

Commissioning Intentions 2016/2019

Walsall Clinical Commissioning Group



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Statement of purpose:

These commissioning intentions set the CCG direction and strategy for delivering the contracts for services to 2019.

Overarching Approach

It is important to be clear at the outset that we face a significant and collective challenge to achieve financial balance across the system. The timetable as set out in the national planning guidance requires a pragmatic means of achieving contract sign off by the due date, whilst dealing with all the relevant technicalities. An immediate shared view is required (between commissioners and providers) of this challenge and the range of initiatives we can share to meet our respective but linked QIPP and CIP targets, whilst taking account of the other factors set out below.

We are proposing that we meet with the major providers and partners in the system as early as possible to develop an open, transparent, collective financial plan that moves us away from a traditional transactional process.

1.0 Introduction

1.1 The proposal from Walsall CCG is to have a collaborative approach to the agreement of contracts, working with our main partners in Walsall to agree:

- The fundamental changes that need to be made to achieve a sustainable health and care system.
- How the resource available to the Walsall system should be allocated between its different elements to optimise outcomes (health, care, and financial) for the system as a whole.

1.2 Provided we are able to reach agreement on resources and contracts with our main partners, we intend that Walsall Together will be the key Partnership through which we work together over the next two years to deliver the transformation in service delivery, costs and outcomes that will be needed to deliver our collective and individual plans.

1.3 We expect the providers in the Walsall health and social care economy to work in collaboration to identify how these savings can be achieved through implementation of the Walsall together model, there is expectation from NHSE and the CCG that there will be a clear focus on efficiency in 17/18 and 18/19 in order to create a sustainable health economy in Walsall.

1.4 These commissioning intentions will lay the foundations for two-year contracts which will need to reflect two-year activity, workforce and performance assumptions. It is expected that by the 21st October we will need to have reached agreement on the details of the shared financial plan and whether or not a genuine partnership approach is achievable and can meaningfully

determine how risks will be managed and responsibilities for improvement assigned to respective parties within the system.

- 1.5 There is a mandated target deadline of all 2017-19 contracts to be signed by 23 December 2016 (Milestones for achievement are attached in **Appendix 1**).
- 1.6 Access to formal arbitration will be our last resort. Our expectation is that our providers work in true partnership together with the CCG to sort out any differences without the need for arbitration, and failure to do so will be seen as a clear failure of collaboration and good governance.

Summary of intentions

- 1.7 These intentions are designed to build upon and implement the strategic objectives set out in our 5 year strategic plan and the four key priorities set out in our Operational Plan for 2016/17, and clearly state our intentions for the next two years for our main providers. As per the NHS planning guidance our shared tasks are clear: implement the Five Year Forward View to drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards whilst we achieve local targets to moderate demand growth and increase provider efficiencies.
- 1.8 The key priority areas for Walsall are:
 - Recovery of Performance to offer efficient and effective care
 - Restore quality of services with a focus on improving urgent and emergency care services
 - Improving health outcomes for our population
 - Maximising value and securing financial balance.
- 1.9 Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models; medicines optimisation; and improving the management of continuing healthcare processes.
- 1.10 We need to ensure the sustainability of general practice in Walsall by implementing the General Practice Forward View, with a clear primary care strategy that includes the plans for Practice Transformational Support, and how we will achieve the ten high impact changes. As per the NHS Business Planning guidance the CCG intends to spend approximately £3 per head, this has to be found from within our existing allocations. This will be aligned to practice transformational support, as set out in the General Practice Forward View.
- 1.11 The financial challenge in the Walsall health economy is significant, with an identified saving of 5.4% by 2019 which equates to a financial gap for the CCG

of £25M for 2016/17, £19M (stretch target of £25M) for 2017/18 and £12M for 2018/19 (stretch target of £14M).

- 1.12 The CCG will agree a joint plan to deliver the requirements of the Better Care Fund (BCF) from 2017/18 via the Health and Wellbeing Board. The plan will build on the 2016/17 BCF plan. It is expected that BCF funding will explicitly support reductions in unplanned admissions and hospital delayed transfers of care
- 1.13 The CCG expectation is that all parties work collaboratively through the Walsall Together partnership and within the Sustainability and Transformation Plan; to ensure the most efficient use of available resource and to deliver the outcomes contained within this commissioning intentions document. Through the “Walsall Together” programme we have developed a new model of care for Walsall’s health and care system which will be the delivery vehicle for our transformation agenda. Further development and implementation of this new model of care is central to our plans to address the challenges facing the CCG and the wider health and care system.
- 1.14 In July 2016 Walsall CCG (WCCG) was rated as “Inadequate” in the annual NHS England rating of CCG and placed in special measures due to a serious deterioration in its financial position and failure to achieve key national performance standards. The CCG has been directed by NHS England to prepare an Improvement Plan, including a Financial Recovery Plan, and the CCG’s commissioning intentions for 2017-19 reflect the priorities and actions required to achieve the necessary improvements in the financial position and delivery against key performance standards.
- 1.15 We hope that we will be able to address these challenges and deliver the new model of care through continued collaboration and these commissioning intentions set out our approach to taking this forward. We will expect all providers to engage positively with the transformation programme and to implement changes agreed through the programme, supported where appropriate by contract variations.

2.0 Alignment with The Black Country STP

2.1 The STP is taking increasing importance in the system, not least because the new planning guidance introduces the concept of an STP-wide planning control total which therefore brings the four CCGs planning into one arrangement.

2.2 The CCG Governing Body has established a clear set of priorities for the ongoing development of the STP.

- The first key component of the STP is the placed-based delivery of care, which in Walsall is the Walsall Together programme.
- The second key component of the STP is the horizontal integration agenda across the system.

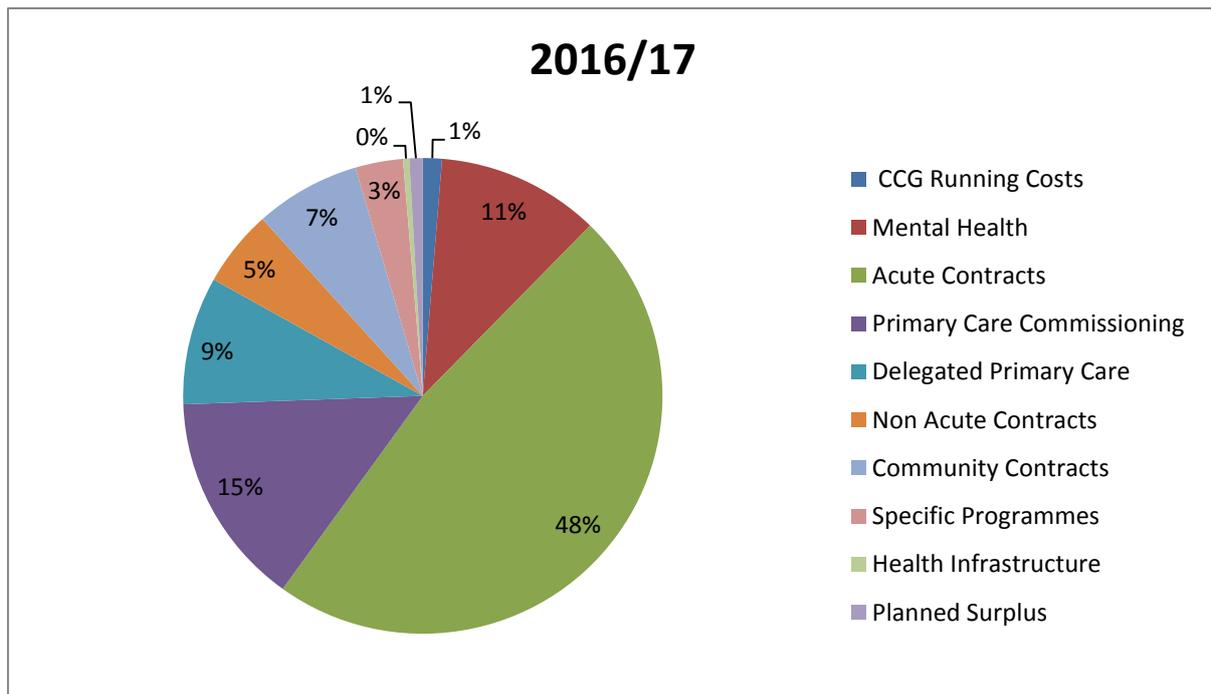
2.3 Our commissioning position for the development of this Black-Country wide component of the STP is:

- The STP needs to clearly articulate the added value of the joint working across the Black Country and therefore needs to focus on the materially significant strategic changes that will genuinely add transformational value across the whole system.
- We intend to work in partnership with the other three CCGs to adopt a single approach where this is needed to support the horizontal integration agenda.

3.0 Financial Summary

- 3.1 Walsall CCG faces considerable financial challenges in the period 2016/17 – 2018/19 as it enacts the financial recovery plan to return to financial sustainability which is a key requirement of the directions placed on the CCG.
- 3.2 A medium term financial plan has been produced utilising national and local planning assumption which describes the scale of the challenge. Based on these assumptions the CCG needs to identify £31M in QIPP savings in the financial years 2017/18 (£19M) and 2018/19 (£12M).
- 3.3 In order to provide some mitigation against schemes failing to deliver the proposed savings target the CCG is planning to develop a QIPP programme of £25M in 2017/18 and £14M in 2018/19.

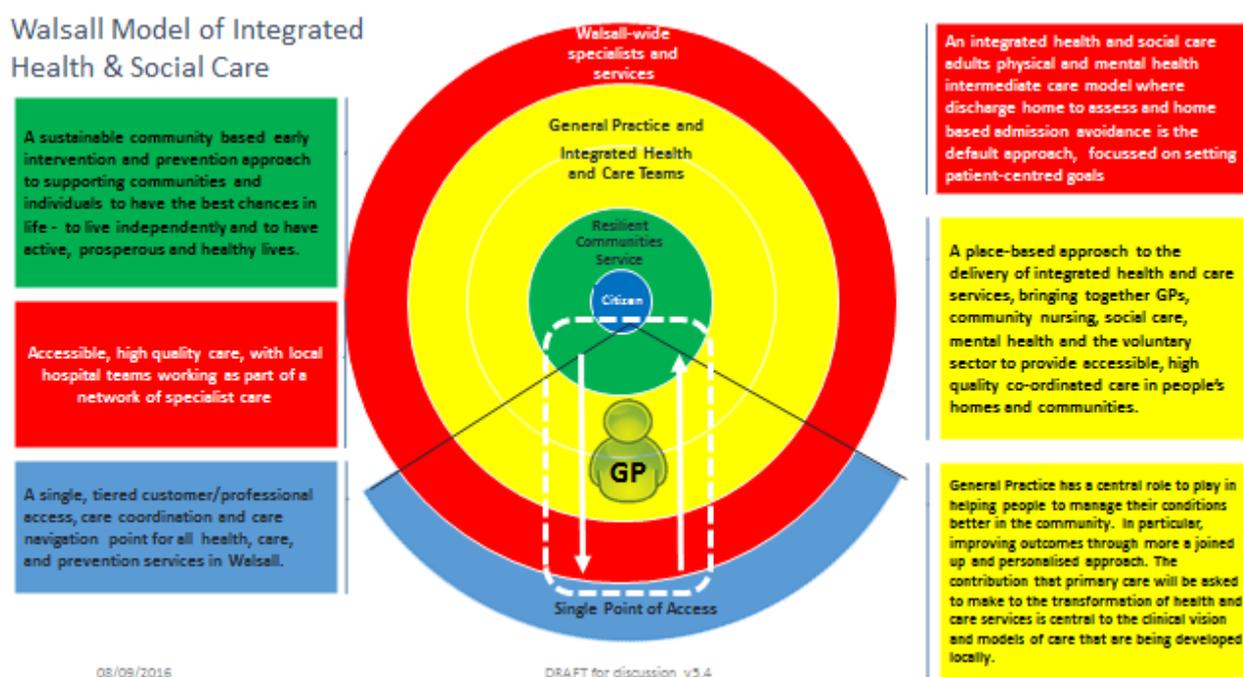
Fig 1. The Closing 16/17 recurrent expenditure expressed as a pie chart apportioned to each of our main providers



- 3.4 At this stage the total QIPP opportunity for our main providers is identified as: WHT - c£21M over two years; DWMHT - c£3M over the next two years. Further detail will be provided at the meeting with major providers and partners that we are proposing to hold in early October.

4.0 Transformation: Our Model of Care

The diagram below provides a visual summary of our model of care:



4.1 Our main partners, as members of the Walsall Together Partnership Board, are familiar with the model and the collaborative transformation projects that have been established to further develop and implement it.

4.2 Our shared partnership commitment to action, embodied in the new model of care, is that:

- We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities.
- We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways.
- We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs.
- We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs.

- We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model.
- This collaborative working and movement towards true integration is also underpinned by a complementary process of developing standardised best practice pathways of care. Through this we will ensure that all services provided outside of the Walsall Together model are commissioned in a way which incentivises optimum outcomes for the patient, maximises efficiency and enables effective communication back with the GP.

Prevention/Resilient Communities

- 4.3 All healthcare providers will be expected to ensure that their staff receive appropriate support and training to support patients to manage their own health and wellbeing and to incorporate this into their professional practice/service delivery where appropriate.
- 4.4 We are committed to safeguard the health of employees.
- 4.5 All healthcare providers will be expected to support any reasonable requests made for their support in relation to the Walsall Together Resilient Communities project.

Access to Services/Best Practice Pathways

- 4.6 All healthcare providers will be expected to engage positively with the work of the Walsall Together Access Project, which will be developing plans to simplify, integrate and standardise access to services for patients.
- 4.7 Providers will be expected to support the CCG in the development of referral protocols, systems and pathways that maximise opportunities for patient self-management and for the provision of care in primary and community settings.
- 4.8 As a minimum, providers will be expected to demonstrate that they are offering and promoting an effective advice and guidance service to GPs any complying will the associated national guidance.

On-going Health and Care Needs

- 4.9 Where people have on-going care needs we will expect providers to work effectively together to ensure that consistent high quality care appropriate and proportionate to identified needs and working to maximise self-care and independence is provided across the care pathway.
- 4.10 Whilst, for the majority of patients with on-going care needs, their care will principally be provided by their general practice the CCG will expect local

providers of specialist services, and in particular their senior clinical staff, to have a leadership role in relation to the whole population and to support commissioners to identify and address unwarranted variation in care and treatment that is causing poor health outcomes, poor patients experience and/or excess cost.

4.11 We expect better management of patients with on-going health and care needs to reduce demand for acute hospital services and will incorporate these reductions into our contract activity plans.

Integrated Health and Care Teams

4.12 The development of integrated health and care teams, serving a defined population and 'joining up' community nursing, social care, mental health and primary care is a key part of the new model of care.

4.13 Benefits are expected to include:

- The teams will be better able to co-ordinate care for patients who are supported by multiple professionals, including the frail elderly and those with the most complex care needs.
- Stronger practice alignment to integrated teams and continuity of care in support the management of long term conditions.
- Enhanced capability for place based teams to build and promote resilient communities.
- Improved efficiencies (e.g. travel costs, travel time), releasing time for patient care.

4.14 Local providers are collaborating, through the Walsall Together Programme, to create these new teams. Staff will still be working within their existing organisational structures, but will also be part of cross-organisational multi-disciplinary teams. We anticipate that these team structures will be in place by 31 December 2016.

4.15 Once the team structures are in place the next phase will be for them to develop new ways of working and best practice care pathways through a supported process of learning and prototyping and drawing on best practice and experience from other areas, including from the national Vanguard programme.

4.16 We expect the Integrated Health and Care Teams to reduce demand for acute hospital care and will incorporate these reductions into our contract activity plans.

4.17 It will be important that contractual agreements and contract management support the move to more integrated service delivery and the place-based structures for the integrated teams. To this end we wish to engage with providers prior to contract agreements being completed to agree how we will:

- Establish priorities, activity/finance plans and key metrics at team level that are incorporated into agreements with WHT, DWMHT, Walsall Council and GPs.
- Monitor and manage activity, finance and performance.

4.18 Integrated working and the development of new pathways will require services and staff to work differently together. These changes will therefore need to be supported by a programme of change management and organisational development agreed jointly with WHT, DWMHT, Walsall Council and local GPs.

Intermediate Care

4.19 The Walsall Together Intermediate Care project is preparing a business case to support proposals for a new model of intermediate care. Local providers have been engaged in the project and the CCG will, subject to approval of the business case, seek to incorporate the proposals into contract agreements from April 2017/18.

4.20 The key aims of the service are:

- Provide a locality based health and social care, community and voluntary sector integrated team with responsibility for complex patients requiring discharge from an inpatient bed or additional support in a health or care crisis to remain at home.
- The service should receive referrals through a single point of access.
- 'Discharge Home to Assess' and support to remain at home in a crisis should be the default position, (home being the patients' usual place of residence).
- The service should undertake shared generic assessments, to be completed by any member of the team, so that patients do not have to re-tell their story.
- People should be provided with the necessary support in a community setting to maximise their independence and recover from a period of ill-health before they are assessed for their longer term health and social care needs.
- The integrated community provision should ensure people have access to appropriate care in the right place at the right time closer to their home.
- The service should use shared chronological notes to document the patients' journey.
- The service should enable people to regain confidence and be able to contribute and be part of their local community.
- The service should increase the identification of, and support to informal family carers to ensure that their needs are also met.
- The service should ensure effective interfaces with the wider system to ensure seamless and coordinated care.
- The service should operate seven days per week.

- The service should ensure that the needs of informal family carers are identified and supported.
- The service should achieve integration through a new shared culture, mind-set, values, objectives, working processes and practice.
- The service should work collaboratively across the whole system to achieve real transformation with continuous monitoring and learning embedded to allow service evolution and improvement. The benefit of Integrated locality teams should include reduced admissions, re admission and Length Of Stay
- Intermediate care redesign benefits should include reduce delay transfer of care

5.0 Expectations on delivery

- 5.1 We will focus on commissioning services which are clinically effective, safe, provide a positive patient experience and support the delivery of compassion in practice whilst achieving maximum value for the Walsall pound.
- 5.2 We continue to expect to see quality at the heart of all services to ensure that patients receive consistently good quality healthcare with the best possible outcomes and will only commission services that meet national quality standards and will focus on areas where we do not benchmark well as per the Right Care programme.

6.0 Commissioning Principles

- 6.1 The underpinning principles for the commissioning of services are:
- Commissioning to reduce demand, reduce cost and using the right care approach and to improve health outcomes and reduce health inequalities by putting patients, carers and the public first
 - Ensuring consistent, high quality safe healthcare services are delivered in the right place, by the right person at the right time
 - Reducing unwarranted clinical variation
 - Delivering a sustainable local health economy
 - The providers should utilise CQUIN and other such incentives as drivers for change to support delivery through the new model of care.
 - WCCG intention is not to pay higher than national tariff for any patient pathway.

6.2 WCCG is ambitious and intends to push the boundaries of excellence at scale and at pace, with “Walsall Together” moving us towards:

- Implementing outcome based commissioning which embraces the principles of early support, empowerment and personal responsibility; supporting the Health and Wellbeing Board agenda; keeping people well and at their lowest point of dependency.
- Driving and implementing innovative new models of provision, using new approaches and technologies to empower patients, drive efficiency and maximise the positive impact of NHS resources through the “Walsall Together” delivery plan.
- Integrating commissioning to offer better integrated and better value public services which promote the philosophy of the Health and Wellbeing Strategy, using the Walsall Together and Better Care Fund processes.
- Encouraging all of our providers to provide proactive and enabling prevention services.
- Commissioning acute hospital based services which meet the necessary clinical standards and where the pathways are no more complex and no more expensive than other providers.
- Redesigning of services example COPD and MSK will all be within existing resources and resources may be moved to deliver care closer to home.
- WCCG will not invest into any service that does not have a compensatory decommissioning scheme. The Commissioning Committee will prioritise services that are commissioned and will utilise a robust decommissioning policy to ensure all services under review have a full quality impact assessment prior to any decommissioning. The outcomes of this work will be shared with providers and appropriate engagement will be undertaken with patients and the public prior to any decisions being made. Commissioners will provide further updates as this work develops set against any formal notice periods required under the terms of the Standard Contract. Changes/variance will be made as per national contract rules.

7.0 Specific Intentions: Quality and Safety

Improving the Quality of Maternity Services

- 7.1 WCCG will be working with providers to implement the recommendations laid out within the WCCG 2016 maternity commissioning strategy. The CCG will also be developing the Black Country STP maternity plan and recommendations with Black Country providers and commissioning colleagues.

Implementation of Hyper Acute Stroke Services

- 7.2 Walsall CCG will review the regional stroke recommendations and Walsall Healthcare trust business case to determine the most appropriate model of and provider for delivery for stroke services for the population of Walsall. This will include the provision of a Hyper Acute Stroke Unit (HASU), Clinical thrombolysis expertise and community rehabilitation services. It will be commissioned in line with national tariff price and relevant national guidance.

Review of Clinical Quality Review processes

- 7.3 Walsall CCG will be working with providers to review processes and timings of Clinical Quality Review meetings to maximise the effectiveness of the meetings in providing assurance relating to the quality and safety of commissioned services. The review will ensure meetings are held at a mutually convenient time for the provider and commissioner and papers to support the meeting are available in a timely manner to ensure efficiency. The mechanisms within the contract will also be utilised to support the effectiveness of the meeting.

Improving the Quality and Safeguarding Reporting Schedule 17/18 Contract

- 7.4 Walsall CCG will review the schedule for providers to submit reports relating to quality and safety issues, to ensure the CCG continue to receive assurance on quality of commissioned services and to continue to drive quality improvements for our population. The revised schedule will include the format for reporting agreed by provider and commissioners.

8.0 On-going review of commissioned services

- 8.1 We have reviewed the full range of services commissioned by the CCG and have identified a number of services that we believe do not offer good value either because the cost is high relative to the outcome achieved or there is duplication of provision or there is a requirement to contract under National Contract Rules.
- 8.2 We intend to review and remove duplicated services that fall within the above criteria and following full Equality and Quality Impact Assessments and adherence to the CCG Decommissioning Policy. These will be undertaken on an individual basis as part of a managed programme.

9.0 Transactional Efficiencies: Walsall Healthcare Trust

- 9.1 As detailed in the NHS Standard Contract - Service Condition (SC) 36.22 and National Tariff guidance, the CCG will not pay for Emergency Readmissions, above the agreed threshold, within 30 days.
- 9.2 The CCG will adhere in full to the Marginal Rate Emergency Threshold rule (MRET) as detailed in the 16/17 National Tariff Payment System guidance (or any subsequent updates). A deduction at the relevant rate (currently 30%) will be applied for all relevant activity.
- 9.3 The CCG will remove winter funding from the baseline in the contract for reinvestment in line with urgent care system priorities.
- 9.4 For the Paediatric Assessment Unit (PAU) the CCG currently pay a local price for attendances. The CCG intend to withdraw this local price where an admission is also charged as the assessment element of that admission is covered under the tariff generated for that admission. The PAU local price will still apply where a child is not subsequently admitted immediately following assessment.
- 9.5 There is a planned reduction in the undertaking of Procedures of Limited Clinical Value as per the agreed policy and enacted through the implementation of BLUTEQ and adherence to the policy.
- 9.6 There will be a planned reduction in the cost of Non-Emergency Transport following a detailed review with a clearer specification for use moving to a lower benchmarked average cost.
- 9.7 We expect that WHT will deliver Ante-natal services within the agreed tariff and thus we will expect that they contract directly with the National Childbirth Trust or provide this in house as per contract guidance (see “other providers” below).
- 9.8 We expect that the home oxygen services are delivering to an agreed specification and that WHT review the patient list accordingly to ensure those on the list still require Oxygen therapy (see “other providers” below).
- 9.9 The CCG will cease funding for overheads in the community contract regarding corporate services.
- 9.10 The CCG will cease funding of the overhead cost for integrated equipment services that sit within the community contract element.

10.0 Transactional Efficiencies: Dudley and Walsall Mental Health Partnership Trust

10.1 The CCG intends to remove the current 'cap and collar' arrangement for inpatient and community activity and will revert to the previous block contract arrangement this will require DWMHT to review their operational procedures to ensure that services are delivered in the most efficient way and reduce duplication of service through the Walsall Together programme

10.2 Contract management – We expect the provider to meet agreed local key performance indicators such as maintaining the national average length of stay (of 68 days) for older adults. These will need to be managed within the agreed block contract.

11.0 Transformational Efficiencies

11.1 Transformational efficiencies will be delivered through the new model of care developed through the "Walsall Together" programme. The main themes of the Walsall Together programme are:

- **Access to Care** – Ensuring appropriate patients access the right services at the right time. (Primary Care, Triage and Demand Management, preventative/self-care).
- **Place-Based Integrated Care**- Community Care/ Care closer to home – chronic and long term conditions
- **Complex Care** – Comorbidities Multidisciplinary Teams, frail and elderly, in an acute setting or the community

Walsall Healthcare Trust

Where applicable these intentions also apply to other providers of acute and community services with which the CCG holds a contract.

11.2 There is a shared ambition across Walsall's health and care system to reduce demand for acute hospital services and a commitment to achieve this through the implementation of the new model of care.

11.3 Right Care is a national programme which provides benchmarking information for CCG areas, comparing a number of cost and quality measures against a group of CCGs with similar population characteristics. Walsall partners have also undertaken some local analysis, supported by the Midlands and Lancashire CSU, which identified a range of strategies through which demand for acute hospital activity could be reduced [referred to hereafter as "the Strategy Unit analysis"]

- 11.4 Reflecting this ambition and commitment, the CCG intends to commission a reduced level of acute hospital activity such that the opportunities identified by Right Care and the Strategy Unit analysis are delivered during the two year period 2017/18 – 2018/19.
- 11.5 The CCG will engage with providers to agree the phasing of the activity reductions and the plans to achieve them. We will also seek to agree with providers how the service and financial risk of these changes will be managed, ensuring that incentives are aligned to support implementation.
- 11.6 Implementation of the new Intermediate care model: a locality based health and social care single service with responsibility for complex patients who require support to prevent an acute hospital admission or to facilitate discharge from an inpatient bed.
- 11.7 To support the above intentions and address immediate RTT and Quality issues, an initial focus will be within these specialities:
- **Urology:** 30% of urology activity needs to be repatriated to community through transforming pathways.
 - **ENT:** 30% of ENT activity needs to be repatriated to community through transforming pathways.
 - **Gastroenterology:** 30% of Gastroenterology services needs to be repatriated to community through transforming pathways.
 - **Diabetes:** We must improve the outcomes for people in Walsall with diabetes; the number of amputations has doubled over the last three years. Specifically the focus needs to be on improving the 8 care processes within primary care and review and transform the Community services provision to ensure that it will support PC facilitates self-management.
 - **Cancer and Tumours:** To reach the best benchmarking opportunity we must reduce NEL admissions for cancers and tumours by 517 per annum with a focus on specific areas such as earlier diagnosis for breast, lower GI and lung and improved bowel screening and earlier first treatment for diagnosed patients.
 - **Respiratory:** Lower respiratory conditions both acute and chronic.
 - **MSK:** The CCG intend to commission a fully integrated MSK service. This includes a review of the OCAS triage service
 - **Neurology:** We expect that WMT to recruit substantively for a neurology consultant. A focus will be on reducing NEL admissions and zero LOS. The intention is for a community integrated model for neurology and pain management as part of the Walsall Together program. We also need to see improved community rehabilitation services.

- **Community Paediatrics:** The CCG is undertaking a review of community paediatric services and will commission a paediatric consultant ratio within the community in line with national guidance and benchmarking.
- **Clinical Psychology:** The CCG will review the clinical psychology services for long term conditions for people with physical health needs within the community contract element as this is potentially a duplication of service.
- **End of Life Services:** As part of our strategy to build resilient communities, the CCG intends to commission community provision for end of life services through a tender process that will focus on maximising opportunities for the voluntary sector, this is to enable income generation and match funding.
- **Ambulatory Care Sensitive Conditions:** Ambulatory care sensitive conditions (ACSC) are health conditions where appropriate ambulatory care prevents or reduces the need for hospital admission (or inpatient care), such as diabetes or chronic obstructive pulmonary disease. The changes planned through the Walsall Together programme will need to achieve a reduction in admission for these conditions.

11.8 The CCG expects full delivery of Consultant Connect Advice and Guidance and the introduction of community clinics COPD and diabetes.

Dudley and Walsall Mental Health Partnership Trust

11.9 The current alignment of national and local strategic direction coupled with strong provider appetite for mental health sector reform gives us an unprecedented opportunity within the Walsall Together program to achieve real and sustainable change and improved mental health outcomes and maximise efficiencies. Commissioners have been working with the provider to align their services to the locality teams and work in partnership with the voluntary sector to improve outcomes for our patients.

11.10 Primary Care Mental Health Liaison Nurses will become the single point of access for old age psychiatry and work with their social work and physical health care colleagues to prevent people going into hospital. The move of the day hospital into the community is part of an overarching transformation programme for mental health and will lead to increasing choice and opportunities for service users. As relationships between providers develop, further opportunities for joint working will be explored which will reduce duplication and costs whilst improving outcomes.

11.11 Access to adult mental health services for both routine and crisis referrals are being redesigned, to better meet users' needs, and improve service delivery. Commissioners are working to align mental health services to the Walsall Together model and make more efficient and effective care pathways.

- 11.12 Full implementation of the Older People service redesign program. The intention is to continue with the transformation of services; including the reduction of inpatient beds for older patients, and enhancing community service support. This will be further facilitated through the Walsall Together Resilient Communities program and includes greater integration with the voluntary sector.
- 11.13 The provider will deliver a more efficient model of provision for accessing and assessment for adult MH services. Benchmarking data indicates that up to 66% of all secondary care referrals for Adult Mental Health are inappropriate or do not meet current agreed criteria. This will be reduced to an agreed level within the block contract and managed by the provider.
- 11.14 According to national benchmarking data The Crisis and Home treatment services have significant funding within the current contract value. The CCG will commission a new model which delivers a person centred response and financial efficiencies by removing duplication and unwarranted activity.
- 11.15 The CCG will decommission the three Adult Extra Care Beds and revert back to using these beds as General Adult beds.
- 11.16 The CCG intends to review the health element of the carer support service with a view to potential decommissioning of this service.
- 11.17 The CCG will review the current primary care and IAPT services with the view to redesign and procurement of these services.
- 11.18 Reducing the first attendance and subsequent reviews for all Adult Mental Health Outpatients to fall in line with benchmarking.
- 11.19 Review and redesign the Psychological Therapy Hub to improve outcomes and performance

Primary Care

- 11.20 Review of Locally Commissioning Services
- 11.21 Reduce pharmaceutical expenditure, targeting Right Care opportunities
- 11.22 Implement a policy to restrict the prescribing of Drugs of Limited Clinical Value

West Midlands Ambulance Service/NHS 111

- 11.23 Following an utilisation review the CCG intends to disinvest in its contribution to the multi-agency Black Country Crisis/Triage Car.
- 11.24 Sandwell and West Birmingham CCG will issue separate commissioning intentions for the ambulance service and NHS 111 in its role as lead commissioner for these services

Other providers

- 11.25 Working with DWMHT as the main referral route, the CCG will work in partnership to reduce the number of individual mental health placements.
- 11.26 Working with the Metropolitan Borough Council the CCG will implement a joint assessment tool for section 117 packages of care.
- 11.27 By commissioning additional older peoples community MH services we expect a reduction in the number of clients requiring CHC package of care
- 11.28 The CCG will expect WHT to deliver ante-natal services within the agreed tariff and that they either contract directly with the National Childbirth Trust or provide this in house as per contract guidance. The CCG intends therefore to disinvest from the current NCT service
- 11.29 The CCG will review the use of Urgent Care commissioned services and intend to remove duplication of services. The current contract held with Prime Care may be varied accordingly.
- 11.30 The CCG will undertake a review of the Bay water healthcare home oxygen service in partnership with WHT and the contract will be varied accordingly.
- 11.31 Investment will be made in the Child and Adolescent MH services .The CCG will commission additional services as per The National Transformation Programme. This may sit across multiple providers.
- 11.32 Learning Disabilities: Implementation of the Transforming Care Programme will reduce in-patient beds by a minimum of 50%.
- 11.33 The impact will sit across three key providers: Black Country Partnership Foundation Trust, Cambian Care and Danshull.
- 11.34 Learning Disabilities: The CCG will implement the planned Registered and Nursing Care Tender. The Community based Support Tender will be implemented by the end of 2016.
- 11.35 The CCG will commission an Inpatient Provider Framework with a new clinical pathway. This will result in a reduction in costs of in-patient beds.

- 11.36 The CCG will amend the clinical Pathway in relation to assessment, treatment and discharge leading to reduced admissions.
- 11.37 The CCG will redesign prevention services on a locality model and support the development of resilient communities as part of The Walsall Together programme.
- 11.38 The CCG will develop a plan for an Integrated Learning Disability Service by 2020.

12.0 Rationalisation and maximising efficiencies through contracts

- 12.1 The CCG will seek assurance that all CMU and PAS prices are applied to drugs monitoring and are effective immediately after their release date.
- 12.2 Trusts are required to outline any drug or device uplift over and above the unit price paid
- 12.3 Trusts are required to outline any drugs where VAT is not being paid
- 12.4 Locally agreed or non-tariff prices will be reviewed. The CCG will not pay higher than national tariff for any service.
- 12.5 Commissioners will carry out a review of any day-case activity with a view to working with the Trust to move this activity to outpatient settings where clinically appropriate to do so
- 12.6 Commissioners may undertake a review of any activity being recorded as day-case that could be coded as a home visit
- 12.7 A review of non-consultant led outpatient tariffs
- 12.8 Commissioners expect that the correct treatment function code must be used for outpatient activity
- 12.9 Outpatient telephone consultations: Where clinically appropriate Providers will be expected to move to telephone consultations. This activity must replace face-to-face follow up attendances. They will not be paid as additional activity
- 12.10 Outpatient Nurse Led activities – Commissioners would expect any Outpatient activity seen by a nurse to be coded and charged via a locally agreed price

- 12.11 Planned procedure not carried out – Commissioners will only pay a locally agreed tariff for activity that is for medical or patient reasons (WA14B)
- 12.12 A locally agreed price will be determined for patients attending A&E who leave before being treated
- 12.13 Multiple diagnostic tests occurring on the same day will be reviewed to ensure correct clinical coding is applied. This applies to any scans that occur in more than one area
- 12.14 Procedures of lower clinical value policy will be adhered to and any “excluded procedure” carried out will be challenged unless supported and evidenced by an IFR approval. Case note reviews may be carried out on selected procedures to ensure compliance.
- 12.15 Any patients that have been approved via IFR will be given a unique identifier (Blueteq number if using Blueteq for approval) within an agreed field in SUS.
- 12.16 Activity will be coded as regular day/night attendances with a locally agreed price. This is where a patient is admitted electively during the day or night as part of a planned series of regular admissions for an ongoing regime of broadly similar treatment and who is discharged the same day/next morning.

13.0 System Governance

- 13.1 Walsall Together is a Whole-System Partnership which provides leadership and governance for collaborative strategic planning and a programme of service transformation.
- 13.2 Alongside this however, the commissioning and provision of services still largely retains the traditional boundaries that separate health and social care, physical and mental health and acute and primary/community care. This is increasingly likely to be a barrier to the changes that we are seeking to achieve through the programme and we now believe it is time to take a further set of steps towards formalising these changes through the development of new approaches to the commissioning and provision of integrated services and the emerging new model of care.
- 13.3 The CCG and Local Authority will need, in due course, to consider the commissioning of new models of care in the light of their legal duties, including EU and UK procurement law and, for the CCG, the Health and Social Care Act. At present, however, we believe that our models of care are not sufficiently well developed to enable commissioners to determine the approach to procurement and contracting that will ensure that the best outcomes and value is achieved.

- 13.4 We propose therefore that there should be a further period during which we continue to work collaboratively with existing providers to develop, refine and test the model, following which a formal decision regarding the commissioning of the new model of care will be agreed.
- 13.5 During this interim period we need to have in place for Walsall:
- A system-wide partnership which provides leadership to the Walsall health and care system;
 - A more integrated approach to the commissioning of integrated services and new models of care;
 - Partnership arrangements that ensure the effective governance and leadership of integrated provider services.
- 13.6 In the Walsall Together Partnership we already have the first of these and the CCG is also working with Walsall Council to consider the commissioning issues.
- 13.7 Regarding the provision of integrated services, we will expect WHT, DWMHT, Walsall Council and GPs to demonstrate that they have in place effective partnership arrangements for the delivery of integrated services and the new model of care, addressing operational management, clinical and information governance, financial management and leadership. We will wish to discuss with providers how the integrated nature of the services provided and the partnership arrangements that support their delivery is reflected in contracts.
- 13.8 During the two year period of the contracts the full development and implementation of the new model of care is likely to have significant implications for the services provided under the contracts and the distribution of resources, within the between providers.
- 13.9 It will not be possible prior to contract agreements being made to specify in detail the changes to service provision and associated resources that will take place during the contract period. Notwithstanding this, the CCG will expect that the outcome, performance and financial benefits that the new model of care is aiming to achieve must be reflected in contract agreements.
- 13.10 The CCG will be open to views from providers about mitigating actions that might be taken to ensure that contractual agreements support the development and implementation of the new model of care. These include:
- Fixing contract values (or a significant proportion thereof) in order to give security whilst the provider implements the required changes and/or prototypes new ways of working;
 - Risk pooling resources between services, across providers, where this might facilitate joint working to address key challenges;

- Project management or equivalent support to give providers capacity to make the improvements required;
- Changing contract terms to support new ways of working.

13.11 In seeking to help achieve the CCG's mission "*to improve the health and wellbeing of the people of Walsall*", there will be increased emphasis in ensuring that specifications for services concentrate on the patient outcomes to be delivered rather than specifying the detailed mode of delivery. Key contract components, such as quality standards, performance measures, information requirements and CQUIN schemes, will be focussed on delivering high quality patient care and outcomes. Payment, incentives and contract sanctions will, where applicable, be linked to the achievement of specified outcomes.

13.12 As defined in NHS England's 'Strengthening Financial Performance & Accountability in 2016/17' (21st July 2016), The CCG is committed to agreeing and signing NHS Standard Contracts with providers by 31st December 2016.

Appendix 1

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	22 September 2016
Technical Guidance issued	22 September 2016
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	21 October 2016
National Tariff section 118 consultation issued	31 October 2016
Final CCG and specialised services CQUIN scheme guidance issued	31 October 2016
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	4 November 2016
Final NHS Standard Contract published	4 November 2016
Submission of full draft 2017/18 to 2018/19 operational plans	24 November 2016 (noon)
Weekly contract tracker to be submitted by CCGs, direct commissioners and providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
National Tariff section 118 consultation closes	28 November 2016
Where CCG or direct commissioning contracts are not signed and contract signature deadline of 23 December 2016 is at risk, local decisions to enter mediation	5 December 2016

Contract mediation	5-23 December 2016
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff	20 December 2016
National deadline for signing of contracts	23 December 2016
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts	23 December 2016
Final plans approved by Boards or governing bodies of providers and commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017