The Royal Wolverhampton NHS Trust

NHS Wolverhampton Clinical Commissioning Group

Prospectus for an Accountable Care Alliance in Wolverhampton

August 2017

EY Building a better working world

Contents

Introduction 3

Chapter One: The Case for Change 5

Chapter Two: Our Clinical Model 7

- Introduction 7
- Locality proposition 7
- Stratified Care Model 8
- Definition of benefits 10

Chapter Three: Leadership and Governance of the Accountable Care Alliance 11

- Introduction 11
- Status of the ACA 11
- Role of the ACA Leadership Team 11
- Developing local capacity for accountable care 12
- Integration of the ACA into existing local governance 13

Chapter Four: Financial arrangements to support the delivery of the clinical model 14

- Introduction 14
- Funding accountable care 14
- Financial Governance 15
- Improving value for money for taxpayers 15
- Introduction 16
- Proposed implementation road-map 16
- Engagement 17
- Assurance process 19

Introduction

We are committed to working together to transform services and improve the health and well-being of the population of Wolverhampton. In the context of rising demand and financial pressures, we believe that change to the NHS is not only desirable but necessary.

On 10th May, lead clinicians from both primary and secondary care and senior managers met and committed to the following principles to pursue a Wolverhampton approach to accountable care:

- Our strategy must be **clinically led**. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between "primary" and "secondary" clinicians. We will support the professional development of all existing staff. There is strong clinical support across the health system to work in this way
- We will create a **shared governance** across the parties which will provide system leadership
- We will provide a clear vision for our system that will be our joint public commitment and hold ourselves **mutually accountable** for delivering this
- The alliance partnerships work will be **patient-centred**. We will focus services around the patient, developing innovative unified pathways that provide a more consistent quality of care across Wolverhampton
- We will **shift resources** from hospital to out of hospital services so that more patients are supported proactively in their home and communities
- We will focus on health, developing our approach to **health promotion and disease prevention** to support the wellbeing of our communities alongside the care that we already provide
- We must be **financially sustainable**, making the best use of the resources that we have collectively. This will mean amending the current payment methods as they do not always incentivise best practice

Our proposals for an Accountable Care Alliance are set out in this Prospectus. They are, by necessity, high-level, and much more work will be needed throughout this year to develop our plans further. An outline programme plan is included in this document. The Accountable Care Alliance will bring together the main providers of health and social care in Wolverhampton. We anticipate that members will include:

- NHS Wolverhampton CCG
- Royal Wolverhampton NHS Trust, including the "Vertical Integration" primary care practices whose GMS/ PMS agreements have been sub-contracted to the Trust
- the Primary Care groupings, including Primary Care Home One, Primary Care Home Two, Primary Care Home Three and Unity
- Wolverhampton Local Authority as a commissioner and provider of care, with a particular focus on social care and public health
- Black Country Partnership NHS Foundation Trust which is the mental health service provider in the area. It is expected that this organisation will be integrated with Birmingham Community Healthcare NHS Foundation Trust and Dudley and Walsall Mental Health Partnership Trust in October

The associate members of the Alliance would include the West Midlands Ambulance Service NHS Foundation Trust and commissioners of specialised services.

An Accountable Care Alliance provides a mechanism for us to work together to deliver integrated care that serves our population more effectively. Importantly our proposal includes not only the main commissioners and large providers of services but also will enable our GP practices in their groupings to be a central part of the alliance as we move forward. We believe that true transformation requires a new relationship between all clinicians whether in primary or secondary care alongside the need to overcome organisational sovereignty. This approach will enable us to focus on 'doing the right thing' for the patients and residents of Wolverhampton which in turn will drive high quality, sustainable health and social care services for the future .

The proposal aligns with the direction of the Black Country Sustainability and Transformation Plan that proposes the development of place-based strategies to serve the different communities within the STP footprint.

The proposals represent a statement of our thinking at this point in time and will require further development. We would like to engage with other organisations, with patients and with the broader community, with an intention to introduce the Alliance from April 2018 at a minimum in shadow form.

Signed

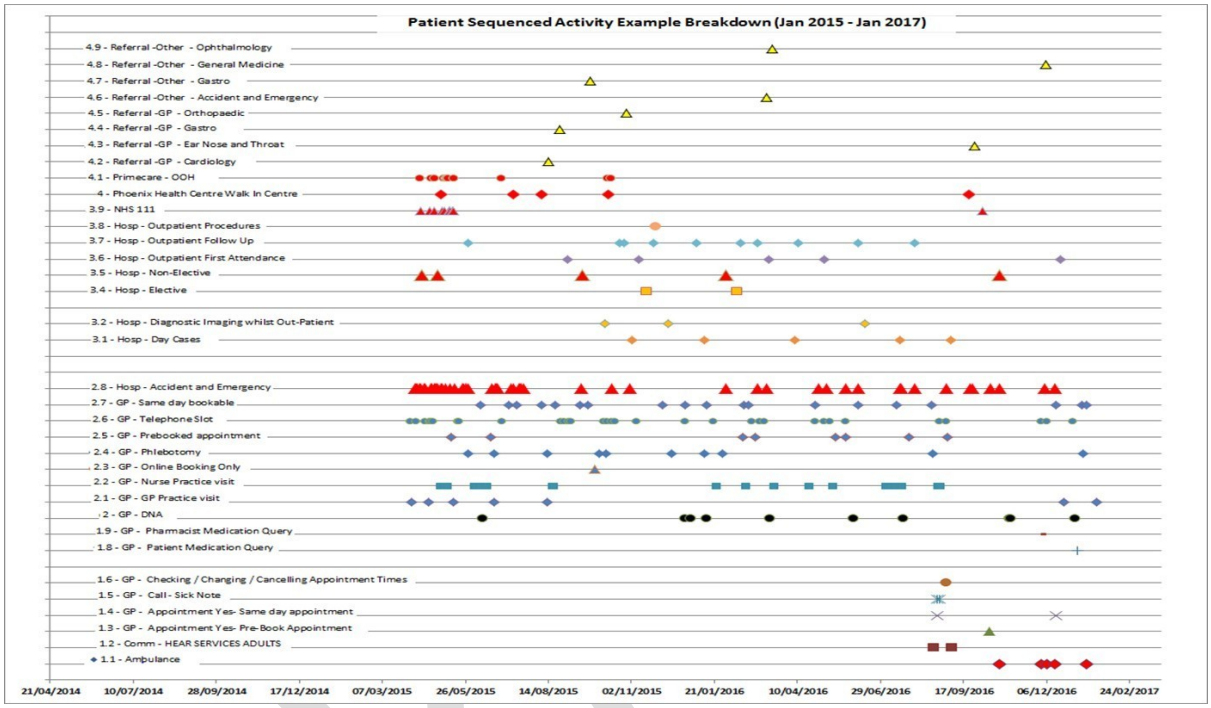
Helen Hibbs
NHS Wolverhampton CCG

David Loughton
Royal Wolverhampton NHS Trust

Chapter One: The Case for Change

In Wolverhampton we face the challenges of a significant increase in demand for primary and acute care seen over recent years. However, we have not always managed this demand effectively with multiple points of contacts and handoffs in the patient journey. The following illustration sets out the combined interventions for a single patient over a period of time and this example could be replicated many times over:

Figure 1: Breakdown of a single patient's care interventions over a two year period



The episodes represent a failure on multiple levels, including:

- poor experience for patient and family
- patient telling the story on many occasions
- multiple attendances to GP practice
- multiple attendances to hospital
- NHS being reactive in its response
- The cost to the NHS was in excess of £35k over a two year period (just hospital activity subject to national tariff); it does not include the cost of primary care, community health care, social care or drugs

The challenge of managing increased numbers of patients with long-term conditions can only be met through a new model of care with primary and secondary care clinicians and carers working together more effectively to support patients with evidenced based information and interventions where appropriate. As the Chief Executive of NHS England, Simon Stevens, has commented:

"We need to tear up the design flaw in the 1948 NHS model where family doctors were organised entirely separately from hospital specialists and where patients with chronic health conditions are increasingly passed from pillar to post between different parts of health and social services"

We have recognised for some time that our model of care must also adapt from the reactive model that was fit for purpose when infectious diseases were one of the primary health problems to a much more preventative and proactive approach which will be able to meet the increasing needs of a population increasingly living longer with a burden of long term conditions:

- The Office of National Statistics (ONS) estimates that the population of Wolverhampton will grow by 6% from 253,000 in 2014 to 268,000 in 2024. There will be a particularly significant growth in the number of older people. The population aged over 65 in Wolverhampton will increase from 42,000 in 2014 to 47,000 in 2024, an increase of 12%

- As people age, they are more likely to develop long-term conditions. Obesity is an important predictor of long-term conditions a high number of people in the local area are obese. Published public health data[1] reports that 28.5% of the population of Wolverhampton are obese, against a national average of 23%. The Wolverhampton Cabinet Member for Public Health described the situation as "a ticking time bomb[2]"

The NHS and local authorities will not have the resources to meet this likely increased demand without radical and ambitious transformation. The Black Country Sustainability and Transformation Plan estimates the financial shortfall across the Black Country to be £512m by 2020-21. Local authorities in the area are anticipating a combined shortfall for social care of £188m in the same period.

Why accountable care?

Accountable care is not an end in itself. Instead it is an approach that is designed to alter fundamentally the experience of individual patients, the outcomes for whole populations and to make more effective the use of scarce resources across the health and care community.

Our vision for accountable care encompasses the following:

- A system of community based, integrated services founded on multi-disciplinary working among health and care professionals
- Joined up strategy and delivery across agencies, ensuring improvements in health and wellbeing and the marshalling of wider community resources in this aim
- Sustainable providers that share a common framework of outcomes, objectives and incentives, and hold themselves mutually accountable for their delivery

[1] Public Health profiles for Cannock Chase and Wolverhampton, dated June 2015
[2] Wolverhampton Express and Star, 21st September 2015

Chapter Two: Our Clinical Model

Introduction

The development of the ACA will unlock new mechanisms for collaboration at a clinical level in a way that has previously not been possible. The ACA will allow us to challenge professional and organisational boundaries and to develop different clinical solutions to meet the needs of the population of Wolverhampton.

Our approach to developing a new clinical model will include the;

- development of a targeted approach to meet the specific needs of the population of Wolverhampton
- development of standardised care models which deliver evidence based interventions across Wolverhampton
- development of locality approaches, delivering integrated care in North East, South East and South West Wolverhampton
- definition of clear benefits cases which would be used to assess and evaluate the impact of the changes and provide an evidence base to support ongoing decision making

This work will build on existing Wolverhampton strategy publications, including the Wolverhampton CCG Primary Health Care Strategy 2016-2020 and the Wolverhampton Health and Care Economy Better Care Fund Plan narrative 2017-2020.

Locality proposition

The ACA proposes to work primarily through three localities; Wolverhampton North East, South East and South West. In developing these localities, we will continue to support the development of primary care at scale. Primary care clinicians in Wolverhampton have already grouped together in three primary care homes, one medical chambers model and one group of vertically integrated practices to work together to support their patients more effectively. As the primary care groupings continue to develop the ACA will be in a position to ensure that they will be well supported by excellent community health services, working closely with social care as well as enabling seamless transition to and from secondary care services and advice where this is required.

This model ensures the patient is at the centre of service provision. An emphasis will be placed on prevention, self-management, healthy lifestyles, early identification and intervention in of those at risk of developing long term conditions. In the cohort of patients who require more services proactive case management, regular medication review and education will be available to provide navigation and support and ensure that people are helped to stay as active and fit as possible for as long as possible. This proposed way of working aligns closely with and builds on the current direction of community neighbourhood teams as set out in Wolverhampton's Better Care Fund plan.

Figure 2: Community Neighbourhood Teams as set out in the Wolverhampton Better Care Fund

Stratified Care Model

As well as addressing access to high quality health and care services, addressing lifestyle, environmental and other determinants of health is also vital to improving health and wellbeing. We recognise that we need to enhance our care model so that it focuses on health promotion and primary and secondary prevention to address the root causes of ill health. As an ACA we have a real opportunity to achieve this in a way that as previously not been possible. Ensuring that our care models are stratified will ensure that resource is targeted at those most in need whilst those with lower needs are empowered to self-manage where appropriate. This way of working will provide us with solutions that are sustainable, cost effective and offer the quality of care and support the population of Wolverhampton require.

A stratified care model at system level means designing a series of aligned interventions and services across the system to meet the specific needs of cohorts of individuals across a disease or clinical grouping.

The illustration below provides an example of a stratification for long term conditions. From this stratification the ACA will develop an understanding of;

- The cohort of patients at each level
- The current service model and the associated resources, funding and costs
- Comparative clinical outcomes for the population

Figure 3: Example of stratification of population for long term conditions

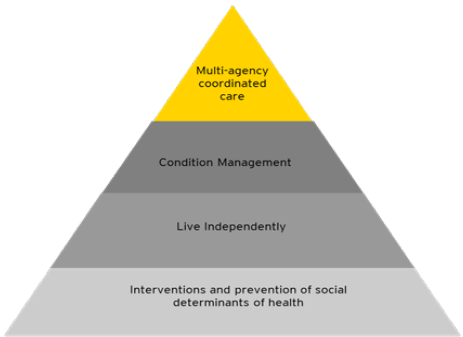
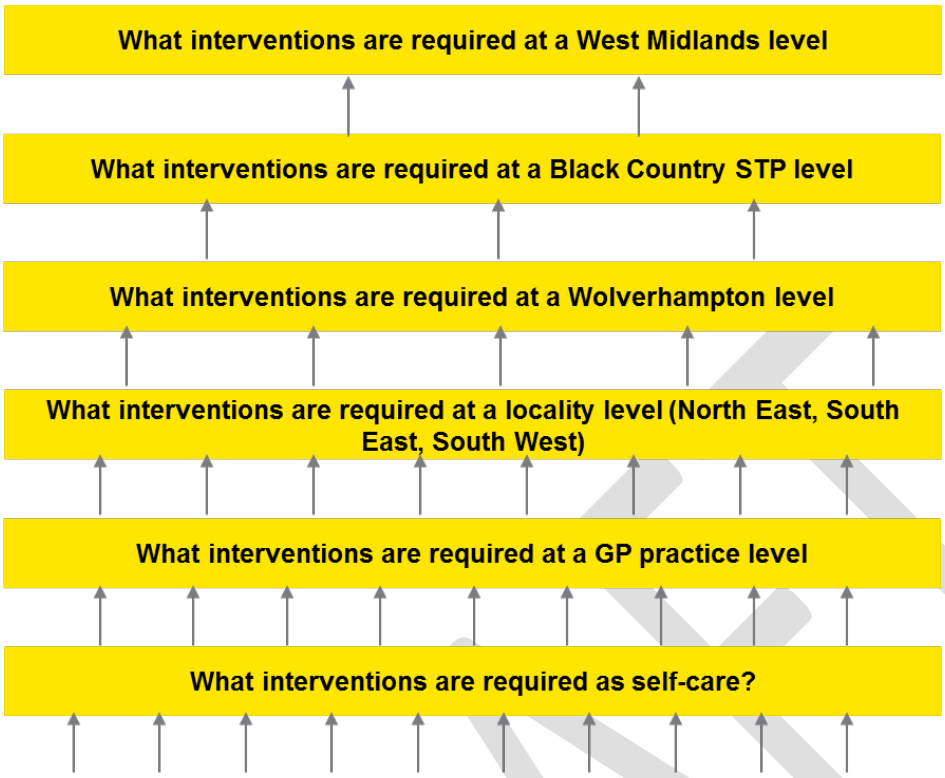


Figure 4: Providing services to address patient needs at different levels of population



In developing the stratified system response, clinical leaders from across Wolverhampton will work with patients, other service providers and key stakeholders to understand the needs of the population and improve the health and well -being of the population by radically redesigning services. We will deploy evidence from the Joint Strategic Needs Assessment and Better Care Better Value indicators to support this work.

Potential clinical groupings we might prioritise in redesigning the clinical model include:

- The Frail Elderly, which would include the treatment of dementia
- End of Life care, enabling patients to die with dignity in a place of their choice
- Patients with multiple long-term conditions (LTCs) including support for patients identified with LTCs adversely impacted by poor mental health and wellbeing
- City wide action plan on delivering Mental Health Five Year Forward view recommendations
- Vulnerable adults, including support with learning disabilities
- Children, recognising the need for effective interventions to promote life-long physical and mental wellbeing. Wolverhampton is a significant outlier for paediatric acute stays of three days or longer
- Continued progress on Public Health improvement priority programmes particularly Infant mortality and CAMHS services

Definition of benefits

We believe our approach will support the following benefits and will use these benefits as a means to assess progress.

Table 1: Proposed benefits of the clinical model

Area	Proposed metrics
Improved Health outcomes	Reduction in health inequalities Prevention of long term conditions Improved management of long term conditions with improved outcomes for patients Early identification and management of both children and adults with incipient and enduring mental health challenges including dementia Reduction in early deaths from cancer Improved maternal and infant health Increased healthy life expectancy
Improved Quality of Care	Reduction in A&E attendances Reduction in Non Elective Admissions Improved access to primary care, and increased satisfaction with primary care Patient satisfaction with the end-to-end care experience Staff perception at all levels that the quality of care in their area has got better over the previous twelve months
More Sustainable local health and care economy	Improved financial performance against projected shortfall Reduction in identified workforce shortages

Chapter Three: Leadership and Governance of the Accountable Care Alliance

Introduction

The aim of the ACA is to develop a coherent system of care for the population of Wolverhampton that delivers high quality outcomes. The ACA will hold itself to account for the delivery of those outcomes and will pool local capacity and capability to ensure the outcomes are delivered.

Status of the ACA

The ACA is a voluntary alliance between organisations which remain sovereign. Under ACA arrangements, existing contractual relationships remain in place, utilising current contracts until it is appropriate to move to new contractual forms being developed by NHS England. However, the ACA partners agree to work together and to common cause, allowing those existing contracts to be delivered and managed differently moving away from the perverse incentives of PBR and ensuring that funding and investment decisions can be made which move resource to where it is most required to deliver the most effective care. This agreement will be underpinned by an Alliance Agreement, based on the template and documentation set out by NHS England

Role of the ACA Leadership Team

An ACA Leadership Team will oversee the work of the Alliance. The Alliance Leadership Team will be made up of the leaders of the member organisations and sets the direction for the ACA. Our proposal is that the existing Transition Board in Wolverhampton will be amended to become the Alliance Leadership Team. Associate members of the ACA would be invited to attend meetings.

Formal evidence! ([3] &[4]) tells us that integrated care needs to be underpinned by the right behaviours- those that support collaboration and shared decision making. This is as true for leadership as it is for front line clinical teams. We therefore will devote time and energy to agree the way to which we want to work together as well as the things we jointly want to achieve.

The Alliance Leadership Team will work by the following principles:

1. Work collegiately to develop coherent plans for the Wolverhampton health and care system
2. Work by consensus. No-one can be over-ruled on any matter. However, once a decision has been made we will all support it
3. Be transparent and open with regard to the challenges we face and have an open book approach to finance, contracting and performance
4. Take no unilateral actions that could result in a cost or workload shift to other organisations, without prior review and agreement in the Alliance Leadership Team

---

[3] Evans J, Daub S, J Goldhar et al, "Leading Integrated health and social care systems: perspectives from research and practice" in Healthcare Quarterly, 2016.

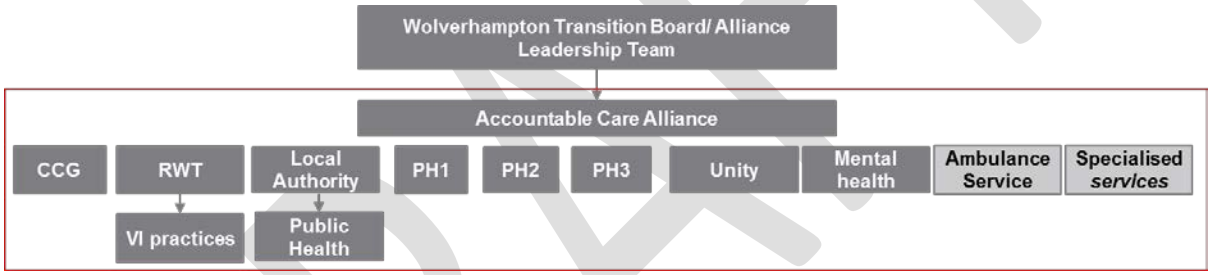
[4] Glasby J, Dickinson H and R Miller. "Partnership working in England – where we are now and where we've come from" in International Journal of Integrated Care, 2011; 11

5. Commit necessary resources and support to the ACA, including participation in the Alliance Leadership Team and supporting groups

We recognise that collegiate working presents challenges and is not straightforward when difficult decisions need to be made. To support our alliance approach we will formally agree a set of 'joint working principles and behaviours' that we hold ourselves mutually accountable to uphold. We will also develop a dispute resolution process to help us maintain a consistent approach to these principles and behaviours. The precise form of resolution is still to be developed, but it is likely to involve Non-Executive Directors in a mediation role.

The proposed partners of the ACA are shown in figure 5 below. It is proposed that those providers and commissioners focused solely or mainly on the population of Wolverhampton are full members of the alliance. Other organisations that work across a larger footprint (such as the ambulance services and commissioners and providers of specialist services) would be associate members of the ACA.

Figure 5: Wolverhampton Transition Board and the member organisations



Developing local capacity for accountable care

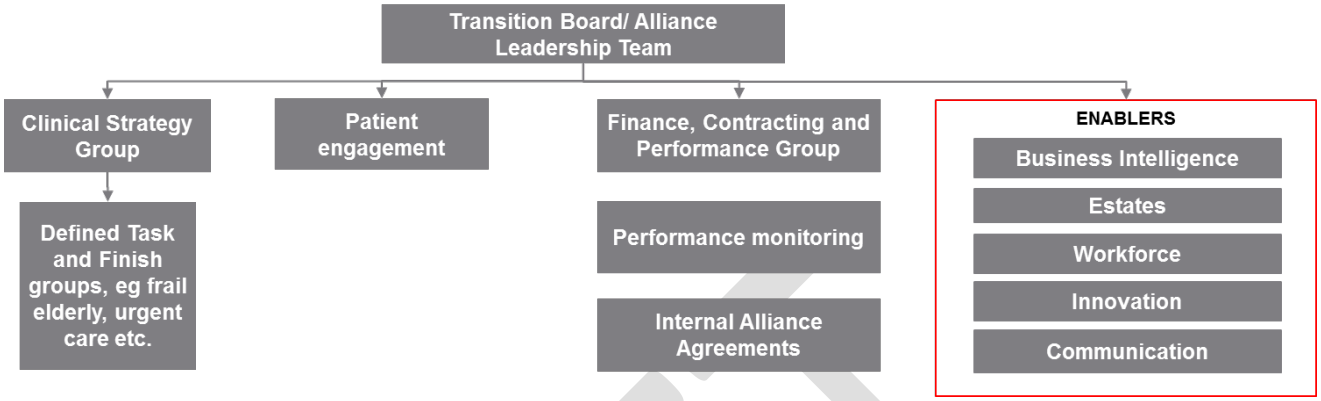
To deliver its agenda, the ACA will require a leadership and management capacity. This will be created by sharing resources across the participating members. We will bring the expertise of the local health and care economy to bear, including primary care clinicians who will have a pivotal role to play.

The following functions to support the work of the ACA are proposed (and set out in Figure 6):

- A Clinical Strategy Group brings together clinicians from different sectors and specialties including public health and mental health to set the strategic direction of the ACA. The Clinical Strategy Group would establish a combined design and delivery team, supported by task and finish groups, as required, to work through defined issues
- A patient representation function. Patient engagement is fundamental to the development of the ACA and its clinical proposals. Engagement is particularly important in the context of competition being replaced by collaboration between providers. 'Voice' as a key input in governance is important
- A separate Finance, Contracting and Performance Group would identify how the clinical strategy would be enabled, overseeing contracting with the Commissioner and between the provider organisations, and monitoring performance

- Separate defined groups would look at defined aspects of service delivery which support a developing clinical model. These might include business intelligence, estates, workforce, innovation and communication

Figure 6: Supporting structures for the ACA



The supporting infrastructure of the ACA will be delivered by staff from the member organisations. This may require some re-prioritisation of existing work programmes to generate sufficient capacity and the diverting away from lower value activities such as contract management. In the transition period some double running will be required.

Integration of the ACA into existing local governance

The ACA is well aligned to the Black Country STP as well as other local and national governance.

The Black Country STP proposes a series of place-based commissioning plans. The ACA will develop proposals for Wolverhampton, including Wolverhampton's contribution to reducing the projected STP financial deficit. The ACA will contribute to the development of commissioning arrangements at the Black Country level, including mental health and specialist acute services.

In the alliance model Wolverhampton CCG will retain its statutory role as a commissioner but as part of the ACA it will work in an open and transparent way with the providers within the alliance (although the formalities of the commissioner: provider split will be observed where it is necessary and appropriate for that to occur).

Chapter Four: Financial arrangements to support the delivery of the clinical model

Introduction

A significant advantage of accountable care arrangements is that they enable different elements of the NHS to work together within a shared financial envelope and facing common incentives. The ACA will ensure that resources are focused on the most clinically and cost effective settings.

Under the current arrangements, acute providers may be financially destabilised if a significant proportion of their activity is transferred to primary and community care without a coordinated restructuring of hospital services, even when it is best for patients. Working within a single, unified funding and decision making framework encourages the transfer of activity to the most appropriate setting, avoiding expensive specialist care by intervening early and co-ordinating services across care boundaries.

This section sets out how we will use new financial mechanisms to support the delivery of the clinical model, creating the right incentives across the system

Funding accountable care

Our approach to funding will be underpinned by the development of a clear view of the 'Wolverhampton pound'. The ACA will oversee the use of our community's financial resources to get the very best value for every pound spent. The alliance will collectively review the commissioning allocation and service providers cost base in respect of commissioned services

While community services are already subject to a block contract, acute hospital activity is governed by PBR. This current mix of contract types is not optimal and does not incentivise the clinical model that we want to provide. The Alliance will use the flexibilities afforded to successful health economies by NHSE and NHSI and will actively consider a range of payment mechanisms for providers to incentivise integrated care. These include the wider use of block contracts and risk sharing for Non Elective activity.

GMS/ PMS services will remain as currently contracted unless GPs choose otherwise, although the aim is for new resources to be directed to primary care via 'enhanced service contracts' and other initiatives including:

- QOF+ Frameworks;
- The development of Practice Staff including Managers and Nurses;
- Practice resilience support;
- Supporting the deployment of resources to different primary care practice delivery models.
- The implementation of quality contracts, where applicable, to provide more equitable services that provide a higher standard of care and enable efficiencies to allow investment in primary and community care.

We will look to incentivise good practice through the finance and contracting system. Quality outcomes agreed by the Clinical Strategy Group will be incentivised through a quarterly payment (a revised CQIN).

While PbR will be suspended in favour of block contracting for some agreed services, we will continue to monitor activity for the purposes of quality and planning (and also for 'external trading' beyond the ACA population).

As services are transformed, we will understand the impact on activity and cost across the system and adjust contracts accordingly in the spirit of gain loss sharing. This will take account of how quickly costs can be released and staff redeployed as appropriate.

We will enable the delivery of our transformation priorities through a series of business cases; each of which will set out clearly the agreed:

- Proposed service change and benefit to patients
- Impact on activity by setting
- Impact on delivery costs by setting and provider
- Any stranded costs and/or semi-variable costs with a plan as to how to address
- Any pump-prime resources required
- Impact on current contracts
- ROI and payback period

Financial Governance

The alliance will collectively review the commissioning allocation and service provider cost base in respect of commissioned service. A Finance, Contracting and Performance Group will bring together ACA Directors (for example, Directors of Finance and Contracting). It will establish mechanisms to transfer resources between and within organisations to facilitate initiatives designed in the Clinical Strategy Group. It is proposed that a set of principles are agreed in advance to support a consistent approach and to avoid, where possible, disputes. These will be fully developed by the group but are likely to include agreements over:

- Calculation and recalibration of block contracts (for example, taking account of annual efficiency requirements including QIPP and CIP)
- Agreement of costs
- Agreement on the timing for the removal of semi-variable and stranded costs
- Agreement of funding for double running/pump priming alternative service models
- Data sharing to support financial transparency within the ACA
- How to work with 'open book accounting'
- How to work towards a single control total for Wolverhampton

Improving value for money for taxpayers

The ACA will focus on getting better value for every Wolverhampton pound. We expect to deliver improvements in value for money by:

- Shifting activity to clinically appropriate and lower cost settings
- Making better use of shared facilities, people and assets across the ACA
- Reducing costs associated with less value adding transactions
- Removing unnecessary health care costs through better upstream prevention

However, we also recognise that the ACA will require initial investment to get up and running. We will explore opportunities for additional funding with regulators and would be willing to explore matching this with local money if we are permitted to access CCG non-recurring money.

Chapter Five: Next Steps

Introduction

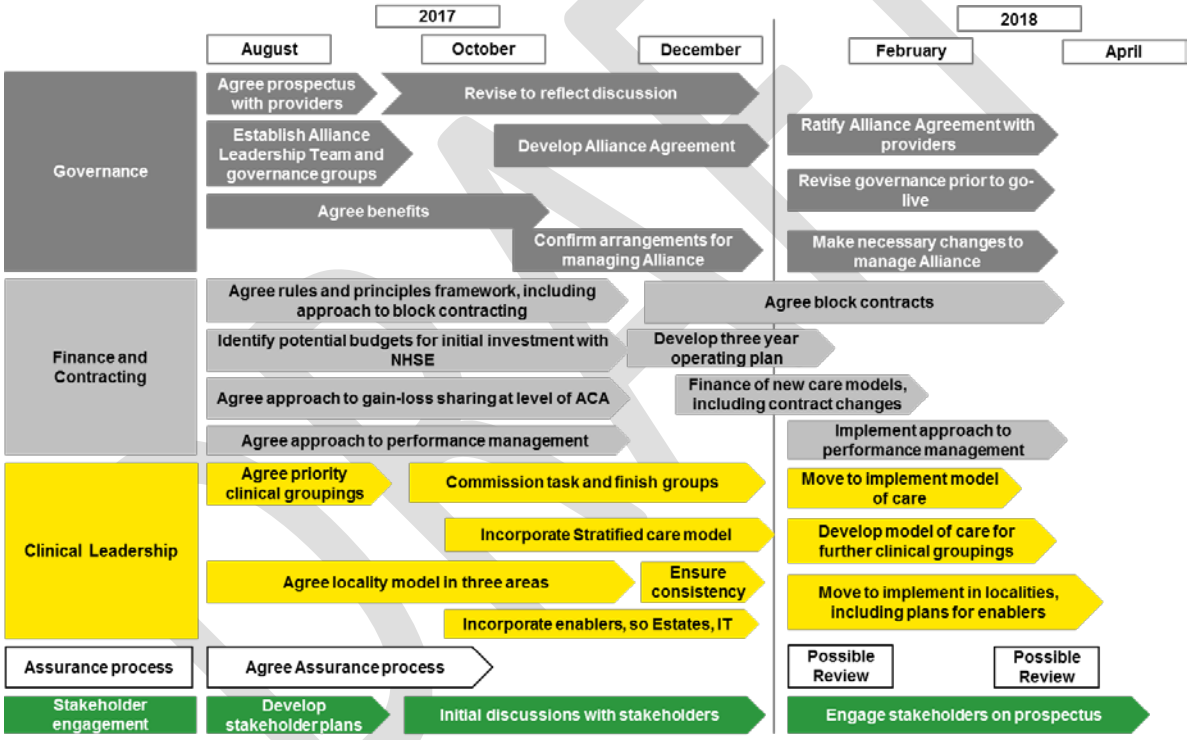
Our work programme is an ambitious one. Our challenge is not just to establish a new Accountable Care Alliance arrangement, but to link it to the ongoing delivery of a clear clinical model. Our intention is that the ACA should be in place from 1st April 2018.

We recognise that there is more work to do to turn this prospectus into a concrete plan for delivery. We aim to carry out this preparation work with significant involvement of the ACA stakeholders and through the implementation of a programme plan. We aim to establish the Alliance Leadership Team and its supporting groups by early autumn to steer subsequent progress.

Proposed implementation road-map

A high-level plan is set out below, setting out the main steps leading to implementation in April 2018. A full programme plan is available as a separate document.

Figure 7: High-level plan for implementation in April 2018



We will work through a number of issues to feed into the emerging Alliance Agreement. These would include the rules and principles framework and an approach to block contracting; potential budgets for initial investment with NHS England and an approach to gain-loss sharing at the level of the ACA. Our expectation is that the Alliance Agreement can be agreed before the end of 2017, with ratification through 'governing bodies' in early 2018.

We will also be working through how best to manage the Alliance. This prospectus sets out initial proposals for benefit indicators and these will be discussed further with local and national stakeholders. We will agree an approach to performance management using those indicators. We will establish what supporting infrastructure is required to manage the Alliance before the end of 2017, so that any changes can be made in the period leading to implementation.

Our clinical community will be developing proposals for integrated care in localities working with patients, social care, voluntary groups and the broader community. The three localities will be North East, South East and South West Wolverhampton. The model of care for the localities will be flexible and enable bottom-up implementation that takes account of local contexts.

As the locality proposals come together, we will consider how to develop an integrated clinical workforce in Wolverhampton, change buildings to deliver enhanced services in localities and exploit opportunities for digital transformation.

In parallel, the Clinical Strategy Group will prioritise clinical groupings where new models of care are required to support progress against the proposed ACA benefits. .

Task and Finish Groups will then define the new models of care for those clinical groups. Business cases will set out how resources should be moved to support the new pathways and what changes are required to contracts.

The ACA will produce or commission supporting analysis of the potential opportunities arising from an integrated clinical workforce, from changes to our combined estate (including the potential role of service hubs) and from digital transformation and service innovation. This analysis will feed into the development of costed locality proposals.

The Finance, Contracting and Performance Group will consider potential means to invest in service models, which will include the redeployment of existing resources alongside any additional funding which we are able to secure for transformation. We would expect to work through these issues in Autumn 2017, to inform the development of a three year operating plan for early 2018.

Engagement

Our proposals can only succeed if we take patients, clinicians, staff and the broader community on the journey. We understand that it will be essential to foster community support and even enthusiasm for our new way of working, and this will be important in explaining the consequences of a transfer of resource from acute to primary care.

The following table provides an initial stakeholder analysis. The leaders of the member organisations will agree a common approach to managing the stakeholders with individuals owning particular relationships.

Table 2: Main stakeholders

Group	Stakeholder	Potential issues
Commissioners	Other CCGs (esp Cannock Chase, Dudley CCG, Sandwell and West Birmingham CCG, South East Staffordshire and Seisdon Peninsula CCG, Walsall CCG)	Would continue to commission services from RWT but be outside the ACA – this may present consistency challenges as new models are introduced in Wolverhampton
	NHS England specialised commissioning	RWT is a significant provider of specialised services, which need to be integrated into new pathways
	Wolverhampton local authority	Commissioner of social care and of public health services will need to be engaged by the ACA
Regulators	NHS England	Would need to approve the ACA and the financial approach
	NHS Improvement	Would need to approve the ACA and the financial approach
Providers	Other acute trusts	Consider impact on patient flows of new Wolverhampton pathways
	Other mental health trusts in the West Midlands	Mental health trusts are working to create an integrated organisation. Service proposals should align with the emerging Wolverhampton service model
	Other community health providers in the West Midlands	Engaging with other community providers is opportunity to share best practice. There is a need for some alignment across the Black Country
Patients and the community	Healthwatch	Important to engage and invest in patient involvement in developing new service models
	Local groups	Patient input will be essential to shape proposals
Clinicians and staff	Clinicians	Important to secure buy-in to the concept and reality of the unified clinical workforce across Wolverhampton
	Staff groups	Staff will want to contribute and engage in new service models and to understand implications for them
	Trade Unions	Will want to be involved in earliest stages, considering the potential implications for staff
STP	STP Leadership	Need to align place-based commissioning proposals to the continuing development of the STP.

Assurance process

Our proposals for a virtual accountable care organisation need to be developed with our regulators

We would envisage that this prospectus forms the basis of a substantial discussion with NHS England about the proposal for an alliance agreement. Subject to their approval, we would then develop a more detailed proposal for December 2017.

We will agree an assurance process with them during which we would expect to work through the following questions:

- Will the service model produce net benefits?
- Are the provider and commissioner capable of managing the contract?
- Have the consequences for other providers been thought through?
- What are the risks associated with the ACA and what is the mitigation plan