships amongst stakeholders and building confidence in the system that change is both necessary but also possible;

      iii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific "do something" scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

      iv. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

c. The development of a comprehensive, Walsall specific Clinical Operating Model (COM) for the future state system of health and care in Walsall. For us, it is critical that a system wide Target Operating Model in Walsall is clinically-led and developed in collaboration with existing service providers and users, with new experiences and knowledge embedded within the wider team. Furthermore the existing model and current service design projects should be challenged as part of this process in order to improve quality and achieve sustainability. To achieve this, we believe that a number of layers need to be collaboratively worked through, to achieve clarity in developing the TOM:

    i. What are your desired end user experiences across end to end health and care delivery?

Figure 23 Developing a Clinical Operating Model

    ii. How will these be delivered through an optimised clinical model/professional workflow?

    iii. How will service models support that workflow end-to-end?

    iv. Do you have the enablers, including workforce, in place to deliver on the future state service models?

    v. How will the Host Provider Board/contractual arrangements ensure the commissioned services are delivered? What incentives and risk sharing options will facilitate the integrated working?

    vi. How will these pathways grow? Can successful initiatives be “industrialised”? Can they be expanded to deliver to the whole population?

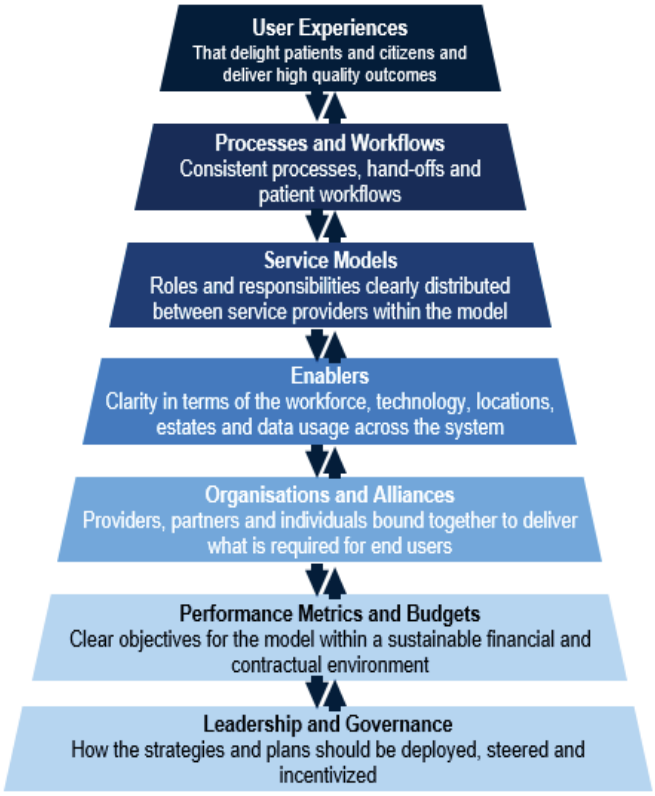
    vii. How will you manage performance and ensure that the money works in the system – and can you transition to this future state?

d. Agreement on the commercial model for Walsall and the roadmap for transition. This will include:

i. How the provider organisations operate alongside the Host provider to deliver the TOM;

ii. Agreeing which commissioner hosted functions can be transferred to the Host Provider, such as IT and support functions;

iii. Agreeing an integrated place based commissioning arrangement across the CCG , Council, and Public Health;



iv. Creating an agreed outcomes framework and associated risk share arrangements;

v. Agreeing the allocation of financial resources to facilitate delivery of transformation phases.

And finally;

3) The creation of a budget and resource commitments to support both internal and external inputs to the process over the next six months. These are broken down as follows;

Internal requirements:

a. Dedicated director time (1FTE);

b. Support for the board meetings/governance;
c. PMO provision, including a Chief Officer;
d. Nominated Work Stream Leads (likely part time);
e. Communication and messaging support (0.5 FTE);
f. Clinical time for backfill for those tasked with delivery;
g. Circa £115k to facilitate Primary Care participation and clinical time release (figures based on a previous proposal to the CCG by the GP Leadership Group);
h. Commitment from organisations to free up resources to participate in the process during the next stage.

Whilst this represents a significant internal investment for the partners, it is fair to say that it builds on the significant commitments that have already been undertaken and the goodwill shown by all to participate in the process.

External requirements:

a. Light touch external support around further definition to the governance structure, but to include legal advice that will ensure satisfaction of the regulatory environment;

b. Significant support to the development of a comprehensive, Walsall wide financial model for the system. This should include:

    i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the "do nothing scenario" for the future;

    ii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific "do something" scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

    iii. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

c. Significant support to the development of a comprehensive, Walsall specific clinical operating model (COM) for the future state system of health and care in Walsall. This to be developed through the initial priority care areas that have been identified and likely working with a "model community" that could then become the early/first adopter of the model for their population. This process would need significant clinical/professional input, which is critical to agreeing a shift in care from higher cost to lower cost settings, as well as in designing the future workflows for example.

d. Significant support to agreeing the commercial model for Walsall and the roadmap for transition. This will include:

    i. Scope of organisational or contractual integration;
    ii. Organisational form for integrated provision;
    iii. Contractual model(s);
    iv. Payment model(s);

v. Approach to risk/reward sharing.

While a detailed budget is yet to be created, at this stage it is recommended that a ceiling budget for external support be set at £400k to support the requirements outlined above.

In terms of cost versus benefit analysis, it is clear that there is a significant opportunity to move towards a more integrated delivery model in Walsall. The analysis within this document (section 3.3.1) illustrates a potential for more integrated working to release annualised savings of between £49m and £153m at a system level.

This is a compelling rationale for continued development of the partnership approach as well as the necessary internal and external investment and commitment to shared progress.

7 Appendices

7.1 References

1 Health Evaluation Data 2015/16 against 2014/15 and Q1 2016/17 year on year

2 Masters R, Anwar E, Collins B et al. (2017) Return on investment of public health interventions: a systematic review. *Journal of Epidemiology & Community Health,* 0, 1-8.

3 Dorling G, Fountaine T, McKenna S and Suresh B. (2015) *The Evidence for Integrated Care*. McKinsey&Company.

7.2 Workshop Attendees

Benefits and Risk Share Workshop attendees 30 November 2017

Name	Organisation	Role
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Andrew Griggs	Walsall Healthcare NHS Trust	Programme Manager / Integrated Care
Paula Furnival	Walsall Council	Executive Director of Adult Social Care
Waheed Saleem	Walsall Alliance (GPs)	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Sally Roberts	Walsall CCG	Director of Governance, Quality and Safety
Alex Boys	One Walsall (voluntary sector)	Chief Executive
Barbara Watts	Public Health	Director of Public Health
Dr Anand Richie	Walsall CCG Alliance (GP Fed)	Clinical Chair and GP
Dr Narinder Sohata	Modality Partnership (GP Partnership)	GP
Ian Rose	The Practice Group (Private)	Engagement Lead
Greg Bloom	Umbrella (GP Fed)	Group Practice Manager
Dr Nasir Asghar	Alliance (GP Fed)	GP
Robin Vickers	KPMG	Director
David Bevan	KPMG	Associate Director
Hannah Lewis	KPMG	Associate

Risk Share and Commercials Workshop attendees 8 December 2017

Name	Organisation	Role

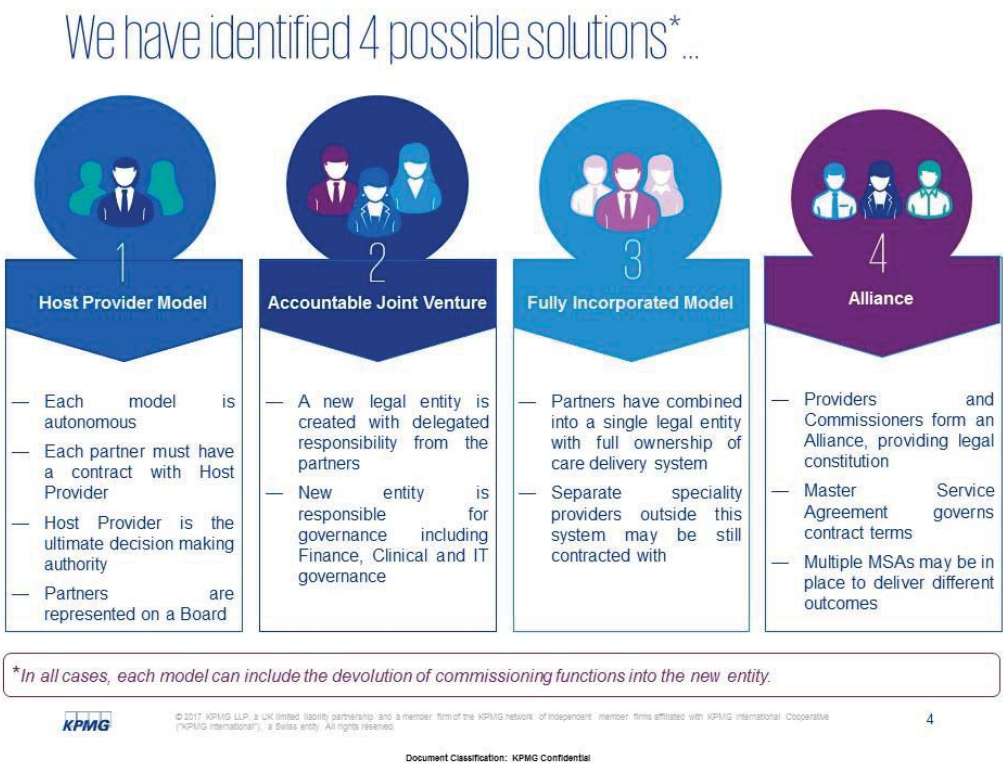
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Tony Gallagher	Walsall CCG	Chief Financial Officer
Andy Griggs	Walsall Healthcare NHS Trust	Project Manager
Waheed Saleem	Walsall Alliance Ltd	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Paula Furnival	Walsall Council	Executive Director Adult Social Care Lead
Rupert Davies	Dudley & Walsall MH NHS Trust	Interim Director of Finance
Paul Tully	Walsall CCG	Director of Commissioning
Sally Roberts	Walsall CCG	Director of Governance, Quality and Safety
Robin Vickers	KPMG	Director
Sebastian Habibi	KPMG	Director
David Bevan	KPMG	Associate Director
Tony Kettle	Walsall Healthcare NHS Trust	Deputy Director of Finance
Paul Stevenson	Walsall Healthcare NHS Trust	Head Accountant

Governance Workshop attendees 4 January 2017

Name	Organisation	Role
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Mark Axcell	Dudley & Walsall MH Trust	Chief Executive and Chair of Walsall Together Provider Board (WTPB)
Andrew Griggs	Walsall Healthcare NHS Trust	Programme Manager / Integrated Care
Paula Furnival	Walsall Council	Executive Director of Adult Social Care
Waheed Saleem	Walsall Alliance (GPs)	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Chris Blunt	Portland Medical Group (Palmaris)	Lead for engagement
Paul Tully	Walsall CCG	Director of Commissioning
Simon Brake	Walsall CCG	Chief Officer
Alex Boys	One Walsall (voluntary sector representative)	Chief Executive
Barbara Watts	Public Health	Director of Public Health
Richard Kirby	Walsall Healthcare NHS Trust	Chief Executive
Sebastian Habibi	KPMG	Director
David Bevan	KPMG	Associate Director

Hannah Lewis	KPMG	Associate

7.3 Extract of Walsall Alliance Model Options Analysis



Alliance Contract Model

Example: Lambeth and Croydon accountable care programmes

Lambeth and Croydon have established commissioner/provider Alliances to improve outcomes and value for defined populations. The Alliance structure provides a framework for joint accountability, alignment of contracts and risk/reward sharing

Commissioners and providers form an Alliance. An overarching Alliance Agreement provides the legal constitution of the Alliance (i.e. contractual joint venture).

- Master Service Agreement sets overarching contract terms e.g. overall budget, outcomes, KPIs, and the framework for risk/reward sharing;
- Commissioners contract with providers within the framework of the overarching Alliance Agreement and Master Service Agreement.

Pros

- The Alliance provides for relationships of 'equal partners';
- The Alliance agreement providers a legal basis for joint accountability;
- The structure provides flexibility on key issues such as scope of transformation and the extent and phasing of provider integration. For example there could be multiple Master Service Agreements governing different service areas or subpopulations under the overarching Alliance Agreement;
- The structure provides a framework within which the governance and contractual form of provider collaboration could evolve (e.g. incremental integration of contracts and/or the emergence of Host Provider arrangements).

Cons

- The governance and contractual structure can be potentially complex;
- Commissioner members of the Alliance may have to continue sharing financial risk with providers;
- Relies absolutely on building and maintaining trust and collaborative behaviours;
- Potentially vulnerable to unilateral decisions to exit the Alliance and/or the failure of individual partners.

Alliance Contract Model: Local Impacts

This option could be implemented within existing organisational structures and would provide a contractual framework for joint accountability, collective decision making, alignment of contracts and risk/reward sharing. The key merits of this option may be as a transitional stage in the development of integrated provider organisations and contractual structures. This option is also potentially viable as an end state solution within which there may be partial integration of provider organisations and contracts whilst other provider members of the Alliance continue to contract bilaterally with the commissioners.

Organisation	Accountability	Impact
Commissioner	All Alliance members are accountable to the other Alliance members under the terms of the Alliance Agreement	Commissioners will contract with providers and share risk/reward within the framework of the Alliance Agreement and Master Service Agreement
Dudley and Walsall Mental Health Trust	Providers are accountable to commissioners through bilateral contracts (albeit that these may be integrated over the life cycle of the Alliance)	Providers will be accountable as Alliance members and through their contracts with commissioners (or as part of a Host Provider or other integrated organisation as/when it emerges)
Primary Care		
One Walsall	Bilateral contracts are subordinate to the Master Service Agreement (i.e. 'contractual wrapper') that is signed by all Alliance members.	
Walsall Council		Some providers may be Alliance members and remain outside of any integrated provider organisation or contractual joint venture that emerges
Walsall Healthcare Trust	The commissioners are obliged to use reasonable endeavours to align third party contracts with the Alliance Agreement and Master Service Agreement where possible	The council may be both a commissioner and provider within the Alliance

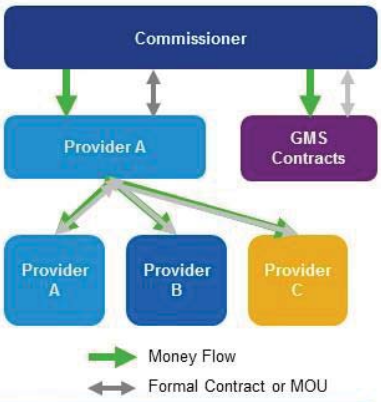
Alliance Contract Model: Local Impacts

As this option may be implemented within existing organisational structures it is likely that statutory duties and employment will remain as now and only change over time if/when integrated provider organisations emerge within the Alliance. For example, this may have implications for provider or commissioner staff (e.g. as commissioning activities transfer to providers and/.or where service provision is governed by a new organisation).

Other key components of the model will be determined by agreement between Alliance members.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Alliance Contract	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside under terms set out in the Alliance Agreement and Master Service Agreement	Commissioner contracts can remain the same but would be governed by the Master Service Agreement and Alliance Agreement	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board	An Alliance Board would be established and all Alliance members would be equal partners. n.b. The Alliance agreement may also provide for Associate Members, albeit that they may or may not be Board members	Board will set strategic direction and facilitate collective decision making under the Alliance Agreement. This would include collective agreement on priorities, transformation plans, risk/reward sharing and the terms of the Master Service Agreement The Board may be supported by an Integrated Management Team and potentially also by a dedicated programme office and/or Strategy and Delivery executive	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board	Likely to remain as now, at least initially, pending the emergence of an integrated provider organisation and/or the transfer of commissioning activities from commissioner to provider organisations

Host Provider Model



Example: MSK, Bedfordshire UK

The collaboration involved an NHS Trust, an NHS Foundation Trust, a third sector organisation and a newly formed corporate joint venture. Each of the participants held a different role in contributing to the delivery of integrated MSK services. The model was used to reduce 'micro-commissioning' of complex care pathways and remove perverse incentives (PbR). Patients are clinically triaged to ensure arrival on the right part of the pathway. Secondary care referrals have decreased and supply chain financial reward has increased.

Commissioner holds one contract with a host provider who subcontracts the rest of services with other providers

- Each provider has a contract or MOU with the host provider;
- host provider cannot 'decommission' services from providers without approval from the Commissioner).
- host provider is responsible for administration of the contract, providing case management and oversight of patient records, monitoring service and quality measures and liaising with the Commissioner.

Pros

- Requires less time and investment for providers to come together, as they can work directly together supported by contracts or MOUs between themselves;
- Using a pre-existing provider with defined governance and decision making processes reduces 'start-up time';
- Enables money to move within the pathway;
- There is a single point of oversight of a contract and entity responsible for delivering agreed outcomes and performance across continuum of care.

Cons

- Success is largely based on collaboration and trust between host provider and other providers. A large risk is if the host provider makes decisions the other providers do not agree upon. May be politically difficult to select a host provider amongst a group;
- All providers must agree to shared savings and risk distribution amongst themselves;
- Possible provider monopoly;
- While the host provider maintains more power, it also incurs more investment (time, money, resources) and risk for that provider.

Host Provider Model: Local Impacts

A Host Provider model can be a quicker and simpler way to implement a new contracting model, as existing governance between the Host Provider and the commissioner is maintained and Primary Care GMS can remain outside of the agreement. Although the provider/commissioner relationship is maintained, elements of commissioning can be delegated to the host Provider.

Organisation	Accountability	Impact
Commissioner	-	Simple to manage as a single contract is required with the LP. Confidence in new model as currently contracting with Provider. Administrative and monitoring costs likely reduced as pass to Host Provider.
Host Provider	**Directly accountable to commissioner**	Greatest time and resource investment both initially and ongoing; would need to consider employment/skill mix to ensure they are able to fulfil contracting, supply chain management and commissioning requirements. To include administrative and monitoring costs inherited from Commissioner. Required to develop MOUs/Contracts with other providers. Has ultimate responsibility for delivery of contracts and will be held accountable by the commissioner. Can maintain existing governance structures and decision making capabilities and enables pathway management.
Dudley and Walsall Mental Health Trust	Accountable to host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Lead Provider.
Primary Care	Accountable to commissioner as holder of GMS contracts and as dictated by MOU/contract with Host Provider for non-GMS functions.	Contract with Host Provider would sit alongside existing GMS contracts. The services as part of the contract would carry reduced risk for GPs, as accountability sits with Host Provider.
One Walsall	Accountable to Host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Host Provider.
Walsall Council	Accountable to Host Provider as dictated by MOU/contract	Potential conflicts with delivering social care if contracted by a healthcare provider. May wish to consider keeping control of commissioning functions. Dependent on initial pathway scope, it may not be appropriate to be included or contribute to the budget, however a board position and collaboration can be maintained until such a point that greater involvement is appropriate.
Walsall Healthcare Trust	Accountable to Host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Host Provider.

Host Provider Model: Local Impacts

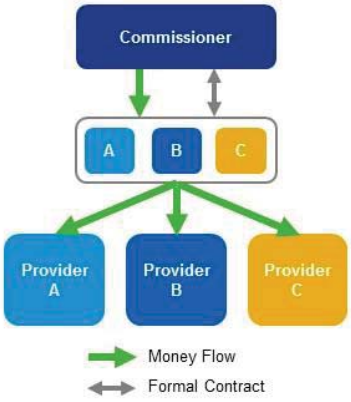
One of the impacts raised highlights the requirements on the Host Provider to manage system risk. If a current provider is selected, this may involve significant organisational change, including the possibility of integration with other providers, which may result in change substantial enough to view the provider as a new organisation.

Consequently it is worthwhile making a distinction between:

- Existing Provider as Host Provider;
- Transformed Existing Provider; capable of managing risk.

Model	Finance	Contracts	Statutory duties	Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Existing Provider as Host Provider	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with Host Provider that then subcontracts to other parties to deliver services it cannot deliver itself	Host Provider only likely to retain statutory duties for functions it can discharge itself	Existing Board of whoever selected as Host Provider	Host Provider existing roles / functions with added responsibility for services now being subcontracted	Unlikely to reduce number and frequency of sub-contractor boards	Staff can be transferred into Host Provider subject to the level of services it proposes to deliver. This could include back office / support staff
Transformed Existing Provider capable of managing risk	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with Host Provider that then subcontracts to other parties to deliver services it cannot deliver itself	Host Provider potentially allocated responsibility for statutory duties due to increased capability and competencies of Board members	Existing Host Provider board refreshed (whether wholesale or in part) so that reflects the new functions.	Host Provider existing roles / functions with added responsibility for services now being subcontracted	Likely to reduce number and frequency of sub-contractor boards as more substantive decisions can be taken safely by Host Provider board	Staff can be transferred into Host Provider subject to the level of services it proposes to deliver. This could include back office / support staff

Accountable Joint Venture



Example: Liverpool Clinical Laboratories (Liverpool, UK)

Liverpool Clinical Laboratories is a contractual joint venture owned by both Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Providers form a new entity (can be a formal or informal arrangement) which becomes the single responsible entity for the management and coordination of services.

- Only requires one contract between commissioners and providers;
- New entity has oversight over objectives, resource allocation, governance, etc. and is representative of participating providers. It is advised that separate work groups be set up to manage Finance, Clinical and IT aspects of new contract.

Pros

- Equitable representation of providers in a new entity, avoiding the need to constantly get provider 'buy in';
- Sharing ownership in new entity can lead to greater buy in to collectively contribute;
- Greater consistency of services provided and integration of care with a new entity providing collective oversight;
- Single provider entity means less contract management and administration from commissioning side;
- Each provider retains its financial and operating autonomy;
- Other providers, such as third sector or community providers, may also be included in the new entity in an informal 'affiliate' way.

Cons

- Providers will need to provide a lot of upfront investment and also time to decide upon representation, decision-making and delegation processes, distribution of any earned shared savings or losses;
- Providers need to endow new entity with enough power to enforce difficult decisions;
- Culturally may be extremely difficult for providers to come together as a new entity.

Accountable Joint Venture: Local Impacts

This model can be framed around specific patient pathways or alternatively focus on whole population; although this is difficult to implement as a first step. The focus may impact which parties are involved, or in the case of Local Authority and third sector parties, which service elements would be appropriate for inclusion. This is the most inclusive and collaborative of the three approaches; recognising the contribution of a range of providers and building on solid partnership working.

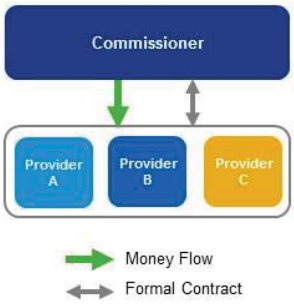
Organisation	Accountability	Impact
Commissioner	-	Most, if not all contracts, subsumed by a single contract with new venture. Risk associated with contracting with new entity and this being stable long term.
Dudley and Walsall Mental Health Trust	Jointly accountable to commissioner	New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Primary Care		Not all GP practices may choose to be involved in an alliance and continued/increased GP buy in may be difficult. Ongoing relationship development between provider partners required.
One Walsall		New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Walsall Council		Decision to be made on which elements would be moved into a joint venture/alliance. e.g Adult Social Care and Children's Services. May be dependent on commissioning functions of the joint venture and the level of control retained over expenditure. New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Walsall Healthcare Trust		New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.

Accountable Joint Venture: Local Impacts

As with the Host Provider model, there are two alternative approaches to a establishing a joint venture/alliance contract; either a contractual or corporate joint venture and the values of each of these should be considered. For example, the corporate joint venture route would result in the creation of a new organisation which can be held to account directly contracted with. There are however implications around tax and legislation if this was the preferred route.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Contractual Joint Venture	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside.	Commissioner contracts can remain the same but there would be a inter-provider contract that would share financial risk and reward of the system performing better / worse than expected	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	Board responsible for allocating funds to projects. Significantly greater potential to take on accountability for performance of business as usual *if* that is the agreement of the providers. The roles however are subject to agreement. The more powers it is given and the money it is given, the more it matters	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board	Remain hired and funded by a host organisation but can join joint teams. The relevance of the host organisation can become increasingly 'nominal' insofar as greater alignment of a System Board with teeth means it is easier to shift to a common culture and get staff to buy in to the vision of integrated working.
Corporate Joint Venture	Corporate joint venture can receive funding	Commissioners can contract with the JV	As above	As above	As above	As above	Staff can be hired by JV but may remain hired by host organisations. There can be tax and TUPE issues related to this model.

Fully Incorporated Model



Example: Geisinger Health System in Northeast Pennsylvania, US

The Gesinger Health System has a more unified and centralised governance structure. Also in the Northeast US, New York Presbyterian Healthcare System in NYC, the University of Pennsylvania Health System and the Johns Hopkins Health System, which are academic health system variants, are a confederation of institutions, clinical centres, and faculty practice plans.

Providers fully integrate/merge into a single new organisational form (e.g., Accountable Care Organisation (ACO))

- New provider group and commissioner hold one contract;
- Integrated provider delivers vast majority of all services with subcontractors as needed.

Pros

- Reduction in management between providers—assuming the integrated entity is functioning efficiently;
- Most efficient model for decision making;
- Greater consistency of care to patients.
- Less politics/no balancing of power between collaborating providers;
- Easier administration/oversight of contract;
- Single provider entity responsible for outcomes and cost;
- No need to distribute risk nor shared savings amongst providers;

Cons

- Most difficult model to set up at the outset. Providers may not want to join. Will require significant investment cost to merge workforce, resources, pathways, estates, etc;
- Commissioners have limited ability to engage in the detail of implementation. Also would be a major liability if the integrated provider failed;
- Patient choice may suffer from a single provider.

Fully Incorporated Model: Local Impacts

For many this model represents a future state rather than an immediate option for change. Although labelled as fully incorporated, it does not necessarily have to involve all organisations in Walsall; some GPs, local authority and third sector services may still sit outside of this. For all parties involved, there will be significant organisational impacts, including staffing implications as the need for individual departments/groups is diminished.

Organisation	Accountability	Impact
Commissioner	-	A single contract with the new entity reduces complexity, however input in to delivery can be limited.
Dudley and Walsall Mental Health Trust	Jointly accountable to commissioner	Obligations as the mental heath provider for the Dudley MCP may exclude the Mental Health Trust from being a fulling integrated partner. The level of involvement/nature of their role and delivery of services would need to be reviewed.
Primary Care		May not be amenable to all GP groups, may increase fracturing and variation in patient care.
One Walsall		May be a joint partner or be subcontracted by new entity.
Walsall Council		May be a separation of care services into the new entity, whist maintaining statutory responsibilities.
Walsall Healthcare Trust		Implications for the Community Services contract currently held by the Trust. Ownership transition to the new organisation/entity.

Fully Incorporated Model: Local Impacts

It should be noted that a fully incorporated model could also refer to the MCP/PACS/ICO models, that many providers are familiar with, alongside the broader ACO/ACS model. The insights below are generic across this range of integrated organisations.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Fully Incorporated Model/Integrated Care Organisation	One organisation receives all funding for in scope services. However, there will always be some services subcontracted or contracted with third parties not "in" the integrated organisation (whether that is the Council or GP GMS funding	One contract (subject to above caveats on funding)	ICO could take on statutory duties	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	ICO takes on all functions	Do not exist for organisations that join ACO	All staff are hired by ICO

7.4 Analysis of commercial models

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Existing Provider as Lead Provider	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with lead provider that then subcontracts to other parties to deliver services it cannot deliver itself	Lead provider only likely to retain statutory duties for functions it can discharge itself	Existing Board of whoever selected as lead provider	Lead provider existing roles / functions with added responsibility for services now being subcontracted	Unlikely to reduce number and frequency of sub-contractor boards	Staff can be transferred into lead provider subject to the level of services it proposes to deliver. This could include back office / support staff
Transformed Existing Provider capable of managing risk	One organisation receives all the money and then passes funding on to sub-contractors.	Commissioners' contract with lead provider that then subcontracts to other parties to deliver services it cannot deliver itself.	Lead provider potentially allocated responsibility for statutory duties due to increased capability and competencies of Board members.	Existing lead provider board refreshed (whether wholesale or in part) so that reflects the new functions.	Lead provider existing roles / functions with added responsibility for services now being subcontracted.	Likely to reduce number and frequency of sub-contractor boards as more substantive decisions can be taken safely by lead provider board.	Staff can be transferred into lead provider subject to the level of services it proposes to deliver. This could include back office / support staff.
Contractual Joint Venture	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to	Commissioner contracts can remain the same but there would be an inter-provider contract that would share financial risk and reward of the	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board.	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be	Board responsible for allocating funds to projects. Significantly greater potential to take on accountability for performance of business as usual *if*	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal	Remain hired and funded by a host organisation but can join joint teams. The relevance of the host organisation can become increasingly

	co-invest in share delivery teams, shared and they will share in financial upside / downside.	system performing better / worse than expected.		operational coverage of the different areas of service delivery.	that is the agreement of the providers. The roles however are subject to agreement. The more powers it is given and the money it is given, the more it matters.	statutory duties but with substantive functions and decision-making at the Alliance Board.	'nominal' insofar as greater alignment of a System Board with teeth means it is easier to shift to a common culture and get staff to buy in to the vision of integrated working.
Corporate Joint Venture	Corporate joint venture can receive funding.	Commissioners can contract with the JV.	As above.	As above.	As above.	As above.	Staff can be hired by JV but may remain hired by host organisations. There can be tax and TUPE issues related to this model.
Fully Incorporated Model/Integrated Care Organisation	One organisation receives all funding for in scope services. However, there will always be some services subcontracted or contracted with third parties not "in" the integrated organisation (whether that is the Council or GP GMS funding.	One contract (subject to above caveats on funding).	Organisation could take on statutory duties.	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	Organisation takes on all functions.	Do not exist for organisations that join the integrated organisation.	All staff are hired by one organisation.

Alliance Contract	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside under terms set out in the Alliance Agreement and Master Service Agreement.	Commissioner contracts can remain the same but would be governed by the Master Service Agreement and Alliance Agreement.	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board.	An Alliance Board would be established and all Alliance members would be equal partners. N.B. The Alliance agreement may also provide for Associate Members, albeit that they may or may not be Board members.	Board will set strategic direction and facilitate collective decision making under the Alliance Agreement. This would include collective agreement on priorities, transformation plans, risk/reward sharing and the terms of the Master Service Agreement The Board may be supported by an Integrated Management Team and potentially also by a dedicated programme office and/or Strategy and Delivery executive.	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board.	Likely to remain as now, at least initially, pending the emergence of an integrated provider organisation and/or the transfer of commissioning activities from commissioner to provider organisations.

7.5 Abbreviations

ACO	Accountable Care Organisations
ACP	Accountable Care Partnership
ACS	Accountable Care System
CAMHS	Children and Adolescents Mental Health Services
CQC	Care Quality Commission
FYFV	Five Year Forward View
IHCT	Integrated Health and Care Teams
MCP	Multispecialty Care Provider
PbR	Payment by Results
TOM	Target Operating Model
DWMHPT	Dudley and Walsall Mental Health
WMBC	Walsall Metropolitan Borough Council
WHT	Walsall Healthcare NHS Trust
WTPB	Walsall Together Provider Board

7.6 Document version control

Document information	
Document Title:	Walsall Together Provider Board : Case For Change and Next Steps
Date:	31/01/2018
Owner:	Mark Axcell, Daren Fradgley, Paula Furnival and Waheed Saleem

Document history			
Version	**Change made by**	**Date**	**Description of change**
0.001	Hannah Lewis	15/12/2017	Document name, merging of economic and financial case to include recommendations.
0.002	David Bevan	22/12/2017	Identification of section owners
0.01	Robin Vickers	04/01/2018	Recommended next steps moved to end of document and populated.
0.02	Sebastian Habibi	5/1/2018	Governance overview
0.03	Hannah Lewis	9/1/29018	Benefits and transformation opportunity moved to Financial Impact
0.8	Hannah Lewis	10/1/2018	Financial Impact added, commercial section amended, org models added.
0.6	Hannah Lewis	26/1/2018	Programme Management Section added, Model of Care initiatives added, Recommended Next Steps amended
2.0	Daren Fradgley	08/02/18	Amendments to case to reflect comments of Walsall Provider Board meeting of 7th February 2018
3.0	Mark Axcell	12/02/18	Remove of track change comments

Document review			
Version	**Reviewer**	**Date**	**Description of review and summary of required actions**
0.8	Waheed Saleem	18/1/2018	Comments provided directly on the document. Minor amendments to GP group summaries and wording.
0.8	Paula Furnival	18/1/2018	Consolidate financial section. Detail population management hub. Add section on commissioning to be delegated to providers.
0.8	Daren Fradgley	19/1/2018	Further description of progress to date and population need.
0.8	Mark Axcell	19/1/2018	Reference wider work e.g. STP, Walsall Healthcare Service review, Mental Health Clinical Model. Clarity on each sections conclusion.
0.6	Mark Axcell, Waheed Saleem	28/1/2018	Staff role title changes, clinical model added.