Birmingham and Solihull Sustainability and Transformation Plan

21st October 2016 SUBMISSION

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Foreword

The NHS in Birmingham and Solihull has a proud history of delivering high quality care to patients and families, and we have much to celebrate about our primary care, community and hospital based services.

We are also in the fortunate position of having already taken many of the bold decisions required to ensure sustainable services for the future over recent years. For example, we bought together the Queen Elizabeth and Selly Oak Hospitals into a brand new state- of –the- art centre in 2010. We have also consolidated many of our standalone specialist centres such as the Eye Hospital on to our main hospital sites to ensure their viability. We are a forward thinking system that does not shy away from doing the right thing for both patients and the taxpayer. As a result, we have some world-leading services right here in our city, serving people from all over the country.

We have worked hard to transform our social care services, focussing on supporting people to live independently for as long as is it is possible for them to do so. We are committed to ensuring our people have a high quality of life within their communities, accessing the care that is most appropriate for them, and if there comes a time when they need us more we want to make sure that the additional support is there.

However, demand for health and social care is growing. Our population is changing and facing many challenges– nearly half live in some of the poorest areas in the country. People in this group you are more likely to have a mental health problem or die from a condition that can be supported. We are also becoming more diverse as a population, with different expectations and requirements of health and care services.

We also know we have significant challenges around the future of community based services including both general practice and adult social care. Both are critical to the successful delivery of a high quality and sustainable future for health and care in Birmingham and Solihull. If we were to do nothing differently, within less than 5 years we would need to build a new 430-bed hospital to cope with the amount of patients needing our services. To do this will neither be affordable or right for our population who want to be kept well, independent and living in their own homes for as long as possible

As local leaders in Birmingham and Solihull, we are committed to working together to ensure that the services we provide meet the changing needs of local people now and in the future.

Within this draft Sustainability and Transformation Plan (STP), we feel that we have set out the first steps in how we might go about making the real transformational changes to the way we work and the services that we deliver. Despite the challenging backdrop to STPs, we feel we have a real opportunity to change things for the better. By developing our current system to be innovative and forward-thinking, making the most of new technology and supporting our people to live well for longer, we can ensure that everyone has a better experience of health and care and the opportunity to be independent for as long as possible for them.

Solihull Metropolitan Borough Council · Birmingham City Council · NHS

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Overview

The Sustainability and Transformation Plan (STP) is about local leaders working together to deliver better health and care for local people. It's no secret that the NHS and in social care are addressing significant financial challenges and increased demand, so both need to work together to make resources go further whilst ensuring that we can still deliver the quality of care people need.

Across Birmingham and Solihull (BSol) , NHS and local government leaders have been working together to think about how we might start to tackle this issue. The STP is an iterative process, and this is the start of a longer transformation journey. It's not a short term plan - this is for long-term, sustainable change over 5 years and beyond

We have taken considerable steps to address previous feedback . A key aspect of this process was acknowledging that our organisations needed to work closer together and build stronger relationships between footprint partners. This has been a crucial step towards reaching an agreed baseline position and in further developing our delivery plans for how we address our future sustainability for health and social care.

Understanding the gap

To gain a better understanding of our system challenges, we have undertaken a detailed analysis of our system including the key gaps in our population's health and wellbeing, care and quality, and financial position. We recognise the scale of the challenge ahead and the level of transformation required to address this but if we get this right there will be considerable benefits for our populations.

Health and wellbeing	• **Deprivation** – 440,000 (46%) of the footprint population live in the "bottom 10%" most deprived areas in England. 1 in 3 children live in poverty • **Mental Health** – people in this percentage are three times more likely to be in contact with mental health services • **Obesity** – 39.2% of Birmingham and 29.9% of Solihull children aged 10-11 were classified overweight or obese in 2014/15 (the national average is 33.2%) • **Diabetes** – the prevalence of Diabetes for those registered with GP practices (aged 17+) in Birmingham is 8.3%, notably higher than the England average of 6.4% • **Infant mortality** – Birmingham is a national outlier for infant mortality (7.1 in Birmingham, 4.9 in Solihull – Deaths/1,000 live births). This is compared to the national average of 4 per 1,000 live births • **Cancer** – cancer mortality rates in all three CCGs are higher than the national average of 285 per 100,000 population (South Central CCG, Cross City CCG and Solihull CCG had cancer mortality rates of 291, 306 and 286 respectively)
Care and quality	• **A and E waiting times** – as reflected nationally, this is a key issue for BSol. Both UHB and HEFT have consistently failed to meet the A and E 4 hour waiting time target of 95% between January to June 2016 • **Delayed transfers of care** – those attributable to the NHS and Social Care across the STP footprint is 17.39 per 100,000 population (worst performing quartile nationally) • **Primary care** – The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and practice nurses per 100,000 population (0.53). The respective figures are Birmingham Cross City CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56 • **Reablement** – both Birmingham Local Authority (LA) and Solihull LA have lower rates than their peer averages for adults aged 65 and over receiving reablement services post hospitalisation. Solihull's rate was just over half that of Birmingham's (1.7% and 3%, respectively)
Finance and capacity	If nothing changes (the 'do nothing' scenario) in the way we deliver care, how we work with families and communities, and prevent early onset of disease, the system would need a further 430 hospital beds. This equates to almost a new hospital, in 5 years time, costing around £600m. When this is added to the social care funding shortfall our total system financial gap is around £721m i.e. additional funding requirement, which is not available to the NHS or social care. We must therefore change the way work together to improve care, quality and reduce the need for large scale funding increases. There are a number of reasons for this, including an increase in activity growth and inflation. Closing this financial gap is possible but it will mean changing the way we do things in the Birmingham and Solihull system.

Executive summary (cont'd)

Understanding the gap – Key drivers

In assessing our problems, we have used a framework to test a number of hypothesis which have helped us identify the underlying key drivers contributing to our position and system challenges as illustrated below (further detail on page 13):

3 Key drivers of our challenges:

1. Suboptimal system wide focus on use of resources

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure.

2. Too much care that can be delivered elsewhere is provided in a hospital setting

Creating bottlenecks and queues with a knock on impact on quality and safety due to rising demand from the ageing population and historical over reliance on acute services

3. Variation in clinical services

Due to unjustified variation in quality and access

If we get this right, following further work, it will mean we can deliver what people say they want:

- A focus on promoting health and wellbeing,
- Helping people to stay independent for longer
- A reduction in health and social care crises,
- A more joined up approach to providing care,
- Greater access to community based services
- New sustainable models of general practice.

Our new models of care will:

- Promote a person centred approach and anticipate problems
- Promote self care and individual and community resilience
- Ensure consistency of care and better experience and outcomes for individuals

Our Strategic Objectives

We have identified and agreed the following three strategic objectives as an approach to address our system challenges and the key drivers which contribute to these:

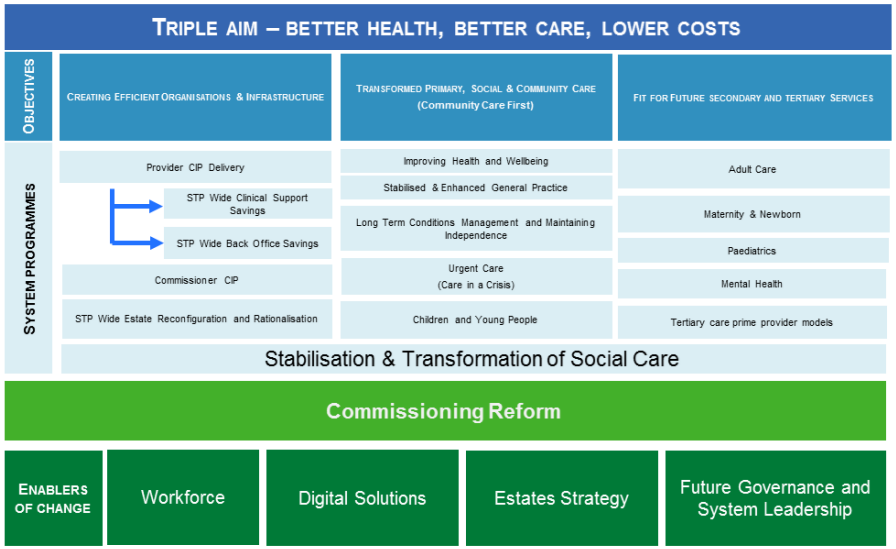
1.  **Creating Efficient Organisations and Infrastructure**	The initial step to building a sustainable health and care system for BSol through creating efficient and lean organisations by achieving successful delivery of CIPs/QIPPs supported by a robust programme of organisational recovery where required, to strengthen current performance. We also need to ensure effective use of our collective estate.
2.  **Transformed Primary, Social and Community Care *(Community Care First)***	Organisations will work collectively to address the growing demand for hospital care. This includes moving activity that is currently provided in a hospital setting into more local settings of care, ideally at home. This will be achieved through the prevention and self care agenda to improve health and wellbeing and through integrated and enhanced primary, social and community care, developing community resilience, and improved use of technology keeping people independent and reducing acute crises. This will include actions to stabilise general practice and social care. Into our work we will incorporate learning from the New Care Models Programme including Vanguards operating within the footprint.
3.  **Fit For Future Secondary and Tertiary Services**	The above two steps will enable us to better understand and manage demand which needs to be dealt with in secondary and tertiary care. We will deliver fit for future services by reducing variation and simplifying access to high quality secondary and tertiary services; including delivering prime provider and managed network models to transform acute services across multiple sites. Into our work we will incorporate learning from the New Care Models Programme including local Vanguards operating within the footprint.

Executive summary (cont'd)

STP Priority Programmes and key enablers

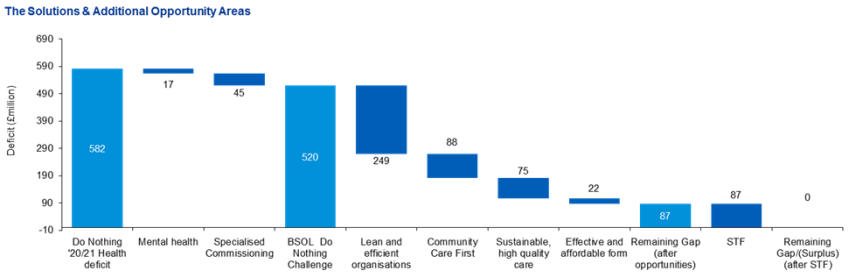
We have developed a number of priority STP programmes for each of our strategic objectives which form the basis of our delivery plan for the system . This will lead to the development and transformation of care and support received by patients and the public.

This is illustrated by our 5 year plan on a page:



Financial Impact Of 5 Year Plan

High level modelling has been conducted on our strategic objectives to quantify the impact and estimated financial savings for these schemes.



Next Steps – to end of March 2017

We recognise the scale and pace required by the system to accelerate the changes required, and the risks to delivery are set out in the plan. A key issue to be addressed as we move forward is that the process to date has focussed on addressing the projected financial gap for the NHS. Further work is now required to address the projected financial gap for social care

Our immediate next steps include:

DATA

- Agree approach to develop a more granular demand, capacity and cost model to generate a more detailed picture to support further planning over next 8 weeks
- Develop and refine analysis on all STP programmes to enable an options appraisal on preferred models
- Establish evaluation criteria
- Support prioritisation by identifying what will make a difference

Delivery & Programme Management

- Strengthen system PMO for the STP programme including additional capacity to support the future governance arrangements and further develop the STP, the delivery plan and implementation at a system level
- Identify and communicate working groups for STP programme and enabling workstreams
- Further develop the various STP priority initiatives into detailed project delivery plans to support programme solutions and operational planning requirements
- Develop a system level programme plan to monitor progress key milestones
- Include 90 Day Plan for immediate delivery

Finance

- Agree the social care financial gap and the impact on the delivery of social care services, and knock on impact on the rest of the system
- Identify opportunities to address remaining financial gap across health and social care
- Agree finance support for the further development of plans
- Develop business cases on priority STP programmes including return on investment

Engagement

- Further develop communications strategy for the STP and commence programme of activities to support wider engagement
- Obtain feedback on proposed solutions across STP programmes
- Agree key messages for STP programmes to support wider engagement including workforce, public, and political stakeholders

Governance

- System leaders and other key stakeholders to develop and formalise governance arrangements
- Define governance roles, responsibilities and terms of reference
- Agree and communicate governance arrangements
- Roll out of future governance arrangements

Understanding the gaps

Planning for health and social care in Birmingham and Solihull

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Understanding the gap: BSol population

The BSol Footprint

- **1.3 million** people
- **2** local authorities
- **3** CCGs
- **182** GP practices
- **7** acute hospitals (**3** specialist facilities)
- **1** mental health trust
- **1** community health trust plus one vertically integrated community provider within an acute trust.

** Additional information provided following June submission*

- Birmingham is the youngest core city in Europe (46% of the population are under 30)
- Solihull has an ageing population (19% of the population are over 65, 13% in Birmingham)
- Birmingham is a diverse city (42% of residents come from an ethnic group other than white)
- Solihull has increasing diversity (11% of the population identify as Black, Asian or Mixed Ethnic Minority – BAME)
- Birmingham is a growing city linked in part to migration (9.9% increase since 2004, Solihull has increased by 3.6% since 2001)
- Solihull and Birmingham both have a prosperity gap reflected in the 10 year life expectancy gap between the least and most affluent wards
- Birmingham has a homelessness level more than three times the England average – 7.6 per 1,000 households against the England average of 2.3 per 1,000 households
- Birmingham has a long term unemployment rate around 2.5 times higher than the England average (19.8 per 1,000 population aged 16-64 against the England average of 7.1 per 1,000 population aged 16-64)

Other key facts

- Annual number of convictions for homicides (2011/13 average) in Birmingham and the Black Country is 2.20 per 100,000 population compared to Greater Manchester 1.18 per 100,000 population
- 90% of the Birmingham adult population owns a smart phone (the highest coverage in Europe), offering significant opportunities for use of new technology
- Solihull hosts significant economic hubs for the footprint – NEC, Land Rover, Birmingham Airport, and the future HS2 hub and associated development (UK Central) – currently drawing in 85,000 workers daily
- Birmingham hosts 5 universities

Understanding the gap: Health and Wellbeing

We recognise the need for improvement in our population's Health and Wellbeing as highlighted below and the Care and Quality Outcomes across Birmingham and Solihull (see following pages):

Vulnerable Groups and Communities

- 440,000 (~46% of the footprint population) live in the "bottom 10%" most deprived areas in England

Within this population

- In Birmingham life expectancy for men is 77.6 years (the national average is 79.4) and for women it is 82.2 years (national average 83.1 years). In Solihull life expectancy for men is 80.3 years and 84.8 years for women
- Birmingham has a gap in life expectancy between the most deprived and the least deprived areas of 7.4 and 4.9 years for males and females, respectively. Solihull has a gap in life expectancy of 10.3 and 10.5 years for males and females, respectively
- 1 in 3 children live in poverty
- People in this decile are 3x more likely to be in contact with mental health services, be admitted for ambulatory sensitive conditions, or die from conditions amenable to healthcare
- Birmingham and Solihull are in the bottom quartile for emergency admissions from falls, and have agreed targets for significant improvement.

Employment

- 59,000 people are on Employment Support Allowance
- This represents 4.5% of the BSol population, compared to 3.7% national average
- Of this population 49% experience a Mental Health condition
- 14% also have musculoskeletal issues
- Only 1% (Birmingham) and 3% (Solihull) of supported adults with Learning Disabilities are in paid employment (the national average is 7%)
- Only 6% of people with serious mental illness (on the Care Programme Approach) are recorded as employed

Health

- Birmingham Cross City CCG and Solihull CCG had 4.5% and 11% higher cancer incidence rates than the national average, respectively
- Mortality rate from cases considered preventable (in 2013/14) was 238 per 100,000 in Birmingham – 30% worse than the national average of 182.7
- Under 75 mortality rate from cardiovascular disease considered preventable in Birmingham is 67.7 compared to a national average of 49.2 (per 100,000)
- South Central CCG, Cross City CCG and Solihull CCG had cancer mortality rates of 291.3, 306 and 286.9 per 100,000 – all higher than the national average of 285.4
- Birmingham Cross City CCG had an incidence rate of lung cancer of 90.2 per 100,000 – 14% higher than the national average. Birmingham South Central CCG had an incidence rate of 97.8 per 100,000 – 23% higher than the national average

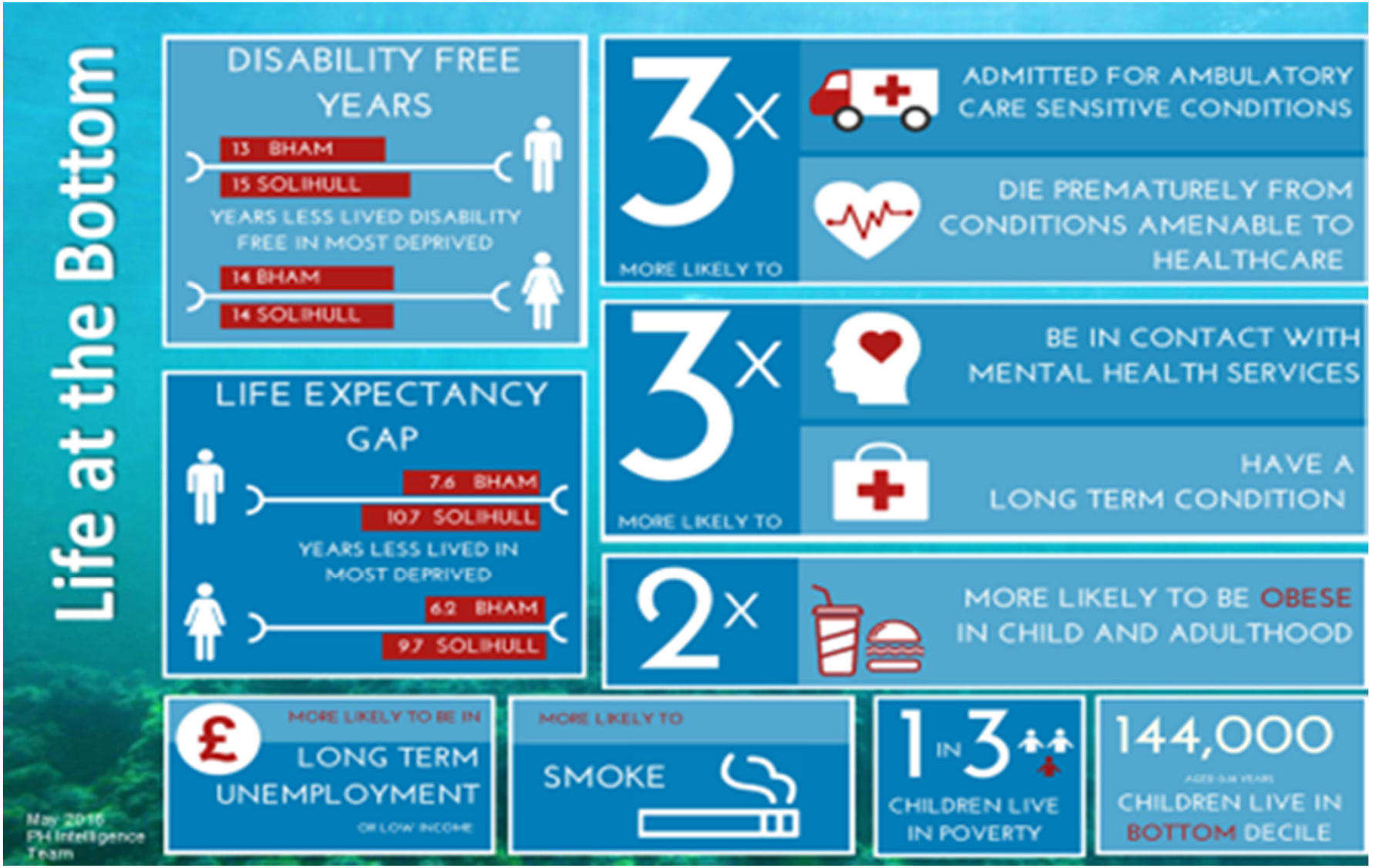
Projections

- Birmingham's population is projected to increase by 146,000 (13%) over the next 20 years
- The largest changes are for people aged 65-84 with a projected increase by 35%
- People aged 85+ are expected to increase by 75% by 2035
- (Children aged 5-14 are projected to increase by 10% over the next decade

Maternity and Early Years and Children and Young People

- Birmingham has high levels of A and E Attendances for 0-4 year olds – 585.9 per 1,000 compared to the national average of 540.5 per 1,000
- There is high infant mortality of 7.1 deaths per 1000 live births in Birmingham and 4.9 in Solihull .This is compared to the national average of 4 per 1,000 live births
- 39.2% of Birmingham and 29.9% of Solihull children aged 10-11 were classified overweight or obese in 2014/15 (the national average is 33.2%)

If you live in the most deprived areas you are:



Understanding the gap: Care and quality

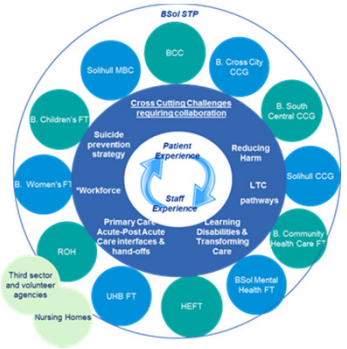
Overall, each individual organisation is responsible for addressing care and quality gaps at a local level through their own governance processes and structures. However, there are a number of challenges that need the engagement and collaboration of multiple organisations in a BSol-wide approach. Fundamental to improving care and quality is patient and staff satisfaction. Engaged/satisfied employees result in higher patient satisfaction and better outcomes.

PATIENT EXPERIENCE

- Whilst the Friends and Family Test (FFT) indicates the majority of people would recommend the service, the challenge is maintaining patient satisfaction whilst transformation programmes are underway.
- There is variation in the FFT scores across the organisations within the STP footprint with many organisations exceeding the national benchmarks *(please note these vary depending on the service):*
  - A and E
    81-85 % (national benchmark 86%)
  - Mental Health
    91-95% (national benchmark 93%)
  - Community services
    88-99% (national benchmark 95%)
  - Inpatient/day cases
    93-100% (national benchmark 96%)
  - Outpatients
    91-95% (national benchmark 93%)
  - Maternity
    91-94% (national benchmark 97%)

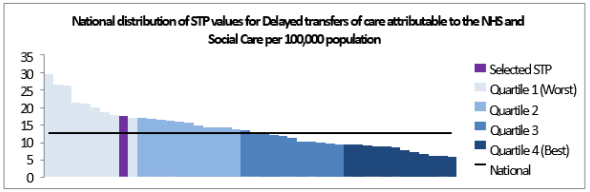
STAFF EXPERIENCE

- There is significant variation in the staff experience across the STP footprint:
  - Staff recommending their organisation as a place to work varies from 44 – 93% (national benchmark 64%)
  - Staff recommending their organisation as a place to care ranges from 56 – 93% depending on the organisation (national benchmark 80%)



PRIMARY CARE – ACUTE CARE – POST ACUTE CARE INTERFACES

This relates to key 'touchpoints' or hand-off's between the sectors e.g. primary care to the acute sector or from the acute sector to community or social care. Analysis on total spend shows that 8% of the over 65s account for 62% of total spend - which reflects the significance of these touch points.



A and E ADMISSIONS

- There is a growth in emergency admissions for conditions which would not usually need a hospital admission (currently 940.8 per 100,000 population).

DTOC

- Delayed transfers of care attributable to the NHS and Social Care across the STP is 17.39 per 100,000 population (worst performing quartile nationally)

A AND E ATTENDANCES

- In FY 2014/15 Birmingham Cross City and Birmingham South and Central CCG were identified for above average emergency admissions of both acute and emergency admissions that would not usually need a hospital admission.

CHC AND DOMICILIARY SERVICES

- There are significant challenges with available capacity as well as variability in quality of care in nursing homes and domiciliary care
- There is also a need to improve quality assurance in relation to personal budgets

PRIMARY CARE

- The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and Practice Nurses per 100,000 population (0.53). The respective figures are Birmingham Cross City CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56

Understanding the gap: Care and quality (cont'd)

LTC PATHWAYS

END OF LIFE CARE

- Across the STP 53.8% patients (Q1 2015/16) died in hospital. This was in the poorest performing quartile against the national figures

MANAGING OWN CONDITION

- 63.3% of people with a long term condition feel supported to manage their own condition (this is in the poorest performing quartile with national benchmark 66%)

RESPIRATORY

- Male under 75 mortality rates from respiratory disease in Birmingham South and Central CCG are 48 deaths compared to the national average of 31.2 (per 100,000)

DIABETES

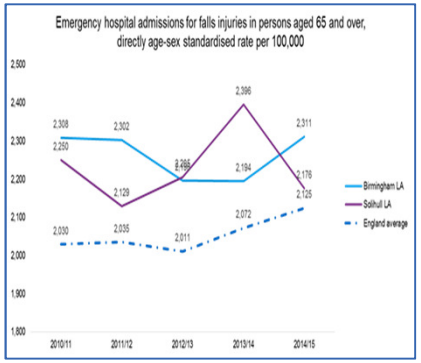
- Diabetes in the population registered with GP practices aged 17 and over in Birmingham is 8.3% – notably higher than the England average of 6.4%

LEARNING DISABILITIES AND TRANSFORMING CARE

- Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020
- There are high rates for people with LD or autism receiving specialist inpatient care (across the STP – 65 per million population)

ELIMINATING HARM INCLUDING HCAI (HEALTHCARE-ASSOCIATED INFECTIONS)

- An estimated annual collective financial opportunity at BSol of between £3.5-4 million has been identified through reduction of falls with harm, pressure ulcers, c. difficile and MRSA (see right for falls injuries requiring hospital admission)
- There needs to be an alignment of efforts across public health, primary and secondary health care, and social care on key infections and events causing harm, that would benefit from a 'joined up' approach to prevention, recognition and management



SUICIDE PREVENTION STRATEGY

- Whilst Birmingham and Solihull are not outliers compared to national averages, there is clear room for improvement as the West Midlands Mental Health Commission has expressed a 'zero suicides ambition'
- In line with national priorities, BSol has agreed an STP-wide suicide prevention plan targeting high groups and locations and whilst led by the Mental Health Trust, there will need to be input from primary and secondary care as well as social care

WORKFORCE (ENABLER) ***SEE APPENDIX***

- In order to deliver this transformation in care and quality there will need to be changes within the workforce including:
  - Upskilling and retraining of staff to be able to manage higher acuity patients in community and primary care settings (the number of staff this will impact has yet to be quantified)
  - Addressing shortages in GPs and nursing staff in the community and reduce the reliance on temporary staff
  - introduction of a range of different skills and competencies in community based care, including care navigation and wide skilling approaches to existing roles

Understanding the gap: Key drivers

Our detailed analysis of BSol has enabled us to have a deeper understanding of the challenges within the footprint and the areas of improvement required across BSol's care, quality and financial performance. In assessing, we have used a framework to test three key hypothesis to help identify the underlying key drivers which may contribute to our problems and overall challenges.

1. **SUB-OPTIMAL SYSTEM WIDE FOCUS ON USE OF RESOURCES**

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure

2. **TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING**

Creating bottlenecks and queues with a knock on impact on quality and safety due to rising demand from the ageing population and historical over reliance on acute services

3. **VARIATION IN CLINICAL SERVICES**

Due to unjustified variation in quality and access

SUB-OPTIMAL USE OF RESOURCES

DELAYED TRANSFERS OF CARE (DTOC)

- There are a high number of delayed transfers , causing lost bed days and exacerbating operational difficulties in patient flow. Whilst there is a large amount of non-acute bed capacity, there are still significant issues around timely discharging of patients.
- Heart of England Foundation Trust (HEFT) has the highest number of days amongst its peer group, while University Hospital Birmingham Foundation Trust (UHB)is in line with its peer average. The primary reason for delays at both organisations being nursing home placement or availability. Similarly, Birmingham Community Healthcare NHS FT (BCHCFT) is third highest in its peer group for total delayed days amongst comparable community trusts, the primary reason being availability of nursing home placements.
- For Birmingham and Solihull NHS FT and the Royal Orthopaedic Hospital NHS FT (ROH) waiting for non-acute NHS care is the primary reason for delays

HIGH LENGTH OF STAY

- Recognising that DTOC are a key challenge for some patients, opportunities still exist to improve organisational efficiency to reduce length to stay.

ESTATES INFRASTRUCTURE

The BSol footprint currently comprises circa 650 buildings with 1000+ property interests. The quality and utilisation of the estate varies significantly across the footprint

There are areas of sizeable estate void. Across the footprint there are voids within LIFT buildings of circa £5m and £1m within the NHS Property Services portfolio

Providers use a considerable range of asset management options to secure tenure, including PFI, making rationalisation difficult to realise without considerable risk

There is unwarranted variation in the delivery facilities management (FM) support services across all providers exacerbated by disjointed procurement models

Providers complain of a lack of control over the provision and value for money at Local Improvement Finance Trust (LIFT)and NHS Property Services premises

Estates management is fragmented across 7 providers and 2 property company management teams

COMMUNITY BEDS

There is a high number of community beds supplied by all providers across Birmingham and Solihull when compared to peers

ACUTE BEDS (BETWEEN APRIL AND JUNE 2016)

HEFT had the second highest occupancy percentage amongst its peer group at 90.5%

UHB had the highest occupancy percentage amongst the peer group (99.1 % occupancy compared with 91%)

ROH has the highest occupancy rate (85% - 90%) amongst three comparable specialist orthopaedic Trusts

COMMISSIONING

The move to three CCGs across BSol has been perceived by providers and other key partners as a lack of unity in our approach to commissioning. National STP guidance clearly indicates that future CCG allocations will be contingent on robust system planning and working

** Please note that there are additional drivers but these have been identified as the key drivers of the STP (as a whole)*

Understanding the gap: Key drivers (cont'd)

1 SUB-OPTIMAL SYSTEM WIDE FOCUS ON USE OF RESOURCES

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure

2. TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING

Creating bottlenecks and queues with a knock on impact on quality and safety due to rising demand from the ageing population and historical over reliance on acute services

3. VARIATION IN CLINICAL SERVICES

Due to unjustified variation in quality and access

TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING

POOR ACCESS TO PRIMARY CARE AND COMMUNITY SERVICES

- Birmingham Cross City CCG has the second lowest number of GPs per 100,000 population amongst its peer group, and almost half that of South Central CCG. Solihull CCG has the third lowest number of GPs per 100,000 population amongst its peer group. Birmingham Cross City CCG also has the third lowest number of practice nurses per 100,000 population against its peer group
- Both Birmingham LA and Solihull LA had lower rates than their peer averages for adults aged 65 and over receiving re-ablement services post hospitalisation. Solihull's rate is just over half that of Birmingham's (1.7% and 3%, respectively)

LOW NUMBER OF CARE HOME BEDS

- Solihull has the second lowest number of care home beds per 10,000 population (older than 65 years) amongst its peer group, while Birmingham is in line with its peer average.

MENTAL HEALTH

- There is a marked higher prevalence in Birmingham of patients requiring complex inpatient care with Birmingham second highest in its peer group for incidence of psychosis per 100,000 population
- In regards to psychosis two week wait times Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) reports 25% of patients starting treatment within two weeks of referral – which demonstrates recent steady improvement.

EMERGENCY ADMISSIONS THAT SHOULD NOT REQUIRE HOSPITAL ADMISSION

- Birmingham Cross City, South Central and Solihull CCGs had over 4,300 emergency admissions per 100,000 patients due to lack of community based alternatives/ fragmented services in 2014/15

VARIATION IN CLINICAL SERVICES

INAPPROPRIATE DUPLICATION OF SERVICES

The STP is working with Services to identify where any inappropriate duplication and variation is occurring which does not have a patient benefit.

VARIATION IN CLINICALSERVICES

MATERNITY

- Fragmented service provision with variations in outcomes across the system

CANCER

- All three CCGs (Birmingham Cross City, Birmingham South Central, and Solihull) ranked either first or second best for the proportion of cancers diagnosed early (stage 1 and 2) relative to their peers
- However, Birmingham Cross City CCG was the third worst performer against its peers and South Central CCG was the second worst performer against its peers for the 62 day cancer waiting standards from urgent GP referral in 2015/16
- The mortality rate for men from causes considered preventable is 311.7 per 100,000 population compared to the national average of 230.1. A 35% higher rate in Birmingham.

MENTAL HEALTH

- In 2016/17 across age ranges and provision BSol has a number of out of area admissions
- Birmingham Cross City CCG had the highest number of Improved Access to Psychological Therapies (IAPT) referrals waiting over 90 days for first assessment at the end of May 2016 within its peer group – this is the same service for al l CCGs

ORTHOPAEDICS

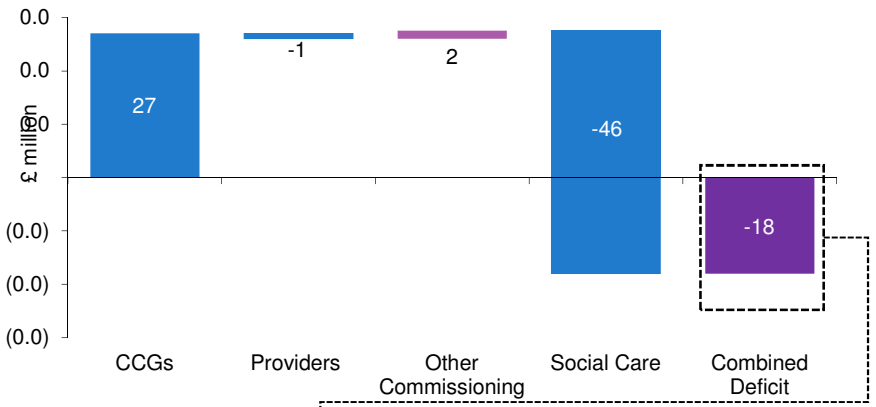
- Fragmented service provision with variations in outcomes across the system

Understanding the gap - Finance - 15/16 through to 20/21

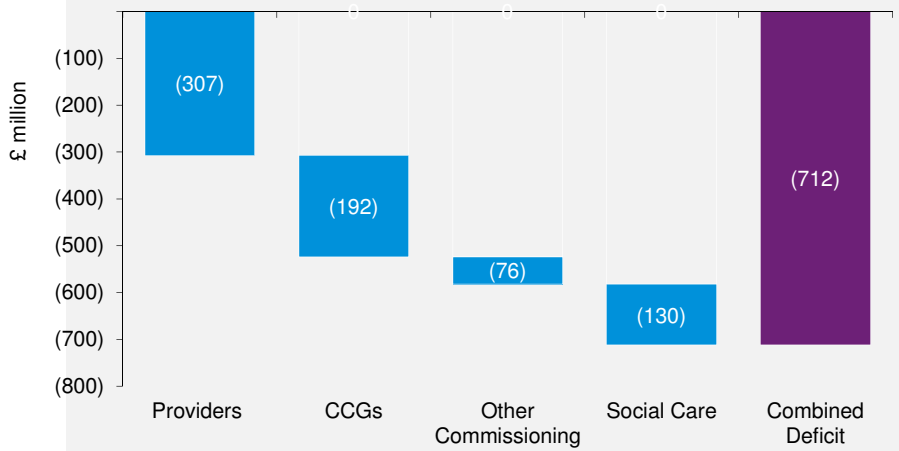
- The combined 16/17 forecast position for the health and care economy is an overall deficit of £18m. This is driven primarily by the £46m deficit in social care, with the health sector showing a forecast surplus for 16/17 of £24.5m
- As the chart opposite shows, by 2020/21 the overall combined health and care sector deficit for the Birmingham and Solihull STP grows to a £712m in-year deficit position
- The composition of the 20/21 combined deficit can be seen in the chart below, with the single biggest driver in the growth of the deficit being providers, which grow from a £1m to £307m deficit position.

NB Control Totals have not been agreed by NHS Organisations

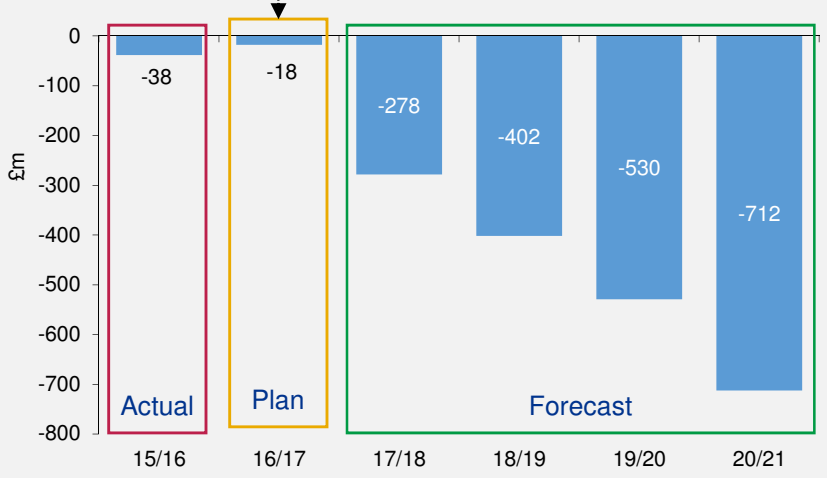
16/17 Forecast deficit by organisation type



20/21 Do Nothing Deficit by organisation type



20/21 Do Nothing financial Gap

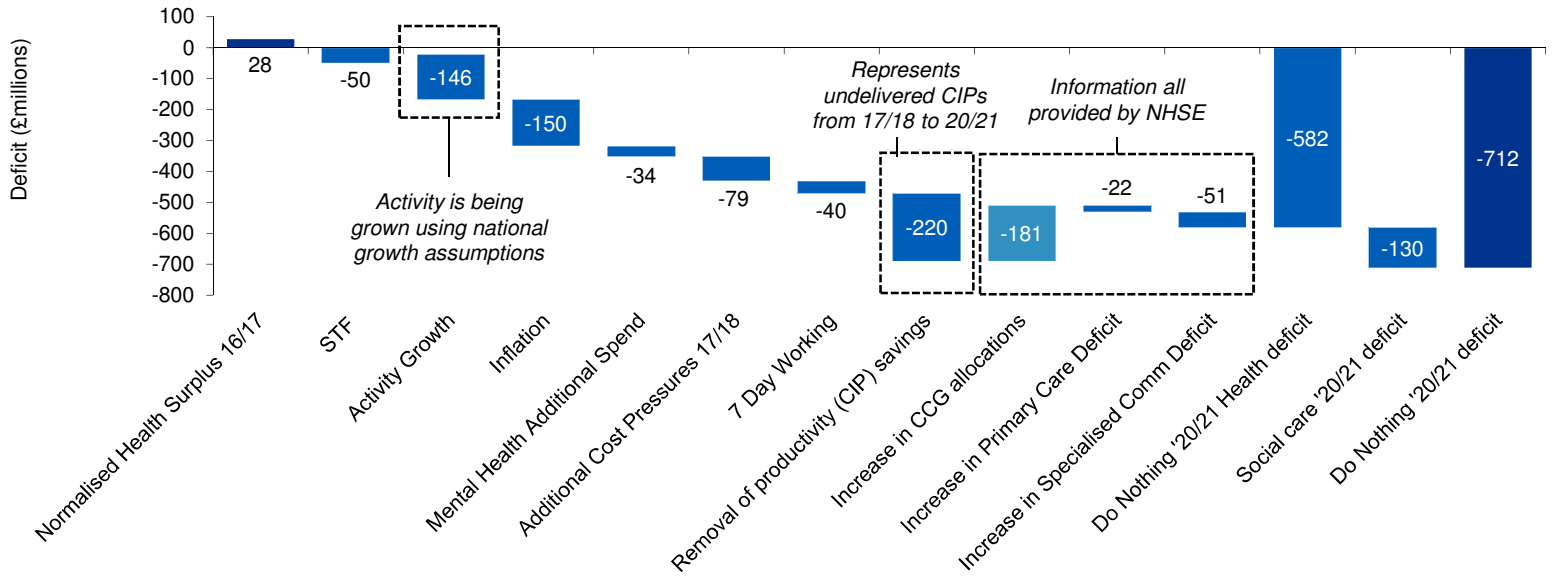


Understanding the gap: Finance (cont'd)

FINANCIAL GAP ANALYSIS – 'DO NOTHING'

The below chart shows the breakdown of the increased financial gap between the planned 2016/17 position and the forecast 20/21 position

Drivers of the Forecasted Health and Care Gap



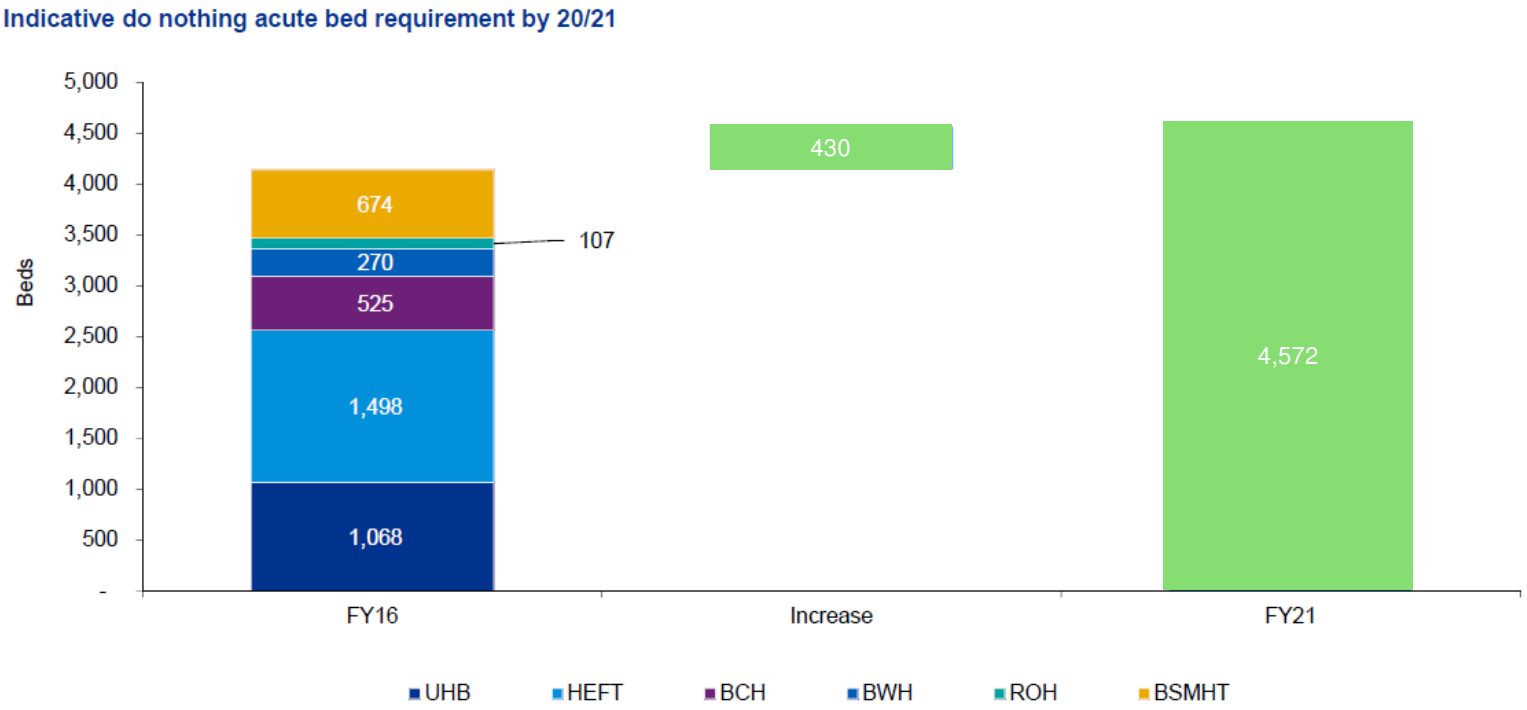
Footnote: this does not include the impact of the move to 17/18 tariff, other than the impact of the average tariff deflator. HRG4+ and top up changes are not taken into account

Understanding the gap: Capacity

We have not yet performed detailed demand, activity and capacity modelling which would provide a much more accurate and granular understanding of future capacity requirements across the system. However, the below chart shows the illustrative increase in acute beds required by 2020/21 in the 'do nothing' scenario, assuming the national activity growth assumptions, constant length of stay and utilisation during the forecast.
The FY16 bed numbers have been taken from the most recent NHSE publication of bed availability and occupancy
This suggests that if nothing were to change an additional 430 inpatient beds would be required in the system to manage the increasing demand – this is the size of a typical general hospital and there are not empty beds available to cover this demand. In addition the required workforce is also not available.

Therefore our plans are designed to:

- Avoid the need to open an additional 430 inpatient beds over the current baseline which would otherwise be required as outlined below



Addressing the gap

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Strategic objectives

Understanding the three drivers to our collective challenges has enabled us to develop our approach on how to address these challenges and informed the solutions required to build a sustainable health and social care economy for BSol and to address the substantial health and wellbeing challenges on our patch. Our approach is based on three strategic objectives as outlined below, each of which have a number of priority programmes identified to achieve sustainable high quality health and social care.

1.  **CREATING EFFICIENT ORGANISATIONS AND INFRASTRUCTURE**	The initial step to building a sustainable health and care system for BSol is through creating efficient and lean organisations. This will be done by achieving successful delivery of CIPs/QIPPs supported by a robust programme of organisational recovery where required, to strengthen current performance. In addition there are opportunities to make better use of our resources by ensuring effective use of our collective estate.
2.  **TRANSFORMED PRIMARY, SOCIAL AND COMMUNITY CARE** *(COMMUNITY CARE FIRST)*	The organisations will work to address the growing demand for hospital care. This includes moving activity that is currently provided in a hospital setting into more local settings of care, ideally at home. This will be achieved through the prevention and self care agenda to improve health and wellbeing and through integrated and enhanced primary, social and community care, developing community resilience, and improved use of technology keeping people independent and reducing acute crises. This will include actions to stabilise general practice and social care. Into our work we will incorporate learning from the New Care Models Programme including Vanguards operating within the footprint.
3.  **FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES**	The above two steps will enable us to better understand and manage demand which needs to be dealt with in secondary and tertiary care. We will deliver fit for future services by reducing variation and simplifying access to high quality secondary and tertiary services; including delivering prime provider and managed network models to transform acute services across multiple sites. Into our work we will incorporate learning from the New Care Models Programme including local Vanguards operating within the footprint.

If we get this right, following further work, it will mean we can deliver what people say they want:

- A focus on promoting health and wellbeing
- Helping people to stay independent for longer
- A reduction in health and social care crises
- A more joined up approach to providing care, greater access to community based services and new sustainable models of general practice.

Our new models of care will:

- Promote a person centred approach and anticipate problems
- Promote self care and individual and community resilience
- Ensure consistency of care and better experience and outcomes for individuals

5 Year plan on a page

TRIPLE AIM – BETTER HEALTH, BETTER CARE, LOWER COSTS

OBJECTIVES	CREATING EFFICIENT ORGANISATIONS AND INFRASTRUCTURE	TRANSFORMED PRIMARY, SOCIAL AND COMMUNITY CARE (Community Care First)	FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES
SYSTEM PROGRAMMES	Provider CIP Delivery	Improving Health and Wellbeing	Adult Care
	STP Wide Clinical Support Savings	Stabilised and Enhanced General Practice	Maternity and Newborn
	STP Wide Back Office Savings	Long Term Conditions Management and Maintaining Independence	Paediatrics
	Commissioner CIP	Urgent Care (Care in a Crisis)	Mental Health
	STP Wide Estate Reconfiguration and Rationalisation	Children and Young People	Tertiary care prime provider models
	Stabilisation and Transformation of Social Care		

Commissioning Reform

ENABLERS OF CHANGE	Workforce	Digital Solutions	Estates Strategy	Future Governance and System Leadership

Critical decisions

Strategic objective	Immediate critical decision(s)	Decision enablers
Creating Efficient Organisations and Infrastructure	• Agree 'recovery plan' (for those organisations requiring one) to accelerate the pace and delivery of productivity and efficiency improvements across all organisations • Agreement between health and local authorities for a shared approach to estates and BSol-wide Estates strategy • Consensus on closure of unused/surplus estate and other quick win opportunities delivered	• Identification of further opportunities for system savings and including quick wins to improve efficiency and financial position e.g. collective staff bank • Options appraisal on BSol estates and future requirements aligned with proposed STP programmes including a System Estates inventory with current utilisation and status report
Transformed primary, social and community care (***Community care first***)	• Universal agreement of the modelling of the impact of the new model • Agree support required for stabilisation and extended access to general practice • Universal agreement on the role and purpose of Multidisciplinary Teams – the geography, professional make up and operational leadership, patient cohort, provider incentives and the performance measures used to review their impact • Agree alignment and interdependencies with Secondary and Tertiary Programme including Estates and operation of MDT model	• Defined operating model to identify requirements such as future workforce and estates • Detailed modelling to quantify and assess impact of new model • Detailed options appraisal including future benefits, forecast savings and investment requirements • Engagement including Local Medical Committees ('LMC') and other groups, workforce and public engagement • Primary care ownership of plans
Fit for future secondary and tertiary services	• Adult acute care opportunities will be identified following capacity and demand modelling • Agree how capacity and resource are best aligned to support the MH recovery focus and eliminate out of area placements • Agree on Organisational commitment to delivering the maternity programme at pace through a lead provider contracting model • Agree on Organisational commitment to delivering the paediatric programme at pace through a network model which includes all stakeholders • Agreement with regional specialised team on prime provider pathways of care that will be supported for tertiary services	• Demand and capacity modelling exercise to identify current baseline and assess future requirements aligned to new operating models • Development of more detailed future Operating models including using inputs from modelling exercise – to consider activity, beds, workforce, costs • Workforce and public engagement
Overarching system decisions	• Agreement upon preferred enabling BSol governance model	• Identify best practice and options for BSol governance model and guiding principles supported timeline for implementation

Solutions

CREATING EFFICIENT ORGANISATIONS and INFRASTRUCTURE

1a. Clinical Support Savings
1b. Back Office Savings
2. Commissioner CIP
3. STP Wide Estate Reconfiguration and Rationalisation

TRANSFORMED PRIMARY, SOCIAL and COMMUNITY CARE

(Community Care First)
4. Community Care First Programme Summary
5. Solihull Together
6. Improving Health and Wellbeing
7. Stabilised and Enhanced General Medical Practice
8. MyHealthCare – GP Access Fund
9. Long Term Conditions Management and Maintaining Independence
10. Urgent Care – Care in a Crisis
11. Children and Young People

FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES

12. Adult Care
13. Maternity and Newborn
14. Paediatrics
15. Mental Health
16. Tertiary care prime provider models

OVERARCHING

17. Stabilisation and Transformation of Social Care
18. Commissioning Reform

Solihull Metropolitan Borough Council
Birmingham City Council
NHS

Creating Efficient Organisations and Infrastructure

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

1a. Creating Efficient Organisations and Infrastructure: Clinical Support Savings

SRO: Dame Julie Moore | **Relevant leads: Andrew McKirgan**

Organisations involved*: UHBFT, ROH, BCH, BWH, BSMHFT HoEFT, CCGs, Primary Care, NHSE*

Strategic objective:

We will develop a single integrated laboratory model across Birmingham and Solihull that will deliver a high quality pathology service by ensuring there is standardised and consistent care, equity of access thereby enabling the most cost effective model of laboratory provision. This will include developing high volume centralised laboratory provision for routine work whilst maintaining the specialist expertise required across BSol. Our service will be underpinned by a highly skilled and effective workforce supported by an IT structure that is interoperable so patients and clinicians on all sites can easily access data.

Outcomes:

Outcome:	Metric inc. baseline	Timeframe
Standardised care, consistent across BSol	Performance against service standards.	2019
Improved patient outcomes	KPI metrics	2019
Improved utilisation of resources	Unit Cost	2019
Improved recruitment and retention	WTE vacancies/turnover rates	2019
Improved specialist cover	Turnaround times	2019

Stakeholder Engagement and consultation: NHSE, provider organisations, GPs, neighbouring STPs and patient groups.

Top 5 Milestones	2017/18	2017/18-2020/21
Cross provider project group established	X	
Development of 5 year phased plan for BSol	X	
Establish appropriate contractual models	X	
Phased Implementation		X

Context/Description:
It is estimated that 70%-80% of all healthcare decisions affecting diagnosis or treatment involve a pathology investigation. Pathology services exist on all provider sites across Birmingham and Solihull yet there is considerable variability in:

- Laboratory Technology
- Standard Operating Procedures
- Integration with EPR/clinical systems
- Turnaround times
- IT interfaces
- Extent of 3rd party test delivery
- Recruitment and retention
- Research

Demand for pathology is expected to grow as a result of:

- Increasing numbers of patients with chronic diseases
- Development of more personalised medicine and preventative medicine; rising patient and clinical expectations
- A shift to increasingly supporting frail patients in the community.

To improve quality and efficiency the Lord Carter Reviews argued for:

- Pathology networks with single management structures
- Laboratory collaboration/consolidation

Within the BSol footprint a combined Women's and Children's Foundation Trust and closer collaboration between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust provides a real opportunity to develop a place based laboratory model that delivers best outcomes at best value. This will build on the system collaboration achieved on Genomics.

Investment required:
The level of investment required will need to be identified once model has been agreed

Estimated financial benefits:

- Improved productivity
- Reduced clinical variation
- Improved clinical outcomes

Risk	RAG	Mitigation
Lack of cross organisational commitment to transformation		STP governance structure Proposed reduction in provider organisations and improved relationships.
Availability of capital for IT, equipment, estate, transport and logistics		STP financial modelling and early discussions with NHSE regarding capital to support system integration.
Inability to realign existing MES contracts delays phased implementation		Effective relationships with suppliers and early engagement regarding the transformational strategy.

1b. Creating Efficient Organisations and Infrastructure: Back Office Savings

SRO: TBC | **Relevant leads: BSol CFOs**

Context: Partnership arrangements already exist between a number of the healthcare organisations in the city however there remains scope to go further in sharing back office functions and reducing costs within the city.

There are three key partnerships:

BSol CCGs	Working in collaboration with CCGs in the Black Country the BSol CCGs have recently re-procured CSU services resulting in savings in back office delivery. The three CCGs are now setting out a path to merging organisations which will further reduce duplication of roles and function, and allow more effective decision making at a footprint level. This will facilitate the move to commissioning of new models of care and reduce costs by over £5m.
Acute Providers	Significant enabler to change will be the proposed case for change by HEFT and UHB and also BCH and BWH plans. BCH / BWH have stated a clear willingness for UHB / HEFT to provide back office functions to them in future resulting in a shared service across the 4 main acute providers in the STP footprint. This will include Finance, HR, IT, Procurement and Payroll. ROH has expressed an interest in participating.
Mental Health/	BSMHFT are in discussion with partners within its region wide MERIT vanguard around sharing BCHC and reducing costs of back office functions. CHCFT, given its extended footprint across multiple STPs, is working with its partners in 'Transforming Care Together' around back office provision targeting savings of £1m.

Vision / Aims:
Working in partnership to delver effective back office functions

Minimising costs of delivery to allow retention of resources for front line delivery of healthcare.

Reshaping commissioning to work at BSol level and to move towards commissioning of new care models.

Workstream Summary and Key Milestones:

BSol CCG merger (subject to consultation) proposed for April 2018. Timescale to be confirmed around interim steps in agreement with NHSE with realisation of earlier benefit dependent on approval to progress to single management team and commissioning function.

Acute Providers – the proposed case for change by HEFT and UHB, and BCH and BWH plans. The transactions will immediately start to consolidate the 4 current back office functions into 2. For example, payroll by Nov 2016. A common clinical IT solution across BSol providers will be supported by UHB's 'NHS Global Digital Exemplar Funds' award.

Key Assumptions:

Wider governance changes within CCG and acute providers (BWH & BCH and UHB & HEFT) are supported through formal processes with regulatory bodies (including commissioners, NHS Improvement and the Competition & Markets Authority). Academic evidence indicates the management and corporate savings can be achieved within 6-12 months of a merger , providing detailed project plans are in place.

Key Challenges:

There a clear willingness for UHB / HEFT to provide back office functions to BCH/BWH in future resulting in a shared service across the 4 main acute providers in the STP footprint. Key challenges relate to timescale for delivery, the need to migrate to common IT systems/platforms and resource requirements (human and capital).

CCG merger arrangements have similar governance changes that require formal processes with regulatory bodies and challenges.

Key Interdependencies:

- Commissioning reform
- Provision of Facilities Management services is being led within the estates workstream and savings will be captured there.
- Fit for Future Secondary and Tertiary Services

Resource Requirements:

Resource requirements will be confirmed in individual business cases but will include capital investment to achieve common IT platforms/systems.

2. Commissioner CIP

SRO: Diane Reeves	Relevant leads: Mark Das Gupta / Alima Batchelor / Kate Arnold – Prescribing Sue Nicholls – CHC, Diane Reeves - Disinvestment

Context:

A number of commissioner derived savings remain outside of the core STP workstreams where these relate to specific functional areas related to more effective and cost efficient provision. The most significant of these are:

1) Prescribing

2) Continuing Healthcare

3) Disinvestment in less effective services

Vision / Aims: The aims of all three programmes of work are similar and noted below:

To ensure all patients receive the appropriate therapeutic intervention at the best value

To ensure that all patients eligible for CHC receive an effective service in a timely manner provided in the most economic way.

To maximise allocative efficiency into programmes of spend and services that are achieving required results.

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Workstream Summary and Key Milestones:

Prescribing has four key workstreams with a further (Carehome medication) within CCF
The remaining four workstreams are:

Waste Management
Polypharmacy Medication Reviews
Nutrition Reviews
Prescribing Efficiency (ensuring best price)

The CCG CHC strategy consists of a number of areas including

CHC Procurement
Utilisation of high cost packages
Personal Health Budgets

The CCGs are currently developing a prioritisation policy that will support the review and possible divestment from services which are not delivering outcomes envisage (conversely where localised services are having a greater impact these will be scaled up)

Key Assumptions:

Key Challenges:

Pharmacy workforce

Clarity of pharmacy requirements within GPFV

Market response to CHC pricing and procurement

Opposition to disinvestment of services

Key Interdependencies:

CCF - pharmacy schemes and enhanced medical practice

CCF – enhanced support to care homes

IT – remote working and access to patient records

Resource Requirements:

Resource requirements will be confirmed in individual business cases

3. STP Wide Estate Reconfiguration and Rationalisation

SRO: Paul Sheriff

Relevant leads: Guy Carson (Programme Manager), John Guggenheim (Finance Lead), Graham Seager (Acute), Mike Lyden (Primary Care) and Phil Andrews (Local Authority)

Organisations involved: All organisations within the BSol STP footprint

Strategic objective:

To create an estate footprint that is fit-for-future purpose and flexible enough to adapt to and support changes in clinical service models, without the need for additional significant capital investment. This will be achieved by:

- Initial disposal of unused, poor condition, and/or surplus estate to fund estate change programme
- Reduce the known areas of estate void (e.g. in LIFT buildings) and implementation of other innovative opportunities to repurpose existing buildings enabling the delivery of high quality place based clinical services within the natural communities
- Ongoing oversight of estate utilisation across Birmingham and Solihull and planned use on a footprint-wide basis to realise additional benefits and optimised estates utilization.

Outcomes:

Outcome	Potential Metric	Timeframe for delivery
Reduced estates running costs	£m^2	12-18 months
Reduced variation in quality of estates across the footprint	Building condition	18-24 months
Optimised use of estates facilities which meet the future needs of the population for health and social care	Utilisation	18-24 months

Key milestones:

- *In 3 months* we will complete the mapping exercise to provide a baseline for Estates
- *In 6-9 months* we will have identified of surplus estate, proposals to reduce LIFT voids, and identification of other quick win estates initiatives, including options appraisal for identified opportunities
- In *9-12 months we will* have achieved consensus between health and local authorities for a shared approach to estates (One Public Estate and West Midlands Combined Authority) and BSol-wide Estates strategy agreed
- *In 18-24 months we will* have closed unused/surplus estate and delivered other quick win opportunities

Critical decisions to support next steps

- Clarification on potential sources of capital funding to support immediate changes to Estates e.g. Estates Technology Transformation Fund (ETTF) and other sources for investment
- Identify and agree which, if any, Head Leases and/or Freeholds should be obtained from NHS Property Services and CHP to provide the ability and flexibility to make changes to the existing estate and service charge provision

Stakeholder engagement and consultation:

- Repurpose the Local Estates Forum (LEF) to encompass all organisations within the footprint. Principles to be agreed to secure buy-in to the estates vision and quick-win opportunities
- Further engagement with STP programmes and enabling workstreams to develop quick win opportunities

Context/Description:

- The BSol footprint currently comprises circa 650 buildings with 1000+ property interests. The quality of estates is variable across the footprint, a large number of poor quality buildings in Birmingham, and overstretched buildings in Solihull. There is a clear need and opportunity to address poor quality and sub-optimal estate through a planned programme of rationalisation and investment, that will transform care across primary, community, and acute settings and provide an equitable estates footprint for the population of BSol
- An initial baseline for Estates has been completed, and work continues to establish a full asset baseline and condition report for all buildings. Some progress has been made towards identifying initial quick win opportunities that will increase utilisation of modern LIFT buildings providing the potential to enhance primary care and integrated services, and enabling disposal of unused, poor condition, or surplus estate. Further opportunities to make the Estate more efficient and cost effective will be achieved in response to the Carter recommendations.

Investment requirements:

Investment requirements for Estates is still being developed to align with the emerging future models of care, however the underlying assumption is that there will be a need for investment to upgrade and improve the Estate, and optimise the use of under-capacity buildings. This will be self-funded wherever possible by the programme e.g. through benefits realised by quick win disposal of buildings, assuming that capital receipts can be retained, and/or re-profiling of ETTF resources, but centrally provided and other sourced finance will be required for larger strategic schemes

Estimated financial benefits:

Ongoing work by the Estates programme suggests that there are potential benefits of £26m to be realised through quick win estates opportunities, however only £13m has been included currently as a risk-adjusted and prudent savings figure, agreed with FDs, whilst detailed work continues to qualify the additional financial benefits. Quick win opportunities include: reducing LIFT buildings void, disposal of unused or surplus estate, compliance with Carter benchmarks and other hard/soft FM opportunities.

Key underlying assumptions have been identified and are being worked through in further detail to validate the estimated benefits. Additional savings opportunities will also be identified as the Estates Strategy is further developed to support new models of care.

Risk	RAG	Mitigation
Not all stakeholders (internal or external) agree to estates plans		LEF Terms of Reference, Stakeholder engagement and Consultation, Escalation through STP PMO
The STP is unable to obtain the Head Leases or Freeholds to dispose of, or make necessary changes to Estates		Workshop in October with LIFT and Community Health Partnership (CHP); STP to apply for capital receipts
Quick win opportunities do not realise the full estimated benefits		Robust baseline developed, Key assumptions identified, tested and updated
The STP cannot retain capital receipts to fund future estate plans and developments		System to refine and clarify rules and procedures, and remove barriers to single year funding

Transformed primary, social and community care

Community Care First

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

4. Community Care First – Summary (page 1/2)

SRO: Tracy Taylor

Relevant leads: Les Williams (Programme Director) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:

Delivery of a new planned and deliberate care model which moves activity from secondary care into primary and community care settings through:

1. Urgent Care

- Development of 4/5 urgent care centres/integrated service hubs across the footprint, providing immediate access to urgent primary care, diagnostics, pharmacy, treatment of minor ailments (receiving WMAS conveyances), minor procedures
- A single accessible model for step up and step down urgent care services which prevent emergency admissions and enable speedy and effective discharge (recovery model)
- Expansion of 111 as a single point of access for joined up urgent care offer

2. Long term Conditions

- Development of community based multi-disciplinary teams (MDTs)
- Delivery of proactive care management pathways
- Development of a targeted preventative offer for self management and community resilience
- Definition of targeted population for MDT/Integrated Care Network support based on place

3. Enhanced General Medical Practice

- Improve sustainability and resilience of GP through new support team
- Support delivery of the GP Forward View
- Offer an enhanced 8 till 8 service to support patients and improve accessibility
- Development of universal offer and Practice of the Future
- Model based on 29 'natural communities'

4. Children and Young People (CYP)

- Service offer based on the Complete Care For Children model
- Delivery of paediatric integrated community teams on an MDT/ICN basis
- Implementation of a 24/7 rapid response team to meet complex care requirements
- Broadened early intervention offer to reduce crisis and avoid admissions

5. Health and Wellbeing

- Build community resilience through information, advice and guidance
- Use of population based digital interventions
- 3rd sector lead interventions – growing current capacity

Key milestones:

In Year 1 we will:

- Have fully tested financial modelling and obtained system wide sign off to savings targets
- Clarify investment totals and where the funding is to be obtained (critically the pump priming)
- Create further detailed project plans setting out the how we plan to rollout these workstream deliverables
- Clarify ongoing resource to deliver the workstreams
- Put in formal request to draw down initial funding to utilise from 2017/18

In Year 2 we will:

- Design and start phased roll out of the schemes
- Establish the provider incentives and contractual frameworks

Context:

Locally we are applying the NHS Five Year Forward View (5YFV) policy drivers to design this programme to address specific local problem. Birmingham is in the worst quartile on a number of key metrics which these workstreams will address:

- 1 in 3 children live in poverty
- People are 3x more likely to have a mental health condition, be admitted for ambulatory sensitive conditions and die from conditions amenable to healthcare
- There is a 10 year life expectancy gap of 7 years between richest and most deprived areas
- National outlier for infant mortality
- 13% (Sept 16) of primary medical services require improvement
- GPs and nurses in primary care per 1000 pop 2nd worst nationally (also see outcomes targets)

Vanguards and GP Access Fund (wave 2): There are 2 relevant programmes in BSol and we will use these to build in best practice: Solihull Together and MyHealthCare (South Birmingham)

Out of Scope: STP Plus programmes, Secondary and Tertiary care, acute Mental Health services, Maternity and Newborn, core GMS contract, investment in estate and digital

Outcome	Metric inc. Baseline	Timeframe
Reduce number of emergency admissions for ambulatory case sensitive conditions	Target: 632.1 per 100,000 Decrease of 308.7, 32.81% (WQ)	2020/21
Reduction in A and E attendances	Target: 17% reduction (adults), 22% children Baseline: 403,225 p.a (deloitte review)	2020/21
Reduce hospital admissions for falls injuries	Target: 1600 per 100,000 Reduction of 763, 23.63%	2020/21
Reduce delayed transfers of care	Target: 5 per 100,000 Reduction of 12.6 per 100,000, 72% (WQ)	2020/21
Improve quality of general practice	All GP practices rated Good or better by CQC. Baseline: 13% Require improvement or inadequate Sept16 (was 27% Apr 2016)	2019/20
Reduce number of emergency admissions of Geriatric and General Medical Take to be treated in AEC	Target: 25% reduction	2020/21
Reduce A and E attendances through the Enhanced General Medical Practice Universal Offer and UCC's	Target: 30% reduction	2020/21

In Years 3-5 we will:

- Full implementation of deliverables as set out in each workstream
- Move towards Business as Usual with these workstreams
- Embed deliver and review whether outcomes are being delivered
- Review whether savings targets were met

4. Community Care First – Summary (page 2/2)

SRO: Tracy Taylor | **Relevant leads:** Les Williams (Programme Director) and Angela Szabo (Finance Lead)

Critical Decisions to support next steps:

The Programme has been ambitious and bold in setting out the possible extent of change, but there remains more work to be done including further development of the Milestones. More engagement with the Secondary and Tertiary Programme is needed as the CCF Programme represents a change to the level of activity undertaken in traditional acute settings.

The approach in the Programme's 'bottom up' activity and financial modelling is based on the use of national and local modelling assumptions. These were circulated to the Finance Directors' Group after our presentation to their meeting on 18th August, but have not been discussed in any more detail as yet.

In the absence of system-wide agreement, the approach on funding of the reinvestment identified is based on a combination of resources released in commissioner spend from secondary settings and use of the STF and this is highlighted on the relevant sub-programme plans. It is acknowledged that this remains for discussion and agreement, as does the potential level of investment in the Enabler programmes of IT (LDR) and Estates, including the ETTF.

The arrangements for staffing the Programme and workstreams beyond the October submission date are not agreed as yet and this remains a critical decision to be made at STP level.

Stakeholder engagement and consultation:

Regular meetings with BSol GP providers and BSol GP Alliance, LMCs, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes and West Birmingham STP Partners

Modelling

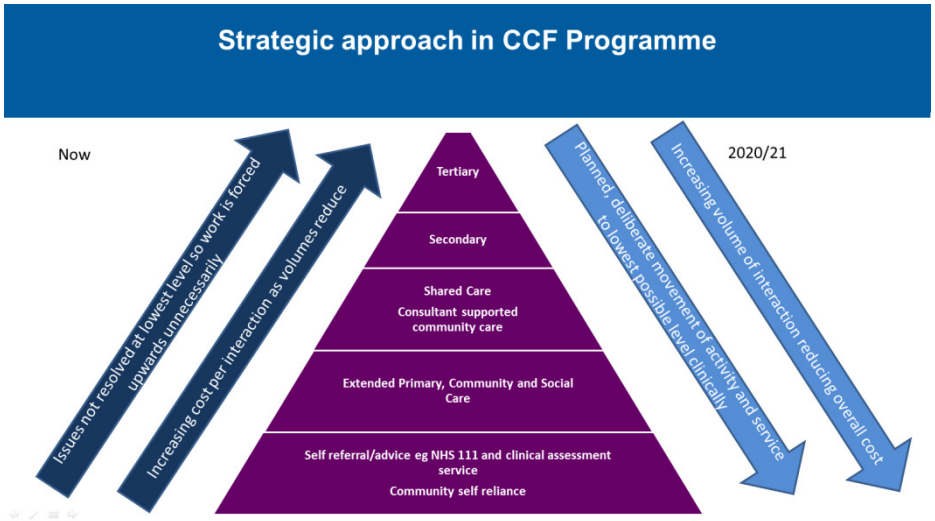
The CCF Programme has undertaken detailed modelling of the opportunities for moving the location of care to community and primary care settings, based on a combination of national and international best practice and achievement of radical ambitious change in the delivery of care. This has indicated on overall opportunity in the range of £30m-£88m net saving for the STP footprint.
This identifies a range of changes and issues which now need to be discussed with providers in greater detail, particularly through the Secondary and Tertiary Programme.

Impact on capacity:

Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Our new model



Risk	RAG	Mitigation
More engagement and contractual incentives required for secondary care to fully support and engage in programme design		STP governance lead appointed. Clarity on wider STP programme governance post submission
Unforeseen reduction in social care impacting on community offer		Shared understanding of LA savings and impact on services
Definition of required workforce and pressures on recruitment and retention of key roles		Involvement of Health Education England and local workforce planning for MDTs/ICNs
Failure to engage and persuade patients and professionals on a new care model		STP agreed communications and engagement strategy needed – including consultation
Level of investment required		Managing demand for secondary care services to release funds for CCF

5. Community Care First: Solihull Together (Page 1/2)

SRO: Patrick Brooke/ Nick Page	Relevant leads: Helen Kelly – Programme Director, Stephen Munday DPH, Dr Mike Baker Solihull CCG GB member, Viv Tsesmelis UHB/HEFT, Sue Hartley BSMHfT

Organisations involved*: HEFT/UHB, SMBC, Solihull CCG, BSMHfT, Solihealth (Primary Care)*

Strategic objective:

The future ambition of Solihull Together is to build upon our strong partnership approach to deliver a community-based model of integrated care. This will transform a system now focused on higher cost acute care to one focusing on earlier interventions, prevention, and wellness that are lower cost, within the context of a sustainable whole system.

This objective will now incorporate the wider ambitions of the STP where it makes sense for a 'place based' approach.
The change programme has already been progressing the four Vanguard service changes as follows:

1. Community Wellbeing Service - improving wellbeing, preventing ill health and escalation of LTCs through provision of advice and support, active management, and coaching that facilitate individual behaviour supported by tools such as wellbeing measures and Patient Activation Measure.
2. Integrated Primary and Community Care Service- transformation and integration of our primary and community teams in to one service that 'wraps around' the needs of the patient, using an MDT approach for at risk cohorts such as complex health and frailty.
3. An improved urgent care service - A joined up approach to urgent care through co location and integrated system working, e.g. Urgent Care Centre and Local Clinical Decision Hub.
4. Digital Population Health and Care Information System – learning from international models a commitment within the Global Digital Exemplar to align population health and care information system to benefit clinical and patient's requirements for access to records, information and analysis which will support flow, decision making and real time information for performance and outcome monitoring.

Outcomes	Draft Metric	Delivery timeframe
Reduction in DTOCs to 2 per 100,000	2	20/21
Percentage of deaths which take place in hospital	42%	20/21
Increase the proportion people with long term conditions feeling supported to manage their condition	BSol ambition to be in quartile 2 of the national data	20/21
Trialling National UEC System Data pack	TBC	20/21

Context/Description:

Solihull Together is a partnership of Solihull CCG, Solihull MBC, Birmingham and Solihull Mental Health NHS FT, Heart of England NHS FT and Solihealth (GP partnership), voluntary and third sector.

- Solihull Together was awarded UEC Vanguard status in August 2015.
- Value Proposition developed and awarded transformation funding in 2016/17 of £1.3m
- The Value Proposition is based on agreement of the Leaders within Solihull Together for a whole system total population approach based on local financial and service challenges which will deliver a sustainable and transformed system, delivering better clinical outcomes and patient, public and staff experience.
- Financial Modelling within our Value Proposition has been the basis of the work and is now included within the STP CCF programme..
- Approach is to accelerate delivery and proof of concept, in Solihull, of a place based model of care which can be replicated and scaled up across the BSol STP.
- Solihull has a relatively high proportion of older people, predicted to continue to rise with a largely acute based system. A priority area is the development and implementation of frailty pathways in Solihull as a centre of excellence, which can be rolled out across BSol footprint.
- To achieve a reduction in DTOCs to 2 per 100,000 to reflect our whole system partnership.
- Firm commitment to continue to evolve the place based model to meet the changing needs of people and improve care quality, access and affordability.
- Main interdependencies - IT, workforce, bed base (particularly community beds), care homes, domiciliary care providers and general market management.

Key milestones:

*In year 1 we will***:**

- Local Area Co-ordinators ('LAC') effectively working with communities, addressing isolation and prevention of escalating needs of people who do not meet current eligibility criteria for formal services.
- Care Navigators working as part of Integrated Community Teams, to impact on admission avoidance; readmissions and to divert/reduce activity in GP.
- Local clinical hub implemented to optimise the use of the Mobile DoS;
- Rapid community response and replicable frailty pathways;
- Scaled up Patient Activation Measure licences used to support people with LTC;
- Scope digital health and care system required for operating model.
- Developed a shared set of system measures

In year 2 we will:

- Define future place based model including firmly understood costs and value.
- Agree appetite for risk within the system.
- Implement an appropriate governance model for implementing a proactive place based system;
- Patient Activation Measure (PAM) Licences fully implemented across Solihull
- Increased digital technology;
- Increased coproduction and engagement of citizens in health and wellbeing

In year 3 we will:

- Align incentives and appropriate governance to drive and sustain place based model
- Collaborate with wider stakeholders to maximise transformation and ambition.

5. Community Care First: Solihull Together (Page 2/2)

SRO: Patrick Brooke/ Nick Page	Helen Kelly – Programme Director, Stephen Munday DPH, Dr Mike Baker Solihull CCG GB member, Viv Tsesmelis UHB/HEFT, Sue Hartley BSMHfT

Organisations involved*: HEFT/UHB, SMBC, Solihull CCG, BSMHfT, Solihealth (Primary Care)*

Current Financial Position*:

- Vanguard Financial Modelling has been the basis of and included within the CCF programme.
- 5-Year Return on Investment (total revenue funding) calculated within our Vanguard as 27%.

£M unless stated		2016/17	2017/18	2018/19	2019/20	2020/21
	Gross savings	0.00	0.32	2.19	4.71	5.05
Revenue costs	From Vanguard	1.30				
	From Local Contribution	0.00	2.01	2.01	2.01	2.01
	Total Revenue Costs	1.30	2.01	2.01	2.01	2.01
	Net savings	-1.30	-1.69	0.18	2.70	3.04

Critical Decisions to support next steps:

- Vanguard Programme funding for 2016/17 is £1.3m used to deliver Vanguard projects - Local Area Coordination, Care Navigators, Integrated Urgent Care and Digital Population Health and Care Information System.
- Confirmation of allocation of 2017/18 transformation funding to continue projects to realise return on investment
- Development of Place Based approach to deliver wider STP ambitions

Investment requirements:

2017/18 - £1.3m to maximise RoI of Vanguard projects

Impact on capacity:

Impact on workforce by 2020/21:

Workforce model *ensuring that staff work to the 'top of their licence' with less skilled tasks being delivered by generic staff i.e. care navigators;*

Enhanced roles within primary and community care, with specialist input as required, to meet the care needs of people with LTC and complex needs

Stakeholder engagement and consultation:

Solihull Together is sponsored by Solihull Health and Wellbeing Board (H&WBB)
Development of the programme has been with stakeholders and experts by experience.
We will continue to utilise these mechanisms as new projects are established.

Key risks:

Risk	RAG	Mitigation
Transformation funding for 17/18 not available which is critical to achieve the Return on Investment		Ensure Vanguard is sited within STP to access STF
Operational and clinical leads focused on short term business as usual		Senior leadership support for delivery of transformation and new model of care and a development model that engages at all levels.
Sustainable workforce to deliver new care model		Develop workforce plan which includes Voluntary and 3rd sector
Impact of organisational decisions which have unidentified consequences for delivering Vanguard		Leadership meetings in place to align strategic direction and support transparent communication

6. Community Care First: Improving Health and Wellbeing (page 1/2)

SRO: Dr Adrian Phillips / Dr Stephen Munday

Relevant leads: Jacquie Ashdown (Public Health Consultant); Lynn Gibbons (Specialty Registrar in Public Health) and Carol Herity (Programme Manager)

Organisations involved: All Public Sector including councils, acute, community, maternity, mental health and primary care providers

Strategic objective:

To enable people to achieve 'active, meaningful and independent lives', through addressing the following priorities:

- Tackling Primary Care Variation
- Employment and Health
- Vulnerable Groups
- Early Years
- Increasing Physical Activity across the population
- Radical upgrade in prevention

Outcome	Metric Inc. Baseline	Timeframe
Increase in proportion of vulnerable groups in meaningful work	• Baseline 5% of those on Care Programme Approach in meaningful employment. • Increase to 9%	2020/21
All public sector organisations to implement PHE Workplace Charter	• Delivery of the Health and Wellbeing CQUIN by 2017 • All Public Sector (PS) organisations to implement Workplace Charter (JA) • Reduction in sickness rates	2020/21 2020/21
Reduction in number of those who receive incapacity benefit	• 59,000 across Birmingham and Solihull, 5% reduction to 56,000	5% reduction by 2020/21
A radical upgrade in Prevention including effective use of new technology, social media and supported behavioural change	• 8% prevalence rate of smoking in pregnancy • 13% prevalence rate of smoking in all adults • Reduction of 10% smoking and alcohol attributable hospital admissions. A decrease in physical inactivity – 36.2% to 35% Birmingham. 27.1% to 26% Solihull	2020/21 2020/21 2020/21
Increase people with LTC feeling supported to manage their conditions – linked to LTC workstream	• Target 66% by 18/19 (increase of 3%), 72.5% by 2020/21 (increase of 8.9% (within LTC workstream)	2020/21
Increase in readiness for school – Public Health Outcomes Framework	As measured via the 2/2.5 yrs. development check. Baseline for school readiness, current baseline for school readiness 61.9% Bham, 75.5% Solihull. Target to be agreed.	2020/21

Critical Decisions to support next steps:

- Sign up to workplace charter and brief intervention skills across the system and all providers
- Employment critical part of mental health workstream

Stakeholder engagement and consultation:

All public sector including councils, acute, community, maternity and mental health providers, primary care through public health leads for each STP work stream, and patients and the public

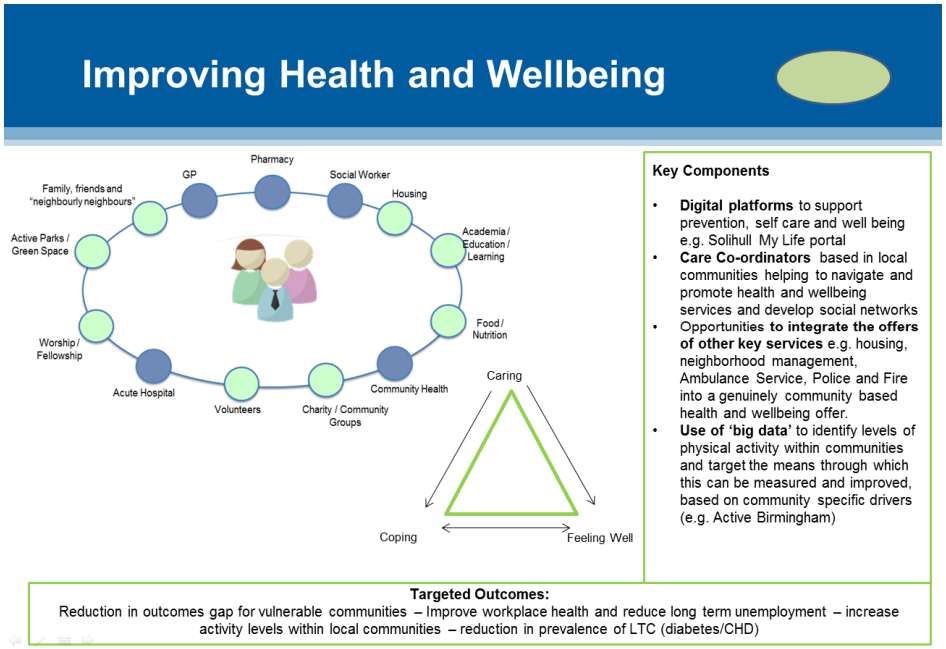
Context:

The aim of the Improving Health and Wellbeing (IHWB) workstream is to address the gap in life expectancy, quality of life and life chances across the life course. Through analysis of the characteristics of the bottom 10% of our population and vulnerable groups we have identified 6 HWB priorities (above in Strategic Objective). It is recognised that these need to be addressed and are an inherent part of the all the STP work programmes and not just Improving Health and Wellbeing workstream.

The focus of interventions will be on:

Those that are in the lower 10% are 3 times more likely to be admitted for ambulatory care sensitive conditions, die prematurely from conditions amenable to healthcare, 2 times more likely to be in contact with Mental Health Services, have a Long Term Condition, and more likely to be obese in child and adulthood. Key issues include:

- Our High Infant Mortality (7.1 in Birmingham, 4.7 in Solihull deaths/1000 live births)
- A significant health inequality gap exists particularly in north Solihull and east/central Birmingham
- Life expectancy and healthy life expectancy are lower for both men and women in Birmingham compared to England
- Cancer and CHD are the leading causes of the life expectancy gap



6. Community Care First: Improving Health and Wellbeing (page 2/2)

SRO: Dr Adrian Phillips / Dr Stephen Munday

Relevant leads: Jacquie Ashdown (Public Health Consultant); Lynn Gibbons (Specialty Registrar in Public Health) and Carol Herity (Programme Manager)

Top 5 Milestones	Actions for Year 1	Actions for Year 2	Years 3 to 5
Radical upgrade in prevention and promotion of wellbeing across the system with a focus on vulnerable groups, physical activity and across the life course	First 6 months: scope discussions and development Agreement achieved through commissioning round with each of the providers. Ensuring Making Every Contact Count (MECC) and in line with Combined Authority develop BSol Physical Activity Action Plan. Scope technological support required.	All Public Sector Organisations (PSO) have signed up to MECC in workforce development. Front line staff are being training in the delivery of Brief Intervention, with a focus on priority areas and vulnerable groups. Action Plan developed for Physical Activity. Implement technological change required to modify public behaviour in seeking help and promoting activity.	Priority area trained (Yr3) 70% of all PSO staff are skilled in MECC+ (Yr4) All PSO staff are skilled in MECC+ (Yr5)
All public sector organisations implement PHE Workplace Charter (WC)	First 6 months: scope discussions and development 6 – 12 months: development of a HBW CQUIN through the commissioning round. Identifying the role of PSO as a major employer and identify how each organisation can improve the HWB of their staff. The HWB CQUIN for each organisation delivered according to their Action Plan and being monitored as part of the contract agreements Agreement to the delivery and initial action plan for the PHE workplace charter by all PSO	Action plan for the implementation of the PHE workplace charter completed and delivery commenced by all PSO	Implementations starts (Yr3) 75% implementation (Yr4) Full Implementation of WC in system (Yr5)
Integrated Early Help Teams and parenting to identify potential and real ACE (Adverse Childhood Experience)	First 6 months: Public Health working with Children and Young People's workstream will identify and develop evidence based models of early intervention and parenting 6-12 months : Programme roll out	Will work with Children's and Young People's workstream on the implementation of the roll out programme across Birmingham and Solihull	Long term reduction in cost across the system (Yr5)
Increased proportion of vulnerable groups in meaningful work	First 6 months: discussions and development with workstreams 6-12 months: work with Mental Health and Wrap Around services to incorporate meaningful work, through influencing the Mental Health workstream	Continue to work with Mental Health workstream to ensure roll out of this intervention	Incremental increases Increasing to 9% (Yr5)
Universal place (including those with LTC) based health and wellbeing services to support independence through information and advice (including use if technology and social media), early support, rehabilitation, behavioural change connecting with community assets and local opportunities, including technological solutions	First 6 months: plan a scoping exercise to understand what is currently available and its format to enable development of a universal offer for Health and Wellbeing 6-12 months: implement scoping exercise	Using the intelligence from the scoping exercise to Identify gaps across the system. Develop a clear plan of interventions and development of a clear plan for delivery, including use of technology and social media.	Implement planned roll out of community wellbeing offer (Yr4) Increase those undertaking self care (Yr5)

Financial Benefits: n/a

IHandWB is an enabling workstream generating savings allocated to other CCF workstreams, stranded costs in acute not included, savings/investments to be approved.

Impact on capacity:

Impact on workforce by 2020/21: development of implementation of MECC+ and 5 Ways. Seamless referral to HWB services and opportunities

Impact on bed base by 2020/21: Detailed in other CCF plans

Risk	RAG	Mitigation
Prevention agenda is not integrated within pathways and across STP workstreams		Prevention integrated in all STP and workforce plans
Workforce Charter not implemented across the system		Incremental implementation through Commissioning Intentions
Infrastructure not funded to implement place based and technological approach to HWB		Clear plan across the systems and natural communities

7. Community Care First: Stabilised and Enhanced General Medical Practice (EGMP) Workstream (page 1/2)

SRO: Dr R Mendelsohn / Dr P Thebridge / Dr A Waddell

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:

The overarching objective is to co-ordinate, oversee, guide and monitor the implementation of the Enhanced General Medical Services strategy to deliver the Community Care First and out of hospital vision and objectives across the STP. The workstream supports the delivery of the 5YFV and GP Forward View (GPFV). The key focus is to develop an enhanced general medical practice offer which is aligned to long term conditions (LTC) priorities and preventative interventions (initially focussing on Frailty, Respiratory, Diabetes, End of Life and Dementia pathways) to deliver the place based integrated community model through a multi –disciplinary team approach (MDT)

- This will include work stream delivery against the following objectives:
- Sustainability and resilience of General Medical Practice (all practices rated good or better)
- A Universal Offer for Enhanced General Medical Practice to reduce health inequalities and improve health and wellbeing of population (to include the review and redesign of current LIS Schemes)
- Extended Access to General Medical Practice 8am to 8pm
- Practice of the Future 2020 – to be worked up with GPs

We will build on existing examples of good practice where enhanced general medical practice and community care are supporting these objectives such as the GP Access Fund 'MyHealthcare' model and the Solihull Together Partnership. We will use the LDR/City4Age and estate review/rationalisation to deliver a radically different approach to delivery of patient care.

Outcomes:

Outcome	Potential metric	Timeframe
Increase in number of patients reporting satisfactory patient experience of general practice	Target: 79%, increase of 10.1% on current baseline	2019
Increase in patients able to access general practice in and out of hours –% of patients able to get an appointment to see or speak to someone	Target: 75%, increase of 8.12% on current baseline	2019
Reduce number of General Practice DNAs	Target: 3.75%, decrease of 3.95% on current baseline	2020/21
Sustainable General Practice – 100% of practices rated as Good or Outstanding by CQC	100% of practices	2018

Context/description:

BSol CCGs have made strong progress in supporting member practices to achieve improved quality outcomes as at September 2016. 13% Primary Medical Services are deemed by CQC as 'Requires Improvement or Inadequate' as at Sept 2016 – compared to STP data pack position of 27% as at April 2016 (illustrating a14% improvement).

NHS FYFV and the GPFV focus on the changing role of general practice and the expectation for GPs to play a key role in the wider co-ordination of care in the community. This work stream delivers against these national drivers.

Issues:

- 2nd lowest in country for GPs and Nurses per thousand of the population
- Nearly 1 in 4 of current GPs are aged over 55 years
- Delivering coherent service plans for populations at scale.
- Definition of natural communities

In Scope:

- Enhanced General Medical Services/Medicines Optimisation (GP and Community)
- Reducing unwarranted variation in primary care/GP Access/Sustainable **U**niversal offer for patients

Out of Scope:

- Core General Medical Services/Out of Hours/People working but not registered with a GP within BSol
- Boundaries/Pharmacy (Dispensing) Optometry and Dental Services

Work Stream Dependencies:

Other CCF work streams/Workforce capacity/capability/IMandT and Estates/Communications and Engagement/Contractual Models

Servic**e Dependencies**:

Urgent Care/Community Pharmacy/Community Nursing Services/Community Mental Services/Social Workers/Third sector/Acute providers/Public health

Critical Decisions to support next steps:

Support for further MCP vanguards/Model for extended vs. enhanced core access/operational leadership at natural communities level/role of CCG locality commissioning networks – decisions will be supported through further dialogue with the GP Alliance and STP Board and further supported by ongoing NHSE guidance on new models.

Impact on capacity by 2020/21:

- Improve ratio of GPs and nurses per 1,000 population – deliver GPFV, BSol share of 5000 additional Doctors over 5 years = 114 increase FTE
- Deliver the GPFV BSol share of 3000 practice based Mental Health therapists = additional 68.4 FTE
- Deliver the GPFV BSol share of 1500 co-funded practice clinical pharmacists = additional 34.2 FTE
- Reductions in bed base are included in other workstreams and overall CCF position

7. Community Care First: Stabilised and Enhanced General Medical Practice (EGMP) Workstream (page 2/2)

SRO: Dr R Mendelsohn / Dr P Thebridge / Dr A Waddell

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

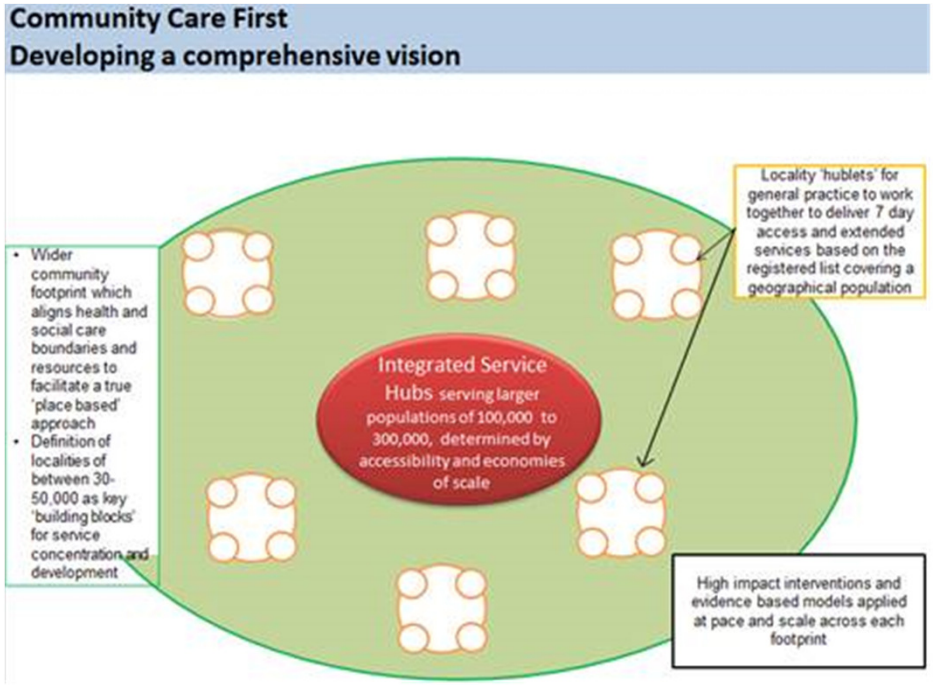
Key Milestones

In Year 1 we will:

- Establish a governance structure including steering group and four supporting workstream groups, by Jan 17 – as follows:
  - Sustainability and Resilience of General Medical Practice
  - Universal Offer for EGMP
  - Extended access to General Medical Practice
  - The Practice of the Future
- Scope and develop a response to the GP Forward View Planning Requirements (January 17)
- Continue stakeholder engagement alongside the wider STP (January 17)
- Develop draft working model of Practice of the Future (May 17)
- Agree the road map for primary care at scale/New Models of Care (May 17)
- Scope the requirements of the universal offer (May 17)
- Scope a framework to support practice sustainability and resilience (May 17)
- Agree the plan for extended access to meet the requirements of the GPFV (May 17)
- Understand and have a costed plan for tackling workforce and workload issues (May 17)
- Commence sustainability programme for General Medical Practice (October 17)
- Implement the ten high impact changes across 10% of practices (October 17)
- Roll out the universal offer to support enhanced general medical practice (October 17)
- Have at least one new model of care progressing through the road map towards an ACO (October 17)

In Years 2/3 we will have:

- Made progress to all practices being CQC rated as good or better
- Have extended and improved access in line with the requirements of the GP Forward View (March 19)
- Deliver sustainable at scale general medical practice, fully engaged and supporting the STP LTC Pathways and objectives



Stakeholder engagement and consultation:

Regular meetings with BSol GP providers and BSol GP Alliance, LMCs, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes and West Birmingham STP Partners.

Risk	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF model and LTC pathways – failure to get funding released from STF to support CCF programme		City Council are STP lead. STP includes Secondary and Tertiary programme. Supported by financial plan and STP Governance Structure.
Universal sustainability and resilience of General Medical Practice is not realised		Resilience workstream, GPFV support programme and Workforce Development programme
New models of care are not clinically or cost effective in isolation		Initial evaluation of GP Access Fund model – taking forward findings
Offer is not equitable across GP providers and natural communities and is over medicalised		Explore methodology for health inequality impact assessment. Include and engage with LA and public. Contractual delivery of universal offer
Primary care feels alienated by change process		Include GP Alliance/LMC on steering/workstream groups, member consultation

8. Community Care First: MyHealthcare -GP Access Fund

SRO: Dr R Mendelsohn

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: MyHealthcare (Southdoc Services), MyHealthcare Practices , Digital and 3rd sector partners- Birmingham Community Healthcare Foundation Trust, Birmingham City Council, CCGs

Strategic objective:

The MyHealthcare model is a successful provider bid for Wave 2 of the NHS England - GP Access Fund. 23 of BSC CCG's practices came together under the umbrella of South Doc Services (a GP co-operative) to deliver an innovative programme working across three geographic hubs to provide place based care.

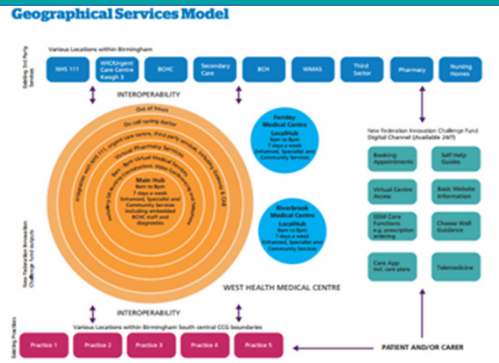
- The intention was to extend GP opening hours and redesign the interface between primary care, community based services and urgent care providers so that patients are able to access a range of services via a single point of contact. The model includes integrated working with the Urgent Care System (NHS 111, South Birmingham Walk In Centre and A and E)
- Service provision has been enhanced so that patients have access to a full range of General Medical Services and enhanced clinical services complimented by pharmacy and nursing support, health, wellbeing and lifestyle services. Creation of the infrastructure and capacity to shift services to a community setting.
- Services are delivered using both physical and virtual platforms via a 'Hub and Spoke model'.
- Patients access services using traditional methods and digital technologies giving a wider range of options to meet their varying needs. Patient Facing Digital services as per 2020 Personalised Health and Care (NIB)
- The model commenced in July 2015 and was successfully scaled up to support last year's winter pressures.

Context:

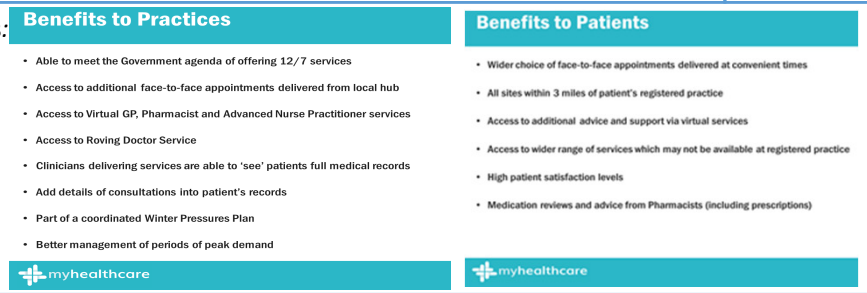
- Developing a new model of care – partnership approach between GPs, MyHealthcare, BCHC, Birmingham City Council
- The model fits well with the STP CCF and Enhanced General Medical Practice Vision and aligns to the GPFV
- The model supports the Local Digital Roadmap and vision for the STP
- The model creates efficiencies and resilience through primary care at scale that benefit whole system.

Service Scope:

- The service currently operates between 8:00am-8:00pm, 6 days a week (with Sunday opening responding to local demand). Delivering on the 7 day care agenda.
- Each element of the service reduces the waste of clinical time and inappropriate demands on urgent care services.
- This creates a systematic approach to alleviate access issues and service pressures by introducing extended hours and increasing the range of services available, with the aim being to convince patients that there is a viable OOHs alternative to A and E.



Outcomes:



Model based on population of 334,000 patients, supported by 1 Main/Virtual Hub, 3 Local Hubs, 2 Mini Hub

* Main hub includes - ICT/Operational Management/Comms

Service	Cost per patient	
Main Hub/Virtual Hub*	£	4.71
Local Hubs	£	2.15
Mini Hubs	£	0.81
Total	£	7.67

Top 3 milestones:

Milestone	Y1	Y2	Y3	Y4	Y5
Rollout across MyHealthcare Federation	Implementation of sustainable model across federation	Move from pilot phase to business as usual	Review cycle	Review cycle	Review cycle
Rollout of Digital Platform	Ongoing development with phased implementation	Ongoing development with phased implementation	Review cycle	Review cycle	Review cycle
Development of MCP	Develop model(s)	Phased implementation	Phased implementation	Phased implementation	Full implementation

Critical Decisions to support next steps

STP support for MCP vanguard application/Model for extended v enhanced core access/operational leadership at natural communities level/relationship to other new models of care/ most appropriate contractual framework

Stakeholder engagement and consultation: Regular meetings with MyHealthcare Practices, BCHC, BSol GP providers and BSol GP Alliance, LMCs, Patients and Public , Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector , Local Authority Social Care Teams, Nursing and Residential Homes

Impact on capacity:

The GMS Contract specifies that GP surgeries must provide services for a minimum of 52.5 hours per week (minus contracted half days). Patients registered with My Healthcare are able to access services for 84 hours per week giving a total of 31.5 additional hours of access per general practice each week. Between December 15 and May 16 there have been at least an additional 32,527 completed appointments as a result of MyHealthcare (the total number will be far higher given the service commenced in a phased manner from July 15.

Top 3 risks:

Risk	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF model and LTC pathways – failure to get funding released from STF to support CCF programme and new models of care		STP includes Fit for Future Secondary and Tertiary programme. Supported by financial plan. STP Governance Structure.
Failure to attract enough additional clinical workforce hours to support new model		Workforce Development programme, creation of attractive TandCs for clinical staff. MyHealthcare CPEN programme.
New models of care are not clinically or cost effective in isolation		Initial evaluation of GP Access Fund model- taking forward findings. Supported by workstream programme.

9. Community Care First – Long Term Conditions Management and Maintaining Independence (page 1/2)

SRO: Helen Kelly / Karen Heliwell (Co-Chairs)

Relevant leads: Nilima Rahman-Lais (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, BCHC, HEFT Community, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:
A partnership approach to empower people with Long Term Conditions and Frailty to be able to self-care supported by a proactive, responsive integrated health and care system via:

- Access – a universal at scale offer for Primary Care to support management of LTCs
- Consistency – standardisation and coproduction of patient pathways and MDTs
- Holistic approach – co-produced and personalised around people
- E-health – digital solutions

Outcomes:

Outcome	Metric inc. baseline	Timeframe for delivery
Reduce in number of emergency admissions for Ambulatory Care Sensitive conditions	Baseline: 940.8 per 100,000 Target: 632.1 per 100,000 Reduction of 32.81%	2020/21
Reduction in health inequalities (life expectancy)	2.5% reduction in preventable years of life lost	2020/21
People with a long term condition feel supported to manage their own condition	Baseline 63.3% – Worse quartile; National Benchmark 66%; By 18/19 – 66% (whilst a 3% increase there is a significant shift across the quartile); BSol ambition to be in quartile 2 of the national data	2020/21
Increase the number of patients able to manage their own condition	Target: 94%, (Aspirational 95%)	2020/21
Reduce percentage of deaths in hospital	Baseline 53.8% National benchmark 47% Target: 42%	2020/21

In year 1 we will:

- Agree geography/footprint of integrated teams (March 17)
- Develop of Operating model including risk stratification and MDT model (June 17)
- Develop a coproduced model of self care to empower people with LTC (May 17)

In years 2 and 3 we will:

- Roll out Multi Disciplined Teams (MDTs) (April 18)
- Have a shared patient record across MDTs (April 19)

Impact on capacity:
Impact on workforce by 2020/21: increase in the number of staff working in Primary, Community and third sector – more detail to follow.
Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Context/description:

A high proportion of people with LTC across BSol do not feel supported to manage their condition. BSol also has a high proportion of the population dying in hospital compared to the national benchmark. This picture can be improved by:

- Early identification via risk stratification
- Proactive management of high dependency patients within the community setting
- Wide scale adoption of self care
- Optimisation of Multi-Disciplinary Teams
- Specialists working with primary care and community teams and patients/carers in a solution focussed approach
- The use of the 3rd sector to support care navigation and target patients that would benefit from social prescribing and other community based support

There is an interdependency across the CCF programme: enhanced general medical practice, urgent care planning, Health and Wellbeing, LTC including mental health. We need to align with mental health across areas such as Improving Access to Psychological Therapies. We anticipate a shift in activity from secondary to primary and community settings away from secondary and tertiary care.

In scope:

The scope of this programme will include: all adults over 18 with a Long Term Condition or at risk of developing a LTC; Frailty/MDT approach- Integrated Community Teams; Support to families and carers; People living in Care Homes; Dementia Community and Mental Health.

Out of scope:

Learning disabilities and autism are out of scope.

Critical Decisions to support next steps:

Universal agreement on the role and purpose of MDT – the geography, professional make up, patient cohort, provider incentives and the performance measures used to review their impact. Patient cohort to be defined based on risk stratification.

Integration of Mental Health and physical health within MDT approach – engagement of voluntary sector on targeted service provision models that can sit in front of complex MDT cases as an effective form of demand management based in the community promoting self management.

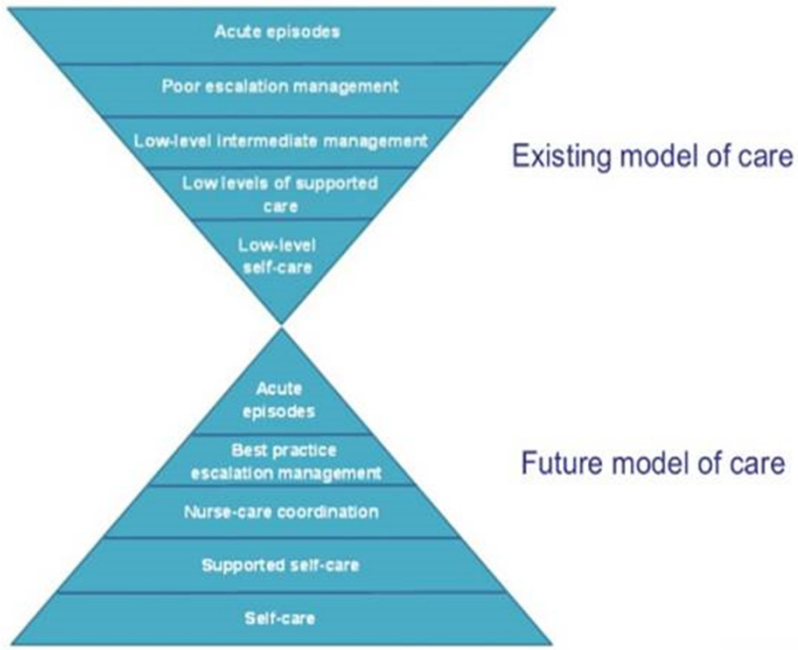
Engagement with secondary care on shift of workforce and skills from secondary to community settings, Social Care Engagement. Experts by Experience, Third Sector, Healthwatch, BVSC.

Stakeholder engagement and consultation:

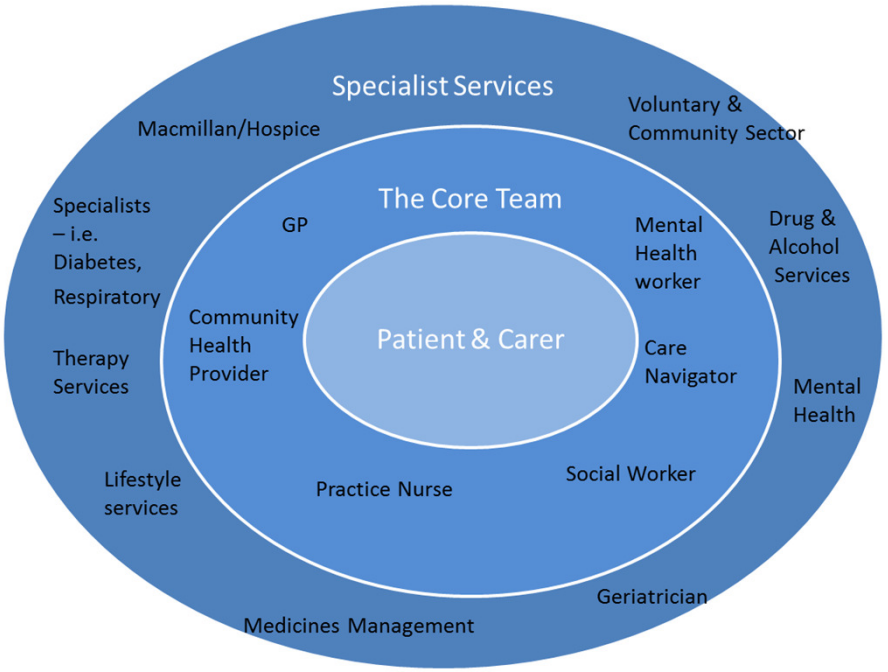
Primary Care, Community Services, Secondary Care, Mental Health, Workforce, Public Health

9. Community Care First: Long Term Conditions Management and Maintaining Independence (page 2/2)	
SRO: Helen Kelly / Karen Heliwell	**Relevant leads:** Nilima Rahman-Lais (Workstream Lead) and Angela Szabo (Finance Lead)
Organisations involved: BSol CCGs, BSol GP Alliance, BCHC, HEFT Community, BSol Acute Trusts, BSMHT, Local Authorities	

Model of Care



The MDT Approach



Risk	RAG	Mitigation
Vision and operating model not agreed across system		MDT workshop to develop shared vision and model for wider consultation with all stakeholders
Availability, capacity and capability of workforce to deliver hinders ability to deliver programme goals		Implementation of HEWM integrated workforce tool
Behavioural change for people with LTC and staff to become solution focused not achieved		Coproduced new model of care and supportive self care packages
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored

10. Community Care First: Urgent Care - Care in a Crisis (page 1/2)

SRO: Dr B King / Andrew McKirgan | **Relevant lead:** Karen Richards (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:
We will have a fully integrated health and social care system that provides a simplified, safe and sustainable 24x7 urgent and emergency care service. We will ensure our population receives high quality and seamless care from easily accessible, appropriate, integrated and responsive services. This will be delivered by:

- One point of access – NHS 111 including clinical assessment, advice and appropriate designation, with robust DOS and directly bookable appointments
- Increased use of paramedic triage and assessment
- Development and implementation of standardised urgent care centres to provide a comprehensive alternative to A and E and ambulance conveyance
- Review and streamlining of front door assessment, creating a single assessment route within the acute hospital, proactively supported by radiology, pathology and specialist support
- Improved hospital flow – implementation of Clinical Utilisation Review and SAFER
- A single model for step up/down care including access management, bed capacity and integrated community teams. Streamlined discharge pathways to reduce the number of hand offs and ensure timely and appropriate discharge.

Outcomes	Metric inc. baseline	Timeframe
Reduction in DTOCs to target of 5 per 100,000	BSC 21.4/BXC 14/SCCG 14	2020/2021
A and E wait time of 95% in 4 hours	Baseline 86.5%/HEFT 89.5%/UHB 92.9%	As per STF Trajectories
%FFT in AE (data released July 2016)	All sites minimum 88% All sites minimum 95%	2018/2019 2020/2021
Reduction in emergency admissions	15% reduction in overall unplanned admissions	2020/2021
Reduction in emergency A and E attendances	17% reduction for adults, 22% for children	By 2020/2021
Trial national outcome metrics – Solihull UEC Vanguard	Baseline due November 16	Trial Nov 16 – Feb 17

Key Milestones:

In Year 1 (by Mar 2017) we will:

- Implement a single point of access including OOH with enhanced clinical assessment prior to A and E/ambulance dispatch. Directly bookable appointments into existing out of hospital provision
- Evaluate GP front door streaming model to inform the service specification of Urgent Care Centres (IUCC's). Agree the model, including patient and public consultation for IUCC's, before commencing the procurement of IUCC's.
- Complete rollout of Clinical Utilisation Review (CUR) within acute and community hospitals (subject to positive evaluation of the pilot)
- Agree terms of reference and approach to review of acute hospital front door assessment
- Agree a system wide A and E plan focused on the 5 mandated areas set out within the NHSE Rapid Implementation guidance
- Review and agree a single approach to discharge pathways including trusted assessor
- Agree the model for community recovery teams including procurement approach
- Agree interim approach to step up/down capacity to facilitate resilience to enable procurement of longer term model

Context:

In common with national trends, the Birmingham and Solihull health and social care economy continues to see growing levels of demand for urgent and emergency care services. This is evidenced through additional pressure on hospital based services, with UHB and HEFT experiencing growth in A and E attendances of 4.1% and 4.9% respectively, and increased admissions of 5.6% and 0.4% during 2015/16. Both HEFT and UHB are experiencing significant challenge in delivering their A and E 4 hour wait STF trajectories for the 2016/17 contractual year. There has also been an increase in delayed transfers of care at both HEFT and UHB. Stakeholders within Birmingham and Solihull have worked effectively together over the past two years through a number of forums including, System Resilience Groups, Urgent Care Programme Board, Better Care Fund and the Urgent, Emergency Care Network to gain a comprehensive view of the issues within the BSol urgent care system.

By way of support and to provide a firm evidence base to the collaborative working, a substantial design process was undertaken during 2014/15. This comprehensive process involved bringing all partners within the urgent and emergency care system together through a series of clinical workshops. Stakeholders worked together to review existing service provision, identifying key areas for focus and redesign. The work culminated in a detailed case for change and a current state summary as follows:

- Services are fragmented, creating confusion for patients on what and how to access services
- Inefficient services are creating incoherent patient pathways
- Continual increases in urgent care demand – as evidenced through additional pressure on hospital based services, with UHB and HEFT experiencing growth in A and E attendances and admissions as highlighted above
- The current system is not financially sustainable – additional £11m invested above contracted amounts to support resilience and improve performance against key indicators
- Failure to achieve the 95% for 4hr waiting time standard at both UHB and HEFT during 2014/15 and 2015/16. STF trajectories are not being met for UHB.

More recently, further analysis work and patient engagement has been undertaken to validate the picture. This work has been aligned to the Solihull Vanguard programme. The BSol urgent care strategy is based on recommendations within the Keogh Review and complies with the interventions set out within the associated UEC roadmap.

In Year 2 (by Dec 2018) we will:

- Develop a comprehensive directory of services to support appropriate designation through NHS 111
- Commence mobilisation of new IUCC's
- Operationalise local clinical hub within IUCC's, providing 24/7 access to advice and treatment, this will compliment the regional NHS 111 hub
- Pilot the agreed assessment unit approach at front door of acute hospitals
- Implement agreed step up/down model
- Evaluate comprehensiveness of agreed discharge pathways including trusted assessor
- Regularly monitor and refresh delivery against A and E plan, demonstrating impact of 5 mandated areas

In Year 3 (by Mar 2019) we will:

- Negotiate relevant service changes into contracts to enable comprehensive evaluation

10. Community Care First: Urgent Care - Care in a Crisis (page 2/2)

SRO: Dr B King / Andrew McKirgan

Relevant lead: Karen Richards (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

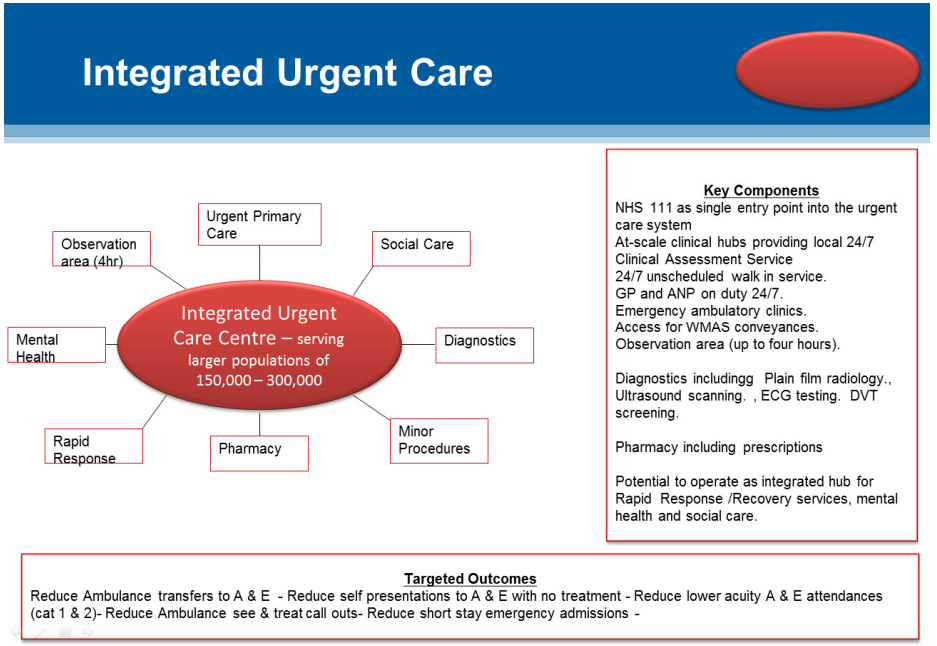
Critical Decisions to support next steps:

- Alignment with secondary and tertiary care programme
- Focused, collaborative approach to develop and agree new models of care, enhanced primary care provision, approach to estates (utilise existing or development of new or a mixture of both) and approach to IT to enable interoperability within the urgent care system

Stakeholder engagement and consultation:

Regular meetings with OSC, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes, West Birmingham STP Partners, BSol GP providers, BSol GP Alliance and UECN.

Top 5 Risks	RAG	Mitigation
Lack of engagement from secondary and tertiary programme		Align UCIC, secondary and tertiary work streams, BSol and A and E Delivery Board
Achieving successful public engagement and consultation outcomes on the role and function of UCCs and the impact on acute services configuration		• On-going clinical workshops between secondary and primary care colleagues to ensure alignment and agreement on UCC model. • Robust on-going engagement with OSC to ensure support when moving to public consultation
Unforeseen increases in demand and reduction in capacity of care services from local authority financial pressures		Development of detailed understanding in relation to proposed disinvestment. Joined up working on the development of MDT's.
Workforce not available to support the UCC model – transfer from acute sector, primary care strategy development and training for new roles		• Development of joint roles across secondary and community • Increase capacity from pharmacists and paramedics
Patient and public gaining confidence in new model.		Development of Communications and Engagement strategy including approach on consultation



Impact on bed base by 2020/2021:

Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

11. Community Care First: Children and Young People (page 1/2)

SRO: Dr Doug Simkiss / John Lees / Dr Mary Montgomery

Relevant leads: David Coles (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, Forward Thinking Birmingham, Local Authorities

Strategic objective:

To provide care for children and young people (CYP) in the community across the Birmingham and Solihull footprint, delivering integrated support to them and their families around social, education and health care that proactively targets local early intervention and prevention

To interface with acute and higher levels of care across all sectors

Strategic Ambition to develop:

- Localism/place based integration: delivered through natural communities allowing practitioner relationships to develop across CYP specialisms – including skilled rapid response teams
- Community Engagement: preventative services through building social capital, enhance community and individual family and child resilience, promoting self help and development
- Biopsychosocial teams: integrated service provision for coordinated interventions for CYP
- Complete Care for Children: joined up MDT teams utilising: Team Around The Child (TAC) and care coordination approaches; Common Assessment Framework (CAF); Team Around the Family (TAF); Education Health and Care Plans (EHCP)
- Learning and development – a shared function across health and care, learning and development function delivered in a joined up fashion by professionals at a locality level.

The programme will pull paediatric expertise and community support into primary care to achieve better outcomes for children, delivered through a natural communities footprint and delivered through an integrated approach utilising developing GP practice hubs. The programme will build upon existing research and best practice through the 'Big 6' programme, focusing on six segmented groupings: Healthy children; Vulnerable children with social needs; Children with complex health needs; Child with a single long term condition, acute mild/moderately unwell children; acute severely unwell children.

Outcomes	Metric inc. baseline	Timeframe
Care and Quality: 1. Effective triage of cases in MDTs in localities resulting in both signposting to community services and more appropriate referrals to secondary care. 2. Learning and development function resulting in improved management of acute mild/moderate childhood illnesses in primary care. 3. Learning and Development function resulting in shared knowledge of the service provision in a locality.	• 38% reduction in acute paediatric admissions • 39% reduction in OPDs, • 22% reduction in A and E attendances • (review and refresh of assumptions on going and to be tested through staged rollout of model) • Rapid response cohort target based on 950 CYP	2020/21
Health and Wellbeing: 1. Community engagement resulting in coproduction of health promoting initiatives. 2. Assets mapping identifying community health and wellbeing resources 3. Readiness for school	• Community engagement delivered across localities through agreed engagement plan metrics • Metric, measurement at 2/2.5 development check	2018/19

Context:

BSol have one of the youngest and some of the most deprived population of children in the country. Additional statistics include:

- younger than national population: 19.8% of population are aged 0-14 years compared with 17.3% nationally (CYP pop of 330,000)
- 46% of population live in most deprived areas,
- considerable financial challenges across NHS and LA commissioning and provision,
- wide variation in services offered and delivered for CYP across BSol
- percentage of the population that are children varies across the STP: 17.4% Solihull, 20.3% BXC, 20.6% BSC.

Estimates nationally suggest that 40-50% of GPs have limited formal paediatric training. This and other factors leads to GPs having limited confidence to assess and treat children, with referral to secondary care for many CYP who could be managed in primary care. There is evidence to that focusing on care in the community can impact on the current increase in numbers of CYP presenting at Emergency Departments, and increasing admissions of CYP to Hospital.

In Scope:

0-18 services, Multi agency integrated approach inc. MDT; Rapid Response provision CYP with complex needs; Long Term Conditions; Special Educational Needs and Disabilities; Enhanced Primary Care access/response for CYP; improved access to paediatrics/child health in a community/local setting, Palliative/EOL care; Big 6 approach.

Out of Scope:

- Over 18s; Specialised commissioned services, urgent care, optometry services, dental services, pharmacy services; Mental Health (FTB); Maternity and Newborn

Work Stream Dependencies:

- Other CCF work streams/Children's STP +/workforce capacity and capability/IMandT and Estates/Communications and Engagement/Contractual Models
- Mental Health (FTB); Maternity and Newborn (BUMPs)
- Fit for Future Secondary and Tertiary Services

Critical Decisions to support next steps:

Definition of transition protocols for children to adult services. Clarity of design of LTC developments across all ages. Challenge to deliver required programme capacity. MDT approach development across Community/Acute/Social Care/Education

Stakeholder engagement and consultation:

Requires regular meetings with BSol Stakeholders including acute/community/mental health providers and primary care, Patients and Public, 3rd Sector, Local Authority Commissioning teams, public health, early years provision/settings and education. Specific development of clinical reference and design group.

11. Community Care First: Children and Young People (page 2/2)

SRO: Dr Doug Simkiss / John Lees / Dr Mary Montgomery

Relevant leads: David Coles (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, Forward Thinking Birmingham, Local Authorities

Key Milestones

In Year 1 we will:

- Develop a clinical reference group, and have reviewed clinical pathway and Paediatric community team options and CC4C approach and Big 6 model (Apr 17)
- Scope and design MDT offer in collaboration with wider CCF programme (Apr 17)
- Review of governance arrangements to support/deliver CYP programme (Apr 17)
- Conduct review of and further design Rapid Response service and develop implementation plan for Rapid Response 'go live' in 17/18 (Apr 17)

In Year 2 we will:

- Complete mapping exercise of children's community assets across health, local authority and third sector by locality natural communities (Aug 17)
- Review and pilot 'Ready Steady Go, Hello' approach (Aug 17)
- Design pilot for Paediatric Integrated Community Team in readiness for 17/18 (Aug 17)
- Finalise Rapid Response pilot and review options to scale up in year (Aug 17)
- Prepare and pilot and roll out patient/community information in collaboration with HandWB leads (Oct 17)
- Review options to develop and deliver 'patient champions' model (Oct 17)
- Roll out Big 6 approach (Oct 17)
- Pilot Paediatric Integrated Community Team in locality (Oct 17)
- Scale up Rapid Response service (Oct 17)

In Year 3 we will:

- Further scale up of Paediatric Integrated Teams in line with Hub development/roll out
- Rapid Response fully operational
- Ready Steady Go Hello, fully implemented across BSol
- Review findings from ongoing developments and implemented programmes

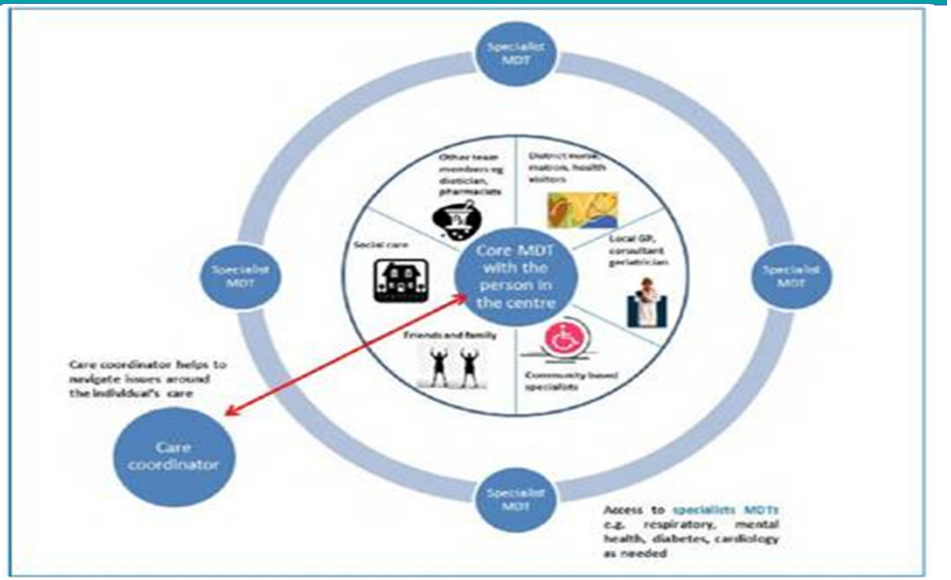
Impact on capacity:

Impact on bed base by 2020/21:

- Impact on bed base by 2020/21:
- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Impact on workforce by 2020/21:

Potential new roles for secondary and primary care as part of MDT approach development. New roles inc. Community Paediatric Nurse Practitioners and opportunity to develop Practice Nurse + roles within primary care.



Top 5 Risks:	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF CYP model and pathways		Overall STP includes Secondary and Tertiary Programme, supported by financial plan. Provider engagement continued through CCF CYP programme meetings/forums.
Specific CYP data may not be available/identifiable across data sets that will enable the programme to make informed decisions about activity and capacity flow and shift and pathway design		Initial data and assumptions to be tested though pilot roll out of Children's Hub and MDT developments. Finance and business intelligence support in programme to work through data requirements.
Impact of local authority commissioning intentions and redesign of local children's services and early years provision on proposed CYP CCF model		CYP CCF programme to link directly with BCC Commissioners through B'ham Early Help Strategic Programme commissioning workstream
Lack of/or limited paediatric expertise available amongst GPs and primary care to support shift in care		Learning and development approach, support and skilling up primary care to treat children's issues and through GP Forward View
Limited engagement of Service Users and wider stakeholders including neighbourhoods to support development of new models and pathways of care		Coordinated programme of engagement and consultation delivered across CCF programme and individual work streams

Fit for Future Secondary and Tertiary Services

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

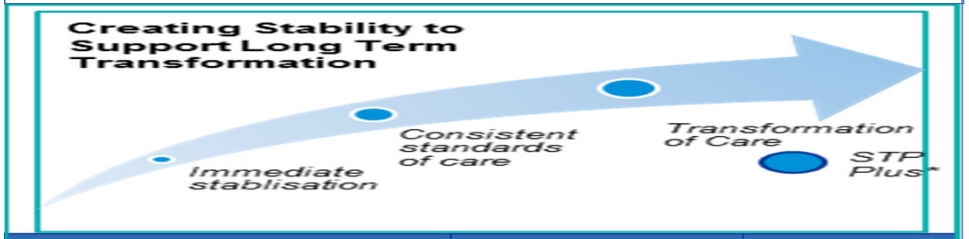
12. Fit for Future Secondary and Tertiary Services: Adult Care 1/2

SRO: Dame Julie Moore | **Relevant leads:** Andrew McKirgan, Jo Chambers/Philip Begg (for orthopaedics)

Organisations involved: UHB, HEFT, BCHC, ROH, Birmingham City Council, Solihull Metropolitan Borough Council Primary Care Services

Strategic objective:

- To provide stabilisation to Heart of England Foundation Trust in terms of clinical quality and financial controls.
- To deliver first class sustainable acute services across the STP footprint that are fit-for-purpose and provide high quality care to our local population, now and in the future:
- To create standardisation of clinical practice with the adoption of single care pathways and a shared set of clinical protocols and quality standards that optimise clinical outcome across Birmingham.
- Provide improved education, training and research opportunities to ensure the best individuals are attracted to come and work across the STP
- Build on the current research and development model with the creation of a single research and development hub creating greater access for the community to innovative new treatments.
- Create a more efficient, effective and integrated workforce
- To deliver better integration of acute care and adult social care for the benefit of patients.
- To manage in partnership with the Black Country STP the transition of services from City and Sandwell hospitals to the new Midland Metropolitan Hospital . Opening 2018.
- To continue to play a collaborative role across STPs with regard to all tertiary services.
- To work across STPs through West Midland Alliances.



Outcome	Metric inc. baseline	Delivery
Standardised of clinical practice / pathways	Performance standards	2018/19
Improved patient experience	Patient surveys	2018/19
Improved access to tertiary patients	Waiting times	2018/19
Improved recruitment and retention	Vacancy rates /Staff Surveys	2018/19
Reduction in acute DTOC rates	DTOC %	2018/19

Context:

Within the BSol STP footprint there are organisations at varying levels of maturity from those requiring stabilisation to those well-advanced on the transformation journey.

Our key challenges in this area:

Financial stability

The Birmingham and Solihull health economy faces significant financial challenges and the STP Leadership Board recognises that stabilisation and sustainable improvement of HEFT and adult social care services are fundamental to creating a solid foundation to the STP.

1. *Lack of clarity of long term governance arrangements for HEFT*
   - At the request of Monitor in November 2015, UHB has been providing support to HEFT and a decision has yet to made about the long term arrangements.
2. *Deficit in adult social care budget*
   - There is a forecast deficit of £30 million for 16/17 which is having a significant impact on acute providers .

There are 7 hospitals, 3 of which are specialist facilities. There is variation in the delivery of care and performance metrics

Workforce Shortages

There are limited resources available both within the primary, acute and community sectors and an ageing workforce. There are also shortages within particular specialty areas

Delayed Transfers of Care

Across the STP footprint there are, every day, hundreds of patients who experience a non-clinical delay in the acute sector which will require a collaborative transformational solution.

Opening of the Midland Metropolitan Hospital in 2018.

The closure of City Hospital has significant implications for the BSol STP in terms of patient flow from West Birmingham into the other Birmingham providers.

Orthopaedic Vanguard

The Royal Orthopaedic Hospital NHS Foundation Trust is part of the National Orthopaedic Alliance, a national vanguard which is developing evidence-based quality standards aimed at reducing clinical variation and improving outcomes for patients at all providers of orthopaedic care.

Critical Decisions to support next steps:

- Determine the long term arrangements for HEFT. This will be determined between the boards of UHB, HEFT and NHSI/NHSE.

12. Fit for Future Secondary and Tertiary Services: Adult Care (page 2/2)

SRO: Dame Julie Moore

Relevant leads: Andrew McKirgan, Jo Chambers/Philip Begg (for orthopaedics)

Organisations involved: UHB, HEFT, BCHC, ROH, Birmingham City Council, Solihull Metropolitan Borough Council, Primary Care Services

Estimated financial benefits:

Benefits will be realised through a variety of activities to be confirmed.

Interdependencies:

There are significant independencies with all other work streams, to be confirmed

Impact on capacity:

Impact on workforce by 2020/21:

- Reduction in utilisation of temporary workforce
- Workforce plan needs to address different models to ensure any change in capacity needs can be met

Impact on bed base by 2020/21:

- *There is currently no expectation that the current acute bed base in the system will reduce. The expectation is that through better collaboration, the work of the CCF work stream and a new model of integrated health and social care is that the system does not have to open in excess of 400 new inpatient beds to accommodate expected growth.*
- *Bed base needs to be created for additional capacity to meet the needs of the NHSE specialised commissioning strategy.*

Investment requirements:

Investment requirements to be clarified.

Stakeholder engagement and consultation:

We will be engaging with a variety of organisations through different forums including Public Sector Organisations (BWH, BCH, S&WB, CCGs, NHSE) Independent sector, Third party/Voluntary sector e.g. Healthwatch.

Engagement with the local communities also forms a vital part of our strategy.

Risk	RAG	Mitigation
Single HEFT / UHB organisation business case not approved		Close working with NHSI/NHSE/ local stakeholders
Lack of cross organisational commitment to transformation		Improved collaboration between organisations to the built upon through STP
Resistance from local communities to any change in service provision		Stakeholder engagement /Communication Strategy
Insufficient available finances at the sufficient time, particularly for any investment that may be required		STP financial modelling and early discussions with NHSE regarding capital to support system integration
Failure to deliver an integrated health and social care model.		Full engagement of BCC / Solihull Council in the STP. Coherent strategy and programme management

13. Maternity and Newborn (page 1/2)

SRO: David Melbourne

Relevant leads: Professor Helen Young **(**Programme Director), Dr Dianne Reeves (Accountable Officer BSC CCG)
Each workstream has a named chair, highly regarded in their field.

Organisations involved: BWH, BCH (inclusive of FTB), HEFT, SandWB, BCHC, BSMHFT, BCC/SMBC, CCG's NHSE, Primary Care Services

Strategic objective:

'Deliver a consistent world class holistic service that empowers women and families to make informed choices and who can access high quality care from a range of providers most suited to their personal choice and clinical need.

The workstream will deliver BUMP (Birmingham and Solihull Maternity Pathway):

by 2018:

- A single point of access for all women
- One stop model offering women greater choice and involvement in their care
- Continuity of carer for the woman throughout
- A uniform model of care delivering consistent pathways
- Appropriate capacity across the STP to support choice of delivery
- Community care delivered from Multidisciplinary Midwifery Team Hubs
- The MMT's would include specialists in:
  - Home birth
  - Sonography
  - Safeguarding
  - Intermediate care pathways including perinatal MH
- A uniform electronic patient record
- Revised contracting and funding model

Once successful in BSol we will review and implement the system across the West Midlands (2020 +). We have submitted a Pioneer bid for early adopter status to deliver Better Births which, if successful, means we will receive additional financial support.

Outcome	Metric inc. baseline	Delivery
Decrease in Mortality (Perinatal/Infant)	20% reduction	2020
Increase in homebirths and MLU births	Of total deliveries • Home birth rate ≥ 5% • MLU birth ≥ 25%	2020
Improved patient experience	• CQC rating of good or outstanding • % of women achieving their chosen place of birth • % of women actively using their PMCB (personalised budget)	2020 2018 2020
A skilled MDT/workforce to deliver the model	• Safe staffing • Use of agency/locums	2020
Consistent criteria, guidelines, pathways across the system	Implementation of policies within each trust	2018

Context:

Our current challenges include:

- A complex population that leads to increased Perinatal Mortality
- The West Midlands has a high rate of stillbirths, early neonatal and infant deaths compared to England and Wales
- Perinatal mortality rates were significantly worse in the West Midlands than for England throughout the fifteen year period 2000 to 2014 ((Birmingham has 7.1 deaths under the age of 1 per 1,000 births compared to national average of 4.0)
- Poor maternal physical and mental health
- Current maternity models are fragmented, inflexible and based on traditional models of care, with higher than average consultant led births, and little involvement of mothers in planning care
- Capacity difficulties due to rising birth rate, complexity of pregnancy, reputation and patient flows
- Inconsistent, inequitable and inefficient services impacting on quality and choice
- Outcomes for children beyond year 1 for children in Birmingham are poorer than comparable cities
- We have workforce shortages and an ageing workforce
- There are capacity issues which means the choice of where women give birth is currently affected by capacity and postcode

Key Milestones:

In Year 1 we will:

- Revise contracts enabling co – commissioning Maternity and Neonatal Services
- Implement consistent criteria, guidelines, pathways across the system

In Year 2 we will:

- Implement Single point of access/Community Hubs
- Deliver the revised care model within BSol
- Deliver a uniform EPR across the system

In Year 3 we will:

- Have appropriate capacity in the right places
- Deliver of the model across West Midlands

Critical Decisions to support next steps:

- Confirmation that both Trusts providing maternity services commit to delivering the programme at pace through a lead provider contracting model
- Confirmation with the Community Care First workstream regarding co-location of staff within Community Hubs, anticipation that SPA will be within 1 such HUB
- Confirmation of a co-commissioned and contracted approach with specialised commissioning for Maternity and Neonatal services
- Discussion regarding affordability of current Maternity Unit estate and alignment with the clinical vision

13. Maternity and Newborn (page 2/2)

SRO: David Melbourne

Relevant leads: Professor Helen Young (Programme Director), Dr Dianne Reeves (Accountable Officer BSC CCG). Each workstream has a named chair, highly regarded in their field.

Organisations involved: BWH, BCH (inclusive of FTB), HEFT, SandWB, BCHC, BSMHFT, BCC/SMBC, CCG's NHSE, Primary Care Services

Estimated financial benefits:

Benefits will be realised through a variety of activity shifts. At this stage our financial insight is fairly limited and we have focused on potential savings from a move to more home births and midwifery led births. We are exploring other areas around estate and rates of surgical intervention and induction of labour but this is in the early stages.

Importantly, we believe our programme will deliver long term health and well-being outcomes for the population.

Impact on capacity:

Impact on workforce by 2020/21:

- There will need to be an increase in midwives, sonographers and obstetricians
- Workforce plan needs to address different models to ensure increased capacity needs can be met

Impact on bed base by 2020/21:

- Modelling exercise to be completed

Stakeholder engagement and consultation:

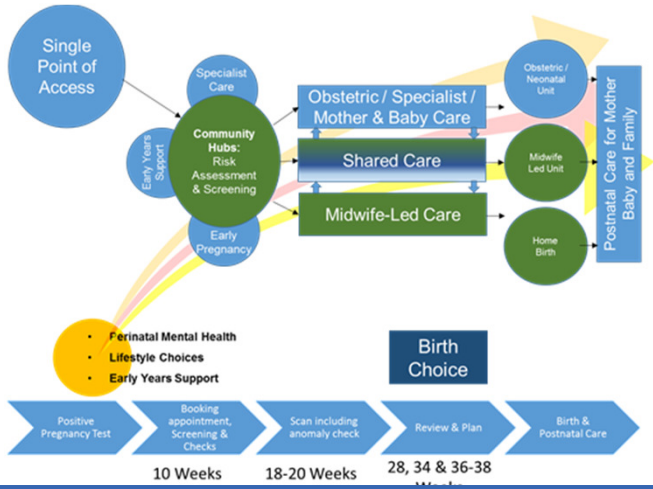
We recognise that engagement with our stakeholders is vital, especially with our women and families. We will be engaging with a variety of organisations through different forums including Public Sector Organisations (BWH, BCH, HEFT, Sandwell and West Birmingham, BSMHFT, BCC/SMBC, CCGs, NHSE, Primary Care,) Independent sector, Third party/Voluntary sector e.g. Healthwatch.

Investment requirements:

Investment requirements are not clear as the activity modelling to support this needs to be developed

Birth	Number of deliveries	Target number of deliveries	Baseline	Target	Target number of deliveries	Average cost per delivery (£)	Future costs (£)	Potential saving (£)
Home births	156	5.0%	0.8%	5.0%	942	166,296	1,004,439	838,143
Midwifery led	2,209	15.0%	11.7%	15.0%	2,827	3,227,349	4,129,882	902,533
Obstetric led	16,480	80.0%	87.5%	80.0%	15,076	26,878,880	24,588,956	2,289,924
Totals	***18,845***				***18,845***	***30,272,525***	***29,723,276***	***549,249***

Our new model:



Risk	RAG	Mitigation
Lack of support by stakeholders for the revised model of care		Strong engagement of all stakeholders and development of engagement and communications strategy
Lack of cross organisational commitment to transformation		17/18 contracts in NHS Trusts/Early adopter site,/MDT programme board
Lack of professional buy in to drive change and culture		Clinical engagement/involvement at every level
Insufficient available finances at the sufficient time, particularly for investment		We are a national pioneer site for choice and personalisation but we have applied for Early Adopter (vanguard)
Workforce shortages and an ageing workforce may limit implementation		Development of a strategic workforce plan Support from academic partners/HEE

14. Paediatrics (page 1/2)

SRO: Matthew Boazman

Relevant leads: Mary Montgomery, BCH - plus links in to CCF paediatric programme

Organisations involved: Birmingham Children's Hospital NHS FT, Birmingham South Central CCG, Sandwell and West Birmingham Clinical Commissioning Group, Birmingham Health and Wellbeing Board, Birmingham City Council, Heart of England NHS FT, Birmingham Children's' Community Health Foundation Trust

Strategic objective:

To deliver healthcare to children and their families closer to home, and to support families to be able to manage their own care at home wherever possible.

This will be delivered through the following objectives:

1. Prevent

- Keeping CYP (children and young people) and families healthy.
- Prevent need for multiple attendances

2. Protect

- Reduce admissions and length of stay in hospital

3. Manage

- Deliver integrated pathways of high quality care across BSol in order to ensure that CYP and families receive the same standards of care wherever they access thereby utilising secondary and tertiary care more effectively for those children who need it

4. Recover

- Deliver more secondary and tertiary care outside the hospital environment

By 2018 we will develop and implement a new **Children's Network** across BSol.
To achieve this we will undertake the following:

- Assess capacity and demand across BSol, initially focussing on high volume acute services
- Embed the pathways for the most common conditions children present with for urgent care 'Big 6', creating a mini- network
- Implement of telephone triage and advice service to provide additional community support
- Redistribute the delivery of paediatric surgical care more appropriate across the footprint
- Determine workforce requirements and capacity
- Create a uniform model of care delivering consistent pathways
- Redistribute the delivery of services more appropriately across the STP

Out of Scope

Specialist orthopaedic surgery

Investment requirements:
The programme will require a dedicated project management resource, clinical leadership time (backfilled PAs) and access to transformation support.

The longer term requirements will not be clear until the initial modelling and impact assessment of the "Big 6" work is underway

Context/ Description:

There is high demand for paediatric services across the footprint. As noted in the CCF programme, BSol have one of the youngest and most deprived populations of children in the country – there is a CYP population of 330,000 (19.8% of population) and 1 in 3 live in poverty.

As well as increasing demand, there are a number of key issues for paediatric acute services:

- 40-50% of GPs have limited formal paediatric training. This and other factors leads to GPs having limited confidence to assess and treat children, with referral to secondary care for many CYP who could be managed in primary care
- Families are frequently choosing to bypass their local A and E services to present for treatment at BCH as it is a recognised leading specialist paediatric hospital
- Consequently there are high rates of paediatric A and E attendances (0-4 year olds: 585.9 per 1,000 compared to the national average of 540.5)
- This impacts on the capacity available to provide speciality tertiary activity at BCH – a major regional, national and international provider for paediatric tertiary care
- There is clinical variation in both access and management for the common conditions presented within the A and E departments across the STP
- At certain times of year there is inefficient utilisation of the capacity across the system

Outcome	Metric inc. Baseline	Timeframe
Reduce A and E attendances	• 38% reduction in acute paediatric admissions • 39% reduction in OPDs, • 22% reduction in A and E attendances	2020
Reduce in hospital length of stay	TBC	
Increase capacity for tertiary services	TBC	
Share demand and capacity across BSol	TBC	
Reduce admissions	TBC	

14. Paediatrics (page 2/2)

SRO: Matthew Boazman

Relevant leads: Mary Montgomery, BCH - plus links in to CCF paediatric programme

Organisations involved: Birmingham Children's Hospital NHS FT, Birmingham South Central CCG, Sandwell and West Birmingham Clinical Commissioning Group, Birmingham Health and Wellbeing Board, Birmingham City Council, Heart of England NHS FT, Birmingham Children's' Community Health Foundation Trust

Key milestones:

In 6 months we will:
- Assess capacity and demand across BCH and HEFT for high volume acute services
- Establish a shared telephone triage and advice service for General Paediatrics
- Embed the 'Big 6' pathways of care management protocol across the STP – (mini network)
- Deliver increased paediatric surgical care at centres other than BCH

In 9 months we will:
- Establish a project for the development of a larger Children's Hospitals Network across BSol
- Assess workforce capacity and demand across BSol
- Further assess acute service capacity and demand across BSol

In 12 months we will:
- Demonstrated joint working across the key Big 6 pathways in paediatric medicine and surgery across HEFT and BCH
- Have reduced the management of some of the conditions within the tertiary centre compared to the baseline*

In Year 2 we will:
- Implemented the Children's Hospital Network across BSol
- Shown a step change in terms of conditions being managed within primary care and conditions not managed at the tertiary centre

* *Note savings for these are largely described already within the CCF work stream*

Critical Decisions to support next steps:

- Approval of work stream by STP programme Board
- Approval of work programme by HEFT, BCH, BCHC and commissioning leads
- Agreement and resourcing of project infrastructure

Estimated financial benefits:

:

The financial benefits are largely realised through reducing the reliance on secondary care acute delivery of care as outlined within the CCF paediatric programme.

The additional benefits relate to the ability to free up capacity for the provision of tertiary care in line with the NHS England development of prime provider models across a range of specialist services, including congenital heart disease, specialist paediatric surgery etc.

Stakeholder engagement and consultation:

- Through existing CYP YPAG group within BCH
- GPS Network
- JCCG
- NHSE
- ROH

Impact on capacity:

:
- Detailed modelling exercise on bed capacity will need to be completed but expected to reduce demand on acute bed provision which will either be closed or used to support delivery of increased tertiary demand
- Increased provision within community and primary care (linked to CCF programme)

Key risks:

Risk	RAG	Mitigation
Stakeholders fail to engage in proposed changes to system (local politicians, staff and public)		Robust engagement strategy to be developed including staff and where required public consultation. Stakeholder communication plan to be developed.
There may be insufficient resource capacity in line with the optimal (most efficient) target model		Main risk relates to establishing primary and community care offer to support the shift in provision and this is mitigated through the CCF programme
Unable to achieve target outcomes within projected timeframes due to commissioning being undertaken by other partners		CCG commissioning bodies will maintain an active dialogue with NHS England about the objectives for the local BSol population
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored.

15. Mental Health (Page 1/2)

SRO: John Short (BSMHFT)

Relevant leads: Joanne Carney (Programme Director) with support from John Lees (Children and Young People)

Organisations directly involved: Birmingham and Solihull Mental Health NHS FT, Birmingham Children's Hospital NHS FT, Forward Thinking Birmingham, Birmingham Cross City CCG, Birmingham South Central CCG, Solihull CCG, Sandwell and West Birmingham CCG, Birmingham Health and Wellbeing Board, Birmingham City Council, National Probation Service, Staffordshire and West Midlands Community Rehabilitation Company, West Midlands Police, Solihull Metropolitan Borough Council

Strategic objective:
"We all want to provide better help for people who are suffering from, or who are at severe risk of, mental health problems." In line with the 5YFV the overarching objective is to ensure that mental health is considered as important as physical health. This will be delivered through the following objectives:

1. **Prevent–** preventing mental health problems and getting help earlier, for people starting to suffer poor mental wellbeing
2. **Protect**– protecting, those who are most vulnerable from the adverse effects of mental health problems including management of the relationship between mental and physical health and ensuring parity of esteem
3. **Manage**– preventing mental health crises and managing them better when they do occur
4. **Recover**– helping people with mental health problems to recover back into everyday life

Outcome	Potential metric	Time-frame
OAT and least restrictive environment (18yrs+) Out of area placements will be eliminated for acute mental health care 5YFV	Number of acute MH Out of Area Treatments (OATs -outside 30m radius) in 2015/16 Baseline: ~12 OAT beds/month in Birmingham, ~2 OAT beds/month in Solihull; Target: 0	2018/ 19
Care within least restrictive environment (<18yrs) Reduction in tier 4 admissions for mental health FiM/5YFV	Number of tier 4 admissions for mental health Baseline and target to be developed in next 6 months following further discussion with health and social care commissioners	2020/ 21
Recovery- (18 +) Increase in proportion patients with MH conditions in paid employment 5YFV	% patients with MH conditions (on CPA) in paid employment Baseline: 4.9% (Birmingham), 9.7% (Solihull) Target: 8.9% (min Birmingham), 9.9% (min Solihull)	2020/ 21
Increase access (<18) In number of CYP with a diagnosed mental health condition receiving treatment from an NHS funded community Mental Health service. FiM	% receiving treatment (baseline to be developed in 16/17 as per Mental Health Five Year Forward View) Target: % increase from baseline to at least 35%	2020/ 21

Context/Description:
BSol faces a high prevalence of psychosis within the local population and a high number of Mental Health Act detentions. Birmingham and Solihull MH Trust has a consistently high occupancy rate of 95% and across the system there are a high number of Out of Area Treatments (OAT) in comparison to peers. Delays to discharge are multi-faceted but partially influenced by demand to non-acute inpatient services and step-down provision. In 2015/16 BSol spent £15.7 million on children with complex needs thus representing a low volume, high cost cohort. As noted in the Future in Mind report, collaborative plans need to be developed with specialised commissioners in line with the new waiting standards and national ambition to reduce usage of tier 4 CAMHS beds. Birmingham already have a home treatment service and 24/7 crisis care so there is now a need to make this consistent across the BSol footprint. Providers and commissioners are committed to tackling known inequalities, including the disproportionate impact of MH conditions on years of life lost and the over-representation of BME groups (specifically young black men) within detained environments.
BSol STP has decided to focus on ensuring care is provided in the least restrictive setting as part of a wider review to ensure that capacity is better aligned to resources and care is provided in the least restrictive setting. This will be enabled by the following areas of work:

- System capacity modelling exercise
- Development of a shared bed management function for 18 years+ across 4 local MH providers (MERIT Vanguard)
- ACO for low and medium level secure services across the West Midlands (REACH OUT)
- Scoping alternatives to admission for <16yrs and 16-18 years e.g. PDU
- Review of Children and Young People (CYP) complex care packages and required improvements to local services.
- Reviewing and improving systems of care in areas including personality disorder, complex trauma, neurodevelopmental conditions and eating disorders

There is an underpinning principle that a recovery focus will reduce reliance on the heath and care system, therefore the second transformation area will involve embedding recovery, employment and training. As the CPA employment rate is lower than comparators, there is an ambition to go above and beyond the national target and achieve radical expansion of the IPS scheme. For young people, this relates to a need to prevent the longer-term consequences associated with not being in education, employment or training (NEET).
These outcomes are being supported by a number of additional initiatives and pilots to further improve MH outcomes for the BSol population including transforming care for people with learning disability and autism and extending IAPT and EIP services. As a footprint, BSol currently spend £250m on MH services (2015/16 recurrent spend). In line with national guidelines, we will review benchmarked data to ensure MH services receive the necessary proportion of total CCG expenditure.
There is an awareness that MH parity of esteem needs to feature across STP programmes and other workstreams, therefore the Programme Board will also monitor the following interdependencies:

- CCF: enhanced general medical practice, LTC management (including dementia), urgent care planning
- Maternity: perinatal MH MDT teams within home treatment/primary care
- Secondary and tertiary care: Psychiatric liaison and dementia/frailty care
- Transforming Care Programme for Learning Disabilities and Autism

Key milestones:
In 6 months we will:

- Complete mapping exercise of alignment of MH projects/pilots to transformation outcomes
- Review of governance arrangements to support MH programme
- Conduct a review of workforce capacity and capability
- Scope evidence base for MH patients in paid employment
- Develop baselines for Birmingham and Solihull the proportion of CYP with MH conditions accessing NHS funded community mental health services
- Put in place a plan for collaborative Tier 3/4 CAMHS commissioning

In 9 months we will:

- Completion of independent capacity modelling exercise
- Confirm strategic direction for MH prevention and wellbeing offer and priorities for Years 2-5

In 12 months we will:

- Agree target operating model based upon insights from capacity modelling exercise
- Submit application for any targeted funding for IPS/forensics
- Approve standardised approach to admissions across 4 MH acute adopting the shared bed management function
- Complete redesign of recovery and employment service model

In Year 2 we will:

- Negotiation with providers on future operating model complete based upon capacity modelling exercise
- Procurement for respite provision/crisis housing complete
- Review and refresh of crisis care concordat complete

15. Mental Health (Page 2/2)

SRO: John Short (BSMHFT)

Relevant leads: Joanne Carney (Programme Director) with support from John Lees (Children and Young People)

Organisations involved: Birmingham and Solihull Mental Health NHS FT, Birmingham Children's Hospital NHS FT, Forward Thinking Birmingham, Birmingham Cross City CCG, Birmingham South Central CCG, Sandwell and West Birmingham CCG, Birmingham Health and Wellbeing Board, Birmingham City Council, National Probation Service, Staffordshire and West Midlands Community Rehabilitation Company, West Midlands Police, Solihull Metropolitan Borough Council

Estimated financial benefits: The MERIT vanguard will support work to deliver efficiencies in areas (Out of Area and A and E) where there are cost pressures through standardised approaches to care and combined bend managements functions.
Areas for potential savings include;

- Supporting earlier discharge/reduction in acute LOS (to national benchmarks levels)
- Savings from treatment within area compared to out of area non-NHS beds, enabled by the MERIT vanguard looking at a shared bed management system (Estimated average cost of out of area treatment per day £500, equating to a £2m cost for non-NHS beds and £429k in PICU beds in 15/16 in Birmingham and £363k in Solihull)

Enabling people with MH conditions to find and/or retain education, employment or training:
Linkage of local ONS data to national statistics suggests the indirect costs of mental health to be ~£731 million, and the direct costs to be ~£514 million. Modelling cannot be completed at this time but areas for potential savings include:

- People with MH conditions securing employment
- Preventing people with MH conditions from falling out of employment
- Reduction in GP attendances, A and E attendances, social care packages upon gaining employment

Critical Decisions to support next steps:
Agree how capacity and resource are best aligned to support the recovery focus and reduce out of area placements – this will be enabled by the independent capacity modelling exercise.
Await recommendation of West Midlands Commission (due to report in Autumn 2016) and integrate findings into programme going forward.

Investment requirements:
In line with the national commitment to increase investment in MH and LD, we must ensure MH receives the appropriate proportion of total NHS spend within the footprint.
In line with the transformation areas, potential areas for future investment include:

- Investment in community capacity, workforce recruitment and workforce training to reduce acute inpatient admissions
- Enabling people with severe mental illness to find and retain employment and additional support for young people
- Pathway redesign for neurodevelopmental conditions

Impact on capacity:
Impact on workforce by 2020/21:
Shift of workforce to community settings inc. delivery of BSol's share of 3000 practice based MH therapists = additional 68.4 (MH FYFV)

Impact on bed base by 2020/21:
To be determined based upon better alignment of acute and community capacity across all age groups

Stakeholder engagement and consultation:
To date there has been strong stakeholder engagement around the strategy including engagement events and system wide representation at Mental Health Programme Board and Delivery Group

Further stakeholder analysis will take place in the next fortnight in order to advance the stakeholder engagement strategy moving forward

Key risks:

Risk	RAG	Mitigation
Stakeholders fail to engage in proposed changes to system (local politicians, staff and public)		Robust engagement strategy to be developed including staff and where required public consultation. Stakeholder communication plan to be developed.
Ability to resource capacity in line with the optimal (most efficient) target model		The capacity modelling exercise will be completed by an independent contractor to reduce any conflicts of interest. The target operating model will be co-designed by stakeholders and potential misalignment between resource and capacity will be highlighted at the earliest opportunity.
Pace and scale of change is not sustainable giving current workforce capacity		Stakeholder engagement strategy to be developed. Robust Mental Health Programme governance to be implemented.
Unable to achieve target outcomes within projected timeframes due to commissioning being undertaken by other partners e.g. NHSE commissioning tier 4 beds		CCG commissioning bodies will maintain an active dialogue with NHS England about the objectives for the local BSol population
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored

16. Tertiary Care Prime Provider Models

SRO: Sarah-Jane Marsh | **Relevant leads:** Andrew McKirgan (UHB), Jo Chambers / Prof Phil Begg (ROH), John Short (BSMHFT), Matthew Boazman (BWH/BCH)

Organisations involved: ROH, UHB, HEFT CCG's Primary Care, NHSE, BCH, BWH, BSMHFT

Strategic objective:
We will develop prime provider models across a range of key specialised services which will support the emerging NHS England strategy for specialised services within the West Midlands. This will link directly with other STP programmes within BSol which are seeking to reduce the non-specialist demand on tertiary providers and will ensure that the capacity that is released is used in order to manage the increased demand for tertiary access. The prime provider models will ultimately support the standardisation of care, address quality issues and improve access and utilisation for specialised services both within the BSol STP and beyond focussing on the areas where there is significant expertise nationally within BSol:

- Orthopaedics (Including specialist orthopaedic surgery for children)
- Mental Health
- Adult tertiary care including cancer
- Maternity and Paediatrics (congenital heart disease, PICU, neonatal care and specialist paediatric surgery

To work across STPs through West Midland Alliances.

Context:
Areas to be addressed:

- High concentration of specialist tertiary care providers within the BSol STP
- Capacity challenges associated with tertiary care access due to competing secondary care demand and poor availability of key elements – PICU/ICU
- There are long waits for some complex orthopaedics, including paediatric spinal deformity
- NHS England specialised strategy across West Midlands is developing prime provider concept for a range of speciality areas
- Model is dependent on other STP work streams (CCF etc.) reducing demand on tertiary centres
- Variations in quality and outcomes
- The Royal Orthopaedic Hospital NHS Foundation Trust is part of the National Orthopaedic Alliance, a national vanguard which is developing evidence-based quality standards aimed at reducing clinical variation and improving outcomes for patients at all providers of orthopaedic care

Investment required:
The level of investment required will need to be identified once the confirmed specialties for developing a prime provider model have been agreed with NHS E and modelling completed

Estimated financial benefits:

- ✓ Improved utilisation with tertiary providers
- ✓ NHS E commissioner benefit across the agreed prime provider models through reduced clinical variation and better outcome

Impact of Capacity:
Workforce:

- Detailed modelling needs to be completed and is dependent on the agreed prime provider models that are developed

Outcome:	Metric inc. baseline	Timeframe
Standardised care, consistent across BSol	Performance against service standards.	2018
Improved patient outcomes	KPI metrics	2018
Improved utilisation of resources within each prime provider network (reduction in out of area placements for MH)	Activity delivered against each prime provider network financial envelope	2020

Top 5 Milestones	2016/17	2017/18
Agree "Top 5" Priority areas with NHS E where they wish to commission a prime provider model	X	
Agree standards of care within each prime provider model	X	
Complete baseline assessment of existing providers	X	
Establish contractual models and phasing for prime provider model		X

Risk	RAG	Mitigation
Agreement with NHS E on prime provider model		Early engagement with NHS England on developing model and fit with emerging strategy
Lack of cross organisational commitment to transformation		Support from NHS England commissioning approach for specialised
Inadequate capacity as tertiary centres to support prime provider model		Link to CCF programme and workstreams and development of managed clinical networks

Critical Decisions to support next steps: Agreement with regional specialised team on prime provider pathways of care that will be supported, discussion and Board approval within individual tertiary providers to support the strategy of developing themselves as a prime provider
Stakeholder engagement and consultation: NHS England, provider organisations within agreed prime provider networks, patient groups

Measuring progress

The following sets out what success will look like for our programmes in 5 years:

Objective	Programme	What Will Success Look Like?
1. Creating Efficient Organisations and Infrastructure	Provider CIP Delivery, Commissioner CIP, STP Wide Estate Reconfiguration and Rationalisation, Stabilisation and Transformation of Social Care, Commissioning Reform	• Improved top 10 productivity and efficiency KPIs • Achievement of CIPs • Financial balance (within system control total) • Reduced estates running costs and square footage • Reduced variation in quality of estates across the footprint • Optimised use of estates facilities which meet the future needs of the population for health and social care • More effective and efficient commissioning processes – fewer gaps and less duplication
2. Transformed primary, social and community care ***(Community Care first)***	Improving Health and Wellbeing Stabilised and Enhanced General Practice LTC Management and Maintaining Independence Urgent Care Children and Young People Stabilisation and Transformation of Social Care Commissioning Reform	• More integrated primary, social and community health services, focussed on prevention and maximising independence as well as high quality care provision. • Increase in readiness for school • Increase in proportion of vulnerable groups in meaningful work • Increase in people with LTC feeling supported to manage their conditions through self management and use of digital technology • Improved access to general practice in and out of hours with more patients able to get an appointment to see or speak to someone • Reduction in DTOCs • Reduction in emergency admissions and A and E attendances that can be managed in other settings • Increased community and individual resilience • Greater focus on outcomes based commissioning
3. Fit for future secondary and Tertiary Services	Adult Care Maternity and Newborn Paediatrics Mental Health Tertiary Care prime provider models Stabilisation and Transformation of Social Care Commissioning Reform	• Improvement in key selected clinical outcomes • Out of area placements will essentially be eliminated for acute mental health care (18yrs+) • Increase in proportion patients with MH conditions in paid employment • Reduction in perinatal/infant mortality • Increase in home births and MLU births • Greater focus on outcomes based commissioning

Overarching Programmes

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

17a. Stabilisation and Transformation of Social Care (Page 1/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga**

Organisations involved: Birmingham City Council and partner organisations

Strategic objective:

The national Better Care policy calls for integration between health and social care by 2020/21, albeit it does not define what this means in practice. Across BSol, we are developing local solutions reflecting our two Local Authorities, at pace, to commission and provide integrated health and social care services across the footprint. A number of our STP programmes, including CCF and Commissioning Reform, also support and underpin the overall stabilisation and transformation of social care.

In Birmingham this means:

Stabilising and transforming social care which responds to the needs of our local population to produce better outcomes for individuals. Our key focus areas are to:

- Enable people to stay as independent and well as possible, for as long as possible. When people do need long term support this is timely, responsive, good quality and enables people to continue to live their lives the way they want to.
- Continue to promote transparency and citizen involvement by building on the local democratic mandate given to City Councillors, leadership by the Health and Wellbeing Board, and support by the Overview and Scrutiny process. Starting from clear, relevant and up-to-date Joint Strategic Needs Assessments, linking directly to and from individual needs assessments specifically and personalised care and support more generally
- Support people to fully participate in their health and care through initiatives including co-production, personal budgets, and developing enabled individuals
- Supporting communities to become resilient in order to reduce unnecessary demand on services
- Ensure effective integration between social care and health services to support people to remain independent and in a crisis to return to independence
- Manage long-term assessment of needs and support delivery to ensure that our citizens receive support, appropriate to their needs
- More widely to use social care as a vehicle to the Local Authority's extensive partnerships to ensure a co-ordinated, system-wide approach to public sector reform and developing an effective interface with the public

Supporting data

- Delayed Transfers of Care attributable to the NHS and social care across the STP is 17.39 per 100,000 population (worst performing quartile nationally). This was much higher than the average of 12.5 in similar authorities.
- Delays attributable to adult social care have increased from 10.7 per 100,000 in 2013/14 to 11.3 in 2014/15. This was much higher than the average of 5.1 in similar authorities.
- 348 reviews for long-term services were carried out in 2014/15 for adults aged 18-64 and 2,672 for adults aged 65+ per 100,000, compared to 310 and 2,876 reviews respectively in the Council's comparator group
- There has been a decrease in adults 18-64 living in long-term nursing or residential services per 100,000 in 2013/14 from 190 to 162 in 2014/15, and an increase in adults aged 65+ from 1,905 in 2013/14 to 1,927 in 2014/15 per 100,000 population.
- 380 people aged 18-64 and 2,717 aged 65+ were accessing community based services (such as home care and day care) in 2014/15 per 100,000 population, compared to 416 and 2,814 respectively in the Council's comparator group.
- There was a decrease in adults aged 18-64 going into permanent residential care from 20 per 100,000 population in 2013/14 to 16 in 2014/15, compared to 14.1 nationally [in 2014/15].

Context/Description:

- The BSol footprint includes 2 Local Authorities, BCC and SMBC, which have very different populations, political priorities, and key drivers.
- Both Authorities have previously developed initiatives that have been tried locally to transform social care and within this context are currently working on their own approaches to social care, which are aligned to the above strategic objectives.
- However for both, integral to managing demand in health and social care is the vision to develop a whole Council approach to building stronger communities and resilient community relationships
- Both Authorities also face significant capacity / workforce challenges across the care sector, reflecting a range of issues, including the perception of the sector, low pay and an ageing workforce

Birmingham

- It is well documented that BCC is currently under the scrutiny of an Improvement Panel following the Kerslake Review which oversees its decisions and actions, including a significant financial deficit of c.£130m by 2020/21. Of this, £123m is apportioned to Birmingham and covers Adults, Children's and Public Health services, assuming that demand continues to increase. Part of the oversight is to ensure the long-term strategy for adult social care is developed in short timescale, within FY 2016/17
- The demography, age profile and population trends, and deprivation and health equality challenges for the City are also well-documented elsewhere within this plan. It is a matter of record and fact that cities such as Birmingham have been hit particularly hard by austerity measures in that area circumstances are such that citizens are more reliant on publicly funded services
- Birmingham adult social care has a strong track record of major transformation and modernisation since 2008, and regular confirmation from vulnerable citizens that they feel safe and supported. But we do need to major on and are now focussed on helping people to help themselves more to remain independent, support communities to become more resilient, and stretch significantly our ambition to support far more eligible people to receive direct payments / self-directed care and continue our recent positive trends to place less people into permanent residential care
- We are particularly mindful that we need to continue to support more younger adults to move from expensive residential care placements into supported living and other community situations, as Birmingham has been relatively high cost in the area for a number of years
- In addition, we need to prepare appropriately and at pace for effective and efficient front-line integration with the NHS and seek strategic partners to develop future plans with. More internally, we also need to strengthen our financial controls, processes and information for managers and ensure that our front-door and assessment process is as tight and consistent as it can be to best manage demand.

17a. Stabilisation and Transformation of Social Care (Page 2/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga, Louise Collett**

Organisations involved: Birmingham City Council and system partners

Understanding the Gap

We have expended significant effort in establishing the BCC position for adult social care in order to provide a firm foundation from which we will measure progress and success in stabilising and transforming adult social care services across the footprint. To do this, we have undertaken analysis on social care expenditure and activity, and will continue our work to model the impact and benefits in shifting activity into home and community services, and are aligning our BCF schemes with our STP programmes. We will also identify additional strategic options to further manage demand and maximise efficiencies, and have recently put in place a new strategy with UHB to manage and reduce delays in transferring patients to appropriate lower acuity settings, or home.

BCC expenditure on Adult Social Care

Expenditure (£'000)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Council spend (excl. Education)	941,989	937,806	902,590	862,812	823,953	812,320
Adult Social Care	287,834	276,885	263,298	232,556	216,255	226,867
% of the Council's overall spend	**31%**	**30%**	**29%**	**27%**	**26%**	**28%**

Figures based on net expenditure

Current position

As at 30th June 2016, the People's Directorate reported a £51.2m overspend projection, bringing the Council's overall cost pressures to c.£60m in 2016/17, resulting from externally driven cost pressures, significant challenges in delivering annual savings agreed by the Council, and additional growth in care packages and prices.

A significant level of savings (£28.4m) was apportioned to be achieved in 2016/17 via whole system reform plans with Health. On the 4th July 2016 a strategy was supported by BSol partners to seek to gain NHSE support to utilise the retained 1% CCG contingency (estimated at £13m) if this were possible to alleviate identified financial gaps in the system. Even If the total of the contingency were to be released into the system by NHSE and made available for adult social care alone this would still leave a £15m gap in that saving which the council would commence plans to save under the principle of 'least harm to the system'. It is now clear that given a thorough review of system finances and NHS pressures the utilisation of the £13m will not be possible under the current NHS priorities. Therefore, extrapolating the savings gap to 2020/21, Birmingham Council faces an overall gap of £123m within the BSol STP footprint for Adults, Children's, and Public Health services.

Requests for Support

Requests for Support	2014/15	2015/16	Increase / (Decrease)
Short Term Enablement	2,837	3,473	22.4%
Nursing Care	148	150	1.4%
Residential Care	310	281	(9.4%)
Community Care	1,207	1,604	32.9%
Low Level Support	7,009	6,068	(13.4%)
Short Term Support	81	128	58.0%
Universal Services	13,301	13,143	(1.2%)
No Services provided	10,830	10,340	(4.5%)
TOTAL	**35,723**	**35,187**	**(1.5%)**

Pressures on Adult Social Care services

There are a number of drivers which are placing increased pressure on our social care services. These include:

Demographics

- The trend between funding and the net effect of demographic growth is on the rise. Between 2015/16 and 2016/17, the level of client need attributable to demographic pressure has been forecast to increase by £12.5m, of which only ££6.5m is funded placing increased pressure on the system.
- Demographic pressures are also more complex than pure population growth statistics. Poverty and sickness are widely accepted as drivers of earlier onset of the effects requiring Social Care, and there is also growth in the number of younger adults with complex care needs where there is little opportunity to reduce these high package costs. Both these factors increase the intensity of demand on Adult Social Care within Birmingham.

Rising Pressures in the Care Market

- There is increasing pressure on the independent sector care home and home support sectors, most recently from the introduction of the national living wage and increasing reliance on sector funding. In Birmingham, one of our largest care home providers has served notice to close 166 beds. Alternative placements will invariably be significantly more expensive, adding increased pressure to our system.

Deprivation of Liberty Safeguarding (DoLs)

- Following the Cheshire West Judgement, the number of referrals and assessments continues to rise resulting in financial pressures. Additional costs resulting from this include; training of and/or recruiting specialist staff (Best Interest Assessors (BIAs)), and a requirement for Section 12 doctor reports to be accessed for each referral. The additional funding made available for this in 2016/17 was c.£625k however despite this injection of additional funds, there remains a c£1.5m cost pressure to the Council.

Public Health Review

- The Government announced reductions in the level of Public Health funding for 2015/16, 2016/17, and further reductions in future years. The service continues to fund Early Years, Wellbeing, Environmental Health and other services provided by the Council, however revised plans for the commissioning of lifestyle services in response to grant changes have been implemented. Major re-commissioning exercises have been embedded and a review of budgets has revealed that a further c.£1m is available to contribute on a one-off basis to support services in the People Directorate. The use of the Public Health Grant will be closely monitored by Public Health England however and any proposals will need to meet the requirements of the grant conditions.

17a. Stabilisation and Transformation of Social Care (Page 3/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga, Louise Collett**

Organisations involved: Birmingham City Council and system partners

Closing the gap

In order to close the Adult Social Care gap, we are considering a range of options and initiatives in Birmingham to further address and manage demand more effectively, and identify further efficiencies. This will be crucially dependent on local system collaboration, and making rapid joint progress with healthcare services towards a much larger, more extensive integration and transformation of the city's health and social care system.

Further Demand Management and Efficiencies:

A number of potential savings initiatives have been identified to close the gap.

These include the closure of adults day services, the reduction in residential respite etc. all underway. However these are dealing with an overspend that is continuing to grow and requires support from the council reserve. We would only propose to add items into this list at the point at which we could show clear net gain.

These are a work in progress and will need to be further validated, and new initiatives identified wherever possible.

A summary position is outlined below:

Proposals (Savings) / New Pressures	2016/17 (£)	2016/18 (£)
Possible Reductions Identified	**(12,547,000)**	**(30,927,000)**

Better Care Fund (BCF) schemes:

We are planning to increase our overall investment in BCF schemes in 2016/17, with a total investment of £101.6m for the year. Investments in these schemes will not only help to stabilise primary and community care services but will provide a strong platform to enable transformation which will help to close the social care gap. We will continue our work to fully align these schemes with our STP programmes, including modelling the benefits and impacts to ensure our resources are focused in the right areas to deliver greatest benefit.

The table opposite outlines the total areas of BCF spend, not just those directly attributable to supporting adult social care.

Delayed Transfers of Care (DTOC):

Across BSol, the delays attributable to adult social care have increased from 10.7 per 100,000 in 2013/14 to 11.3 in 2014/15, and is considerably higher than our comparator group average of 5.1 days.

To address this, we have recently implemented a new approach to discharge and transfers with UHB, our main provider of services, and where the majority of our delays are attributed. DTOC rates will be monitored and reviewed over the next 12 months to manage and improve performance and take appropriate mitigating actions to ensure the expected improvements are delivered.

BCF Scheme	2016/17 Proposed Budget (£)	2015/16 (£)	Increase / (Decrease) (£)
BCF04 – Equipment & Technology (Medequip)	4,649,000	4,584,000	65,000
BCF04 – Equipment & Technology (Medequip)	1,300,000	1,732,000	(432,000)
BCF05 – Care in Crisis / Intermediate Care – Bed Based Provision	1,379,000	1,360,000	19,000
BCF05 – Care in Crisis / Intermediate Care – Social Care Provision	1,415,000	1,395,000	20,000
BCF05 – Care in Crisis / Intermediate Care – Reablement	1,265,000	1,247,000	18,000
BCF05 – Care in Crisis / Intermediate Care – CUR Tool	710,000	700,000	10,000
BCF06 – 7 Day Services	369,000	364,000	5,000
Care Act	3,012,000	2,970,000	42,000
Carer Strategy	1,824,000	1,799,000	25,000
Eligibility Criteria	20,328,000	20,044,000	284,000
Management of Programme	1,025,000	1,011,000	14,000
Community Services	43,163,000	42,530,000	633,000
Reablement – RAID	1,705,000	1,681,000	24,000
Reablement – Communications	47,000	46,000	1,000
Reablement – OPAT	34,000	34,000	0
Non Elective Admission Reduction	6,575,000	6,483,000	92,000
Disabled Facilities Grant	8,803,000	7,764,000	1,039,000
BCF03 – Place Based Integration & Accountable Community Professional – Wellbeing Coordinator	452,000		
BCF03 – Place Based Integration & Accountable Community Professional – Route to Wellbeing	55,000		
BCF03 – Place Based Integration & Accountable Community Professional – MDTs in Primary Care	101,000		
BCF04 – Equipment & Technology	0		
BCF05 – Care in Crisis / Intermediate Care – Enablement	1,113,000		
BCF05 – Care in Crisis / Intermediate Care – Admission Avoidance	1,581,000		
BCF05 – Care in Crisis / Intermediate Care – Bed Based Provision	528,000		
BCF05 – Care in Crisis / Intermediate Care – Implementation of CUR Tool	106,000		
BCF09 – Dementia	65,000		
TOTAL	**101,602,000**	**95,744,000**	**1,858,000**

17a. Stabilisation and Transformation of Social Care (Page 4/4)

Birmingham

Estimated financial benefits:
Adult social care services are under increasing pressure across the footprint, with demand for services increasing steadily year-on-year. We will work closely as a system, across health and social care, to first stabilise existing services and then transform the way that we provide care to cope with the increasing demand from our citizens. As well as internal Local Authority actions, there needs to be a shift in funding into adult social care to be able to maintain the sector, or a solution from outside of the footprint i.e. national policy to deliver sustainability in the context of the wider health and care system and local demographics.

Outcomes	Draft Metric	Delivery timeframe
Reduction in DTOCs to 5 per 100,000 (tbc figure needs to be same as UC)		
Reduction in permanent residential admissions	40	[2015/16]
Increased effectiveness of reablement	18	[2015/16]
Reduction in non-elective admissions (general & acute) by 3.5%	3.5%	[2015/16]

Key milestones: Birmingham

In 6 months we will:
- Achieve a common level of understanding across the footprint regarding the statutory requirements for social care
- Complete financial and activity modelling, which will include social care
- Complete a clinical audit of people in beds to establish a baseline and identify the required future level of care
- Understand the confidence levels required in partner organisations to release resources,
  and identify areas on which to focus that will have the biggest impact
- Explore options for risk and gain share across the system (and agree as appropriate)
- Commence the pilot for the agreed model of care at UHB
- Deliver current programmes to support efficiency, demand management and preparation for integration, re-scoping where necessary

In 12 months we will:
- Develop options/appraise future funding and service delivery models for social care
- Agree the preferred option(s) for future funding and delivery
- Commence implementation of preferred funding and service delivery option(s) that will shift activity 'left'

In 2 years we will:
- Fully deliver the new models
- Review the impact and benefits

Investment requirements:
It is anticipated that investment is essential to maintain current social care services, and build on these to deliver improvements to people's wellbeing and independence such that demand on healthcare services is reduced. In Birmingham, we are already planning to increase our overall investment in BCF schemes in 2016/17, with a total investment of £101.6m.

Investment requirements for adults social care will be determined in detail following the finance and activity modelling, discussions regarding risk and gain share arrangements across the footprint, and an analysis of the provider market resilience and our response to this.

Impact on capacity:
Impact on workforce by 2020/21:
Capacity in this sector will be a long term challenge. Recruitment challenges will be partly improved by introducing more appealing roles (e.g. Local Area Co-ordinators) and increased use of technology to replace the need for some staff capacity. Workforce strategy will therefore be key.

The workforce impact will be determined following finance and activity modelling, and an analysis of market resilience and our response to it.

Impact on acute hospital bed base by 2020/21:
The required impact is defined in the health plans.

Critical Decisions to support next steps:
- Response to national policy direction for social care
- Agreement of the Councils' approach to FY17/18 budgets and beyond
- Agreement on the future model of activity and cost to reduce demand
- Agreement regarding the future commissioning model
- Agreement by all parties for strategic objectives, model(s) of delivery, and investment approach (where investment is needed to facilitate whole system improvements)
- Agreement in regard to risk and gain share arrangements across the BSol footprint, and Solihull place based area.
- Approach to address the current high waiting lists for Deprivation of Liberty Safeguards (DOLs), which relate to hospital and residential settings, as well as Community DOLs. These are a key risk area.

Stakeholder engagement and consultation:
There is strong recognition that continued engagement with stakeholders is vital if we are to succeed in transforming social care services across our footprint. In particular, engagement with service users, and their families and carers who receive support, and well as engagement with and direct involvement of Council Leaders, relevant portfolio holders and wider members to deliver our plans.

Engagement with faith based and other community based organisations will also be key to driving the changes required given our diverse population across BSol (where 42% of our residents in Birmingham, and 11% of residents in Solihull, identify with BAME groups).

Engagement will be through a planned programme and a variety of forums to include the above identified stakeholders, as well as other relevant public sector organisations (e.g. UHB/HEFT, BSMHFT, BCHCFT, ROH, CCGs, NHSE, CQC, Primary Care), Healthwatch, the independent social care sector, community and third / voluntary sectors.

Key Risks	RAG	Mitigation
Risk of Local Authorities having to take in-year spend reduction measures with significant unintended consequences for the wider healthcare system		Engage, understand, and plan jointly in advance of action, with local NHS partners within the agreed STP governance
Lack of available finance at the appropriate time, to maintain current service levels and to build further capacity to support health in diverting to lower cost solutions		Engage with health partners to determine and agree the investment model that will protect / maintain social care and benefit health organisations and service users. Push for change to national funding model
Lack of cross organisational commitment and effective stakeholder engagement and buy-in to drive change and culture		Work in partnership to identify a clear, evidence-based, appealing model for future delivery and continue engagement and involvement throughout ongoing development and delivery
Workforce recruitment and engagement is insufficient to mobilise at pace		Increase workforce engagement, including with Unions
Independent social care market stability continues to deteriorate, so capacity and responsiveness reduces		As part of transformation plans, identify alternative models for long term support, for example, extra-care housing, assistive technology, LA direct development of care homes

17b. Stabilisation and Transformation of Adult Social Care (Page 1/4) Draft v10 18.10.16 | **Solihull**

SRO: Jenny Wood | **Relevant leads: Sue Dale / Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Strategic objective:
'To enable people to stay as independent and well as possible, for as long as possible. When people do need long term support this is timely, responsive, good quality and enables people to continue to live their lives the way they want to.'
To support this ambition, transformation programmes are already underway and will work in alignment with the wider STP plan deliverables to:

- Support people and communities to support themselves as much as possible
- Ensure an effective, integrated approach to commissioning and delivery between social care, health services and wider partners, utilising social care as a vehicle to the local authority's extensive partnerships (e.g. Fire, Police, Housing, Economic Development) thus enabling co-ordinated, system-wide approach to public sector reform and effective interface with the public.
- Embed digital and self-service solutions where it makes sense to do so (e.g. blue badges)
- With health partners, define & deliver an admissions avoidance and hospital discharge model which is resilient, responsive & tailored to improving lives and outcomes.
- Ensure Adult Safeguarding is responsive, effective & works collaboratively with other agencies.
- Develop a clear, integrated approach to supporting children and young people with additional needs to prepare for and move to adulthood ('transitions'), with improvements to health, wellbeing and independence.
- All administrative processes (e.g. invoice payments/customer charging) are streamlined, digitalised and automated where-ever it makes sense to do so.
- Local response to pending National Carer's Strategy, with local change where needed.

Outcomes	Propose Metric (vs15/16)	Delivery timeframe
Reduction in DTOCs to 2 per 100,000 (System-wide target)	2 (17.3)	20/21
Long term support needs of 65+ met by admission to residential care (ASCOF 2A(ii) and BCF indicator)	517 (560)	20/21
Proportion of adults with Learning Disability who live in their own home or with family (not residential care (ASCOF 1-G)	80% (71.4%)	20/21
People who use services who say their quality of life is very good / good	69% (58%)	20/21

Context/Description:

- The BSol footprint includes 2 Local Authorities, BCC and SMBC, which have very different populations, political agendas, and key drivers. The ambition to deliver personalised, quality support and to enable people to maintain independence is a common goal.
- Solihull Adult Social Care has a recent history of good performance, outcomes and financial management. All remaining in-house provider services are CQC rated good and despite delivery of significant savings through the current medium term financial plan, complaints have remained steady and there has been a significant increase in compliments.
- Integral to managing demand in health and social care is our vision to develop a whole Council approach to building stronger communities and resilient community relationships
- We are keen to build on our strong history of engagement and co-production with our citizens, including our online Local Account, our Community Interest Company of Experts by Experience, & driving forward our 'Gold Standard' for Making Safeguarding Personal.
- However, the national funding position for adult social care is now having a significant impact and this is indicated in the emergence of a financial deficit in future years and performance challenges in key areas, e.g., hospital delayed discharges and the responsiveness and capacity in the independent sector market.
- There are significant market fragility, quality and workforce challenges across the sector reflecting a range of issues, including the perception of the sector; a need to better balance quality, market stabilisation and cost; and workforce challenges such as low pay, limited appeal of direct care roles, and an ageing workforce.
- Whilst significant anticipatory and innovative work is continuing to respond to the challenges, there is no doubt that these will not fully address the future funding gap for social care as set out in the finance section.
- Examples of innovation and change include the introduction of Local Area Co-ordinators, an evidenced-based approach to building more sustainable and resilient community networks, with indicated health and social care financial benefits. Another example is the decision to initiate a council-led, care home build for dementia care, recognising that the independent sector market capacity is not likely to provide affordable solutions to the capacity challenge, in the near future.

Key milestones: *In year 1 we will*:

- Progress financial, outcome and activity modelling, to better understand impact of own and wider STP financial and outcome-based plans.
- Jointly with health partners, define and agree the areas of joint or integrated commissioning and delivery and specify the approach to future delivery of functions in these areas. Explore options for risk and gain share across the system (and agree as appropriate)
- Deliver current in-year projects to support demand management for adult social care and the delivery of the current Medium Term Financial Plan savings. Ensure local policy and guidance underpins delivery of strategic objectives.
- Re-scope (where needed) the Adult Social Care Transformation Programme and the Solihull Together integrated health and care programme, to provide a governance vehicles under the STP structure, to ensure an ongoing focus on both BSol and Solihull-place based delivery.

In year 2 we will:

- Agree investment models and options with partners and tailor future service delivery models for social care in light of the results of this, focusing on ongoing delivery of strategic objectives.
- Deliver in-year agreed projects and evaluate new developments e.g., Local Area Co-ordinators.

In year 3 we will:

- Fully deliver the new models
- Review the impact and benefits

17b. Stabilisation and Transformation of Social Care (Page 2/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Supporting data and outcomes: Solihull

- The proportion of Solihull people who receive adult social care services, who are satisfied with those services is 93% (15/16). Comparator range is 84-95%, from annual survey.
- 64% of Solihull respondents, who receive adult social care services, say either they are able to spend their time as they want, doing things they value or enjoy. This is second lowest against comparator councils, with range of 58-74% and we want to improve this. From annual survey.
- Just over 76% of Solihull respondents say that they have either as much control over their daily life as they want, or adequate control. This is below comparator authority average (79%)
- Of those respondents who said that they had tried to find information and advice over the last year 75% said that they found it easy to do so. This is above the England average (73%) and in-line with that for the comparator authorities (range 65%-80%). From annual survey.
- Delays attributable to social care (ASCOF 2Cii) need improving. 15/16 outturn was 7.9 per 100,000.
- Historically low rates of admission to residential care (65+) mean limited scope for further reduction. 560.3 per 100,000 compared to comparator average of 625 (15/16).
- Proportion of adults with a learning disability in paid employment (ASCOF 1E) is low 2.58% compared to comparator performance of 7%. This is an area for improvement.
- There is a large self-funder market in Solihull, which means that the unit costs of independent sector provision are heavily influenced by this.

Solihull MBC expenditure on Adult Social Care:

Expenditure (£'000)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Council spend (excl. Education)	150,559	143,626	142,790	137,884	138,932	138,268
Adult Social Care	54,099	52,905	51,011	51,243	51,153	51,839
% of the Council's overall spend	**36%**	**37%**	**36%**	**37%**	**37%**	**37%**

Figures based on net expenditure

Current position:

Expenditure (£'000)	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Current Overspend Projection against above Adult Social Care Budget	**1,739**	**1,739**	**1,739**	**1,739**	**1,739**	
Savings at Risk (Red)		2,777	2,085	2,868	2,868	
Cumulative Forecast Deficit against above Adult Social Care Budget	**1,739**	**4,516**	**6,601**	**9,469**	**12,337**	**34,662**

The Adult Social Care budget in the first table above assumes that all budget pressures are dealt with and that all the Adult Social Care savings targets are delivered. The second table shows the current forecast deficit against the adult social care budget . In addition, savings rated as red indicate significant concerns about deliverability or significant delayed delivery. The table assumes that all savings rated as green or amber will be delivered in full (see details of savings on page 2).

Savings at risk for 2019/20 and 2020/21 represent the adult social care savings targets for those years, for which no plans have yet been made.

Planning work is continuing, to attempt to improve the current and future financial position, which if successful will reduce the gap. It is anticipated that the majority of the 2016/17 deficit will need to be covered from one-off adult social care reserves. All adult social care reserves will be exhausted by 31st March 2017.

The Council's budget plans assume that the maximum 2.0% adult social care council tax precept will be levied in all years and this funding has been accounted for in the above tables.

Pressures on Adult Social Care services:

There are a number of drivers which are placing increased pressure on our adult social care services. These include:

Demographics/Demand for Services/Rising Pressures in the Care Market:

- There are significant additional costs for inflation, demographics and the impact of the National Living Wage in 2016/17.
- £2.464m of additional funding has been made available to support these costs but despite this, an underlying budget pressure is currently forecast.
- There are additional costs relating to the increasing cost and complexity of care packages. Residential and Nursing spot contracted rates have typically risen by between 3% and 7% in 2016/17 to date, whilst the number of hours of care required for homecare clients has risen by 2.5% on average in this period.
- In addition there has been a significant increase in the number of younger adults with complex care requirements entering the system this year.

Deprivation of Liberty Safeguarding (DoLs):

- Following the Cheshire West Judgement, costs relating to DoLs have increased by £449,000 in 2016/17.

Reduction in funding streams:

- A number of one off funding streams (e.g. Care Act Burdens monies) that were available in previous years to offset pressures are no longer available in 2016/17.
- Solihull's Health & Wellbeing Board has agreed to a £1.1 million reduction to the amount of the Better Care Fund allocated to adult social care (in 2016/17 only) in order to assist with Solihull CCGs financial position. This has however added an equivalent pressure to the adult social care budget for this year.

All of the above contribute to the current underlying budget pressure of £ 1.739 million on Solihull's Adult Social Care budget.

17b. Stabilisation and Transformation of Social Care (Page 3/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council, and system partners

Closing the gap: Solihull

The Council's published three-year Medium Term Financial Strategy 2016-17 to 2018-19 sets out the specific actions that the Council intends to take to deliver savings in adult social care. The savings rated as green and amber are assumed to be deliverable and do not therefore form part of the funding gap on the previous page. The savings rated as red are included in the funding gap. As with Birmingham, the savings are crucially dependent on local system collaboration and a more integrated health and social care system.

Further Demand Management and Efficiencies:

The Council will attempt to make the following savings in adult social care. To the extent that any savings rated as red are delivered, these will help to close the funding gap.

Proposals (Savings) / New Pressures	2016/17 (£)	2017/18 (£)	2018/19 (£)
Supporting People	(135)	(100)	
Review contracts for VCS services			(125)
			(656)
Community Recovery Team	(57)		
Fairer Charging Review	(500)		7
Review of Spot Contracts			
Assistive Technology and Telecare	(84)		
Information and Advice Grants			
Redesign of Day Care	(344)	(69)	(600)
		(372)	
Development of Extra Care		(55)	(165)
Review of support where costs are high		(500)	
Review of Transport			
Small Homes Review		(375)	(147)
Review Internal Reablement Service	(268)		
Review of RAS model and support planning approach	(152)		
	(189)		
	(394)	(380)	
Integrated Care Partnership and Reablement			TBC
Connect Service, Promoting Independence and Demand Management			TBC
Alternative Savings to meet Reduction in ATT Targets			TBC
Release of ASC Directorate specific reserve (one-off)	50		
Release of Chelmsley Wood Primary Care Centre specific reserve (one-off)	15		
Contribution to ASC Reserves	(214)	159	55
Improved working with the NHS		(300)	
Better targeting of Promoting Independence Service		(153)	
Support Planning and Review Staffing		(100)	
		(330)	
Promoting Direct Payments and the Personal Assistant Market		(550)	
Further Development of Domiciliary Care Market		(300)	(250)
Review spot and block contracts for the provision of Mental Health care and support services.			(118)
			(132)
Make better use of CHC for people with continuing health care needs.			(300)
Corporate Savings - Proportion of cross-cutting staff savings	(250)		
Possible Reductions Identified	**(2,522)**	**(3,425)**	**(2,431)**

Summary of RAG Ratings

Red	(394)	(2,777)	(2,085)
Amber	(189)	(385)	(165)
Green	(1,939)	(263)	(181)
TOTAL	**(2,522)**	**(3,425)**	**(2,431)**

Better Care Fund (BCF) schemes: The Council and the CCG have allocated the BCF as follows, spread across council and health expenditure:

BCF Scheme	2016/17 Budget (£)	2015/16 (£)	Increase / (Decrease) (£)
Local Delivery Resource Plan	792,000	792,000	-
Carers Strategy	350,000	350,000	-
Joint Equipment Stores	1,126,000	1,126,000	-
s256 NHS Transfer	4,170,000	4,170,000	-
Disabled Facilities Grant	1,696,000	910,000	786,000
ASC Capital Grant	-	485,000	(485,000)
Care Act Implementation	537,000	537,000	-
Scheme 1: Integrated Care Team	2,996,000	2,996,000	-
Scheme 2 : Discharge to Assess	400,000	400,000	-
Scheme 3 : Falls Prevention	281,000	281,000	-
Scheme 4 : Support to Care Homes	334,000	334,000	-
Scheme 5 : Care Navigation/Information Advice	200,000	200,000	-
Scheme 6 : Ambulatory	670,000	670,000	-
Scheme 8 : Protecting Adult Social Care & Care Act *	763,000	1,763,000	(1,000,000)
Scheme 9 : Implementing Dementia Strategy	100,000	100,000	-
Contingency - For CCG Use against Cost Pressures	1,000,000		1,000,000
CCG Minimum Contribution Increase	278,000		278,000
TOTAL	**15,693,000**	**15,114,000**	**579,000**

* Note - This is a one year only reduction to Protecting Adult Social Care. From 2017/18 the figure will revert to £1.763m plus national uplift factors. Uplift factors will also be applied to other adult social care projects in 2017/18.

17b. Stabilisation and Transformation of Adult Social Care (Page 4/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Current Financial Position*:

The table opposite outlines current pressures. These are based on a forecast deficit position plus savings targets currently rated red (which means indicative of non-delivery or significantly delayed delivery.) The table does not include savings plans anticipated to deliver in full. A rise in inflation or increase in National Living Wage above the current forecast will reduce the budget available for demographic growth and therefore create additional pressure. Modelling assumes Council Tax 2.0% precept and 1.99% council tax annual uplifts. Planning work is continuing, to improve current and future financial position which if successful will reduce the gap. It is anticipated majority of 16/17 deficit will be covered from one-off council funds.

**Status as of 7 October, 2016*

	2016/17	2017/18	2018/19	2019/20	2020/21	Total
	£m	£m	£m	£m	£m	£m
Current Deficit	1.739	1.739	1.739	1.739	1.739	
Savings at Risk (Red)		2.777	2.085	2.868	2.868	
Cumulative Forecast Deficit	1.739	4.516	6.601	9.469	12.337	34.662

Critical Decisions to support next steps:

- Response to national policy direction for social care
- Agreement by all parties for strategic objectives, model(s) of delivery, and investment approach (where investment needed to facilitate whole system improvements)
- Agreement in regard to risk and gain share arrangements across the BSol footprint, and Solihull place based area.
- Manage the significant risks / pressures around meeting statutory responsibilities of Deprivation of Liberty Safeguards (DOLS) in care settings and around Community DOLS, whilst being responsive to developments to be set out by Law Commission in 2017.

Investment requirements:

- It is anticipated that investment is essential to maintain current social care services, and build on these to deliver improvements to people's wellbeing and independence such that demand on health care services is reduced. This will be determined following the finance and activity modelling and discussions regarding risk and gain share arrangements across the footprint. Also, through an update of the adult social care, joint strategic commissioning intentions for the period and associated analysis of the provider market resilience and response.

Impact on capacity:

Impact on workforce by 2020/21:

- Capacity in care sector (in-house and independent) will be a long term challenge. Recruitment challenges will be partly improved by introducing more appealing roles (e.g. Local Area Co-ordinators) and increased use of technology to replace need for some staff capacity. Workforce strategy key.

Impact on acute hospital bed base by 2020/21:

- The required impact is defined in the health plans

Stakeholder engagement and consultation:

- There is strong recognition that engagement with stakeholders throughout, is vital. Especially families and carers who receive support and importantly, engagement and direct involvement of council leader, relevant portfolio holders and wider members.
- Engagement will be through a variety of forums and includes relevant public sector organisations (UHB/HEFT, CCGs, NHSE, CQC, Primary Care, Healthwatch, independent social care sector, third / voluntary sector and faith based and other community based organisations), to drive changes together.

Risk	RAG	Mitigation
Lack of available finance at the appropriate time, to maintain current service levels and to build further capacity to support health in diverting to lower cost solutions.		Engage with health partners to determine and agree the investment model that will protect social care and benefit health organisations and service users. Push for change to national funding model.
Lack of cross organisational commitment and stakeholder buy-in to drive change and culture.		Work in partnership to identify a clear, evidence-based, appealing model for future delivery and continue engagement and involvement throughout ongoing development and delivery.
Workforce recruitment and engagement is insufficient to mobilise at pace		Increase workforce engagement, including with Unions
Independent social care market stability continues to deteriorate, so capacity and responsiveness reduces		As part of transformation plans, identify alternative models for long term support, for example, extra-care housing, assistive technology, LA direct development of care homes.
Risk of local authorities having to take in-year spend reduction measures with significant unintended consequences for the wider health-care system		Remain sighted on national directions and plan jointly in advance of action as far as possible, with local NHS partners, within the agreed STP governance

18. Commissioning Reform

SRO: Nick Page with CCG AOs

Relevant leads: Stephen Munday, Angela Probert, Rhod Mitchell, and Alison Tonge

Organisations involved: Solihull Metropolitan Borough Council, Birmingham City Council, Birmingham Cross City CCG, Birmingham South and Central CCG Solihull CCG, NHSE

Strategic objective:

Whole system and place based approach to commissioning – greater integration and alignment of CCG, NHSE (including specialised services) and LA commissioning, strategy development; focussed on cross-sector priorities and outcome framework.

Aims:

- Improved health and social care outcomes
- Improved quality of care
- Efficient use of resources
- Commissioning demonstrates added value

Outcomes:

The Commissioning Reform Group have identified a number of high level goals including:

- Effective system management underpinned by comprehensive information system
- More effective and efficient commissioning processes – fewer gaps and less duplication
- Greater focus on outcomes based commissioning
- Better value through improved efficiency and reduced costs of commissioning function
- Simpler and more effective governance of commissioning and decision making
- Stronger service transformation approaches, decommissioning and re-commissioning
- Aligned budgets (as a minimum) and agreed risk share arrangements

Context:

There is a need for the BSol footprint to deliver greater service integration and integrated commissioning across the health and social care system. Over recent years, the policy environment has altered the relationships and roles between health and social care commissioners and providers. Across England, commissioning reform is taking place in response to challenges faced by local health and care systems.

The decision of the 3 CCGs to establish a single commissioning voice and the BCC decision to establish a children's commissioning function in response to the development of an arms length Children's Trust provides further impetus to the commissioning reform work.

This work is an expansion of numerous existing joint commissioning arrangements e.g. cohort-focussed programmes between councils and CCGs and integrated commissioning units.

Impact on capacity:

- *Impact on workforce by 2020/21*:
- Consolidation of management structure and back office staff.
- *Impact on bed base by 2020/21* (if applicable): not applicable.

Key milestones: (to be confirmed)

In 6 months we will:

- Assess benefits and scope of greater integration and agree project scope – Sept 16
- Establish Project Delivery Arrangements – Sept 16
- Map and assess existing commissioning arrangements and support functions, incorporating outcome of phase 1 – Oct 16
- Structured conversations and activity with Commissioners to develop thinking – Nov 16
- Workshop to define approach and phasing – Nov 16
- Develop how the function will be delivered with regard to leadership, structure and support – Nov 16
- Develop proposals for new function and structures – Jan 17
- Scope milestones for Phase 2 (delivery of commissioning function)

Key risks:

Risk	RAG	Mitigation
There are insufficient system wide incentives to foster agreement between organisations about the organisational form required		Robust options appraisal based upon recent local data, case studies and strong stakeholder engagement
Lack of stakeholder engagement delays programme as agreements are not reached		Collaborative design of the commissioning function based upon the agreed vision and strategic objectives of the BSol STP. Robust engagement plan.

Stakeholder engagement and consultation:

- SMBC and BCC leadership teams and Cabinets, Directors of Children's Services, Health and Wellbeing Boards, CCG and LA Commissioning teams, CCG senior management and Boards, NHSE, NHSE Specialist Services Commissioning Teams, NHS Improvement, LA Leaders/CP Holders BCC and SMBC, General Practice, Primary Care, Public Health England, NHS Provider Trusts, Schools, Police and Crime Commissioner.
- Detailed engagement plan timetable to be developed. Ambition is to meet with a wide group of stakeholder to understand possible future models.

Critical Decisions to support next steps:

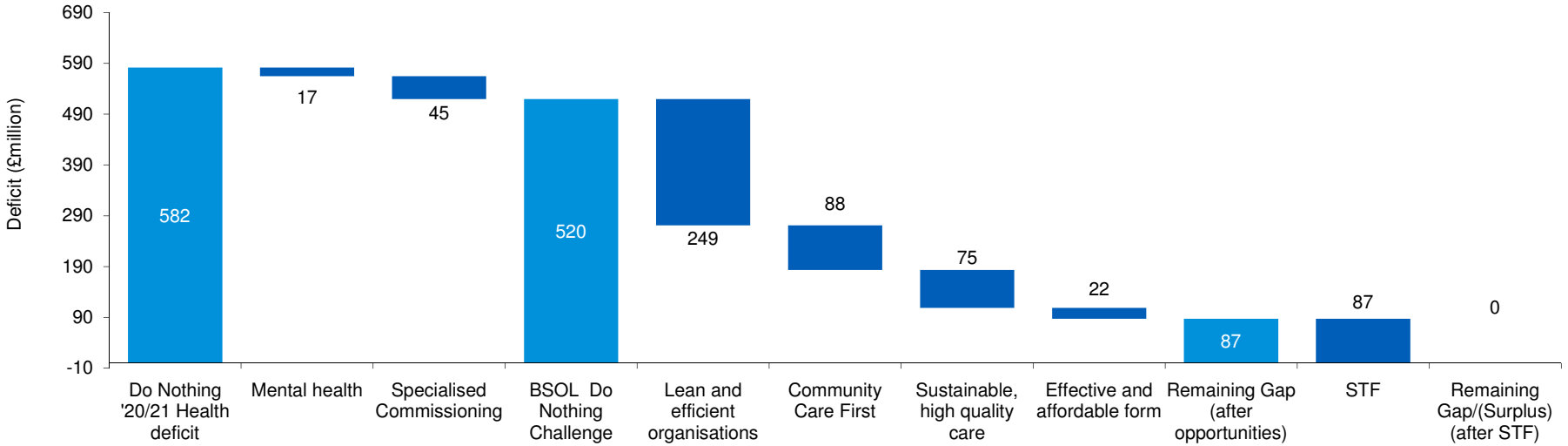
- Identifying those areas where there were realisable benefits in joining commissioning budgets
- Agreement upon preferred enabling system governance model that will deliver an integrated health and care commissioning function
- Agreement upon principles around risk and reward to ensure focus on system wide benefit

Solutions and impact

	Assumptions and target	Net impact of scheme	Solution Type
1	Mental Health: • Savings to be achieved through Mental health Five Year Forward View initiatives in access to IATp, crisis response home treatment teams and SMI physical health which will reduce health expenditure but not necessarily direct Mental Health expenditure.	£17m	Mental Health
2	Specialised Commissioning: • QIPP Programme	£45m	Specialised Commissioning
3	Improving Productivity: • Reduce inefficiencies in support services and back office function (this includes HEFT Recovery Plan) • Reduce variation in clinical service delivery and performance outcomes • Reduce incidents of unplanned care	£249m	Lean and efficient organisations
4	Buy Better: • Improve market management and take a whole systems approach to commissioning to mitigate against anticipated increases such as CHC and prescription cost growth	£35m	New Models of Care/Commissioning
5	Right Care: • Identify areas for improvement from the nationally available spend and outcome indicators • Savings will be produced from reducing unwanted variation and ensuring all commissioning arrangements represent value for money	£18m	New Models of Care/Commissioning
6	Community care: • Develop new models of care for: • High cost patients • End of life care • Long term conditions • Improve use of the 3rd sector to keep people well in the community	£35m	New Models of Care/Commissioning
7	Better Management of Demand: • Reduce demand for acute services through development of proactive out of hospital community based care • Embedding the prevention agenda	£30m	Sustainable, high quality care
8	Fit for Future Primary and Secondary Services: • Reduction in variation in clinical service • Improvements in clinical outcomes, especially when combined with definition of new clinical pathways	£30m	Sustainable, high quality care
9	Better management of bed capacity: • Identify opportunities to better match demand with supply through improved integration of acute, community and social care • This should enable the better management of bed capacity	£15m	Sustainable, high quality care
10	Rationalisation of estate: • Analysis of the utilisation of commissioner and provider estate has identified some estate that is currently unoccupied • Collaboration across the footprint to progress the development of a shard approach to estate utilisation	£13m	Effective and affordable form
11	Organisational Consolidation: • Additional saving beyond 2% productivity saving delivered by merger of BCH and BWH and potentially UHB and HEFT, if the case for change is supported by both Boards	£3m	Effective and affordable form
12	Commissioning reform: • Saving from the consolidation of the 3 CCGs into 1 CCG • Establish an effective commissioning function across the STP that will maximise efficiencies and drive the system wide transformation programmes	£6m	Effective and affordable care

The solutions and potential opportunities

The Solutions & Additional Opportunity Areas



The ‘Do Nothing’ 2020/21 deficit of £582m is reduced by identified Mental Health and Specialised Commissioning savings of £17m and £45m respectively. The remaining BSOL ‘Do Nothing’ challenge amounts to £520m.

The amount attributed to ‘lean and efficient organisations’ is £249m, with £88m attributed to ‘Community Care First’. Together with £75m attributed the impact of ‘sustainable high quality secondary and tertiary care’ and £22m attributed to ‘effective and affordable form’, this leaves a remaining gap of £87m. This remaining gap is closed by £87m of STF funding.

Delivering the plan

Solihull Metropolitan Borough Council

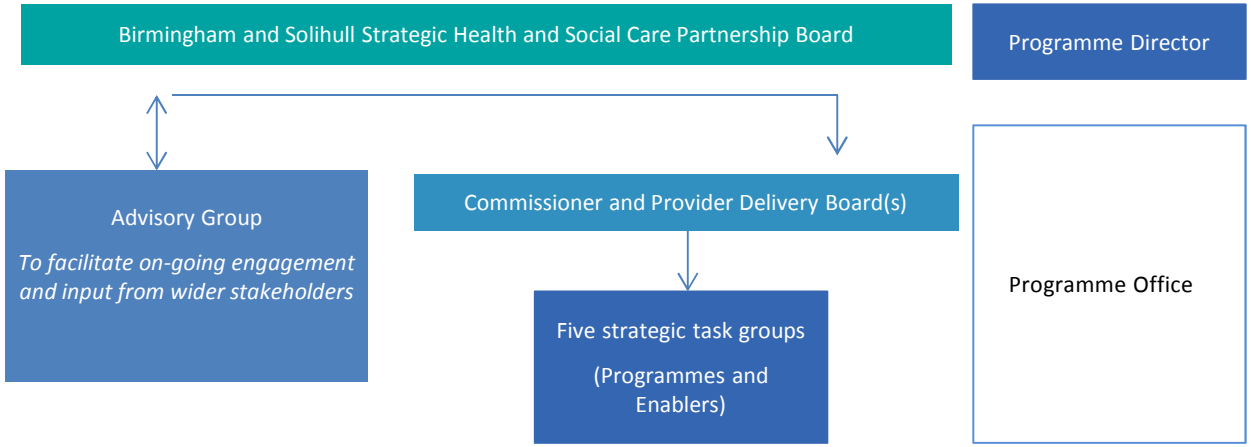
Birmingham City Council

NHS

A new governance approach and strong programme office to drive delivery of the Sustainability and Transformation Plan

EQUIPPING THE SYSTEM TO LEAD THE CHANGE REQUIRED CONFIDENTLY, AT PACE AND ACCOUNTABLE TO PARTNERS AND PUBLIC	Delivering the ambitions set out in our STP requires over twenty major change projects over four to five years involving the combined talents of dozens of organisations and thousands of public servants and private suppliers. Maintaining focus, coherence and pace demands strong leadership, clear accountability, agreed methodologies for change and improvements and transparent reporting. A new trusting culture of partnership and reciprocation will be essential, and new governance approaches and structures will be required to create and embed this new culture. The interdependencies across the system and across the service change projects set out in the STP are complex. A strong programme office capable of linking strategy, investment, delivery and change agenda will enable individual organisations, new joint bodies and the system as a whole to deliver better outcomes through improved services and better use of resources. In developing our governance and programme management infrastructure for our delivery phase we are building on the foundations that we have put in place as a health economy in preparing this submission. There has been valuable learning from this process, what works and what needs to change both in terms of the governance infrastructure and the programme management approach that bests fits the BSol health and social care system. These structures are supported by a strong programme office led by a highly credible and experienced Director. We are currently finalising our work on the governance structure (including such issues as subsidiarity of decision making) – this is being led by Jacqui Smith – Chair of University Hospitals Birmingham NHS Foundation Trust / Heart of England NHS Foundation Trust. A draft of the structure is included on the following page. This is complemented by a parallel piece of work on developing a sustainable programme and project management structure that provides consistency and clarity across the programme, is embedded within the health and social care community, develops a jointly owned financial and activity model and is affordable.

A Proposed new governance structure across BSol



PROPOSED MEMBERSHIP

Birmingham and Solihull Strategic Health and Social Care Partnership	Executive and non-executive health and local authority commissioner and provider representation to enable decision making
Commissioner and Provider Delivery Board(s)	Identified representatives of 3 CCGs, 2 LA, NHS England, Acute, Community, Mental Health, Ambulance, Primary Care, Social Care, Public Health
Strategic Task Groups	Identified SROs for each of the identified themes – will chair inter-discplinary teams that provide high support / high challenge to individual project work-streams
20 individual programmes and enablers	Programme area SROs with project teams built from across the health and social care economy. Utilising consistent project management methodology and reporting.
Programme Office	Led by system wide Programme Director with appropriate support to ensure appropriate support and consistency across the major programmes and change projects

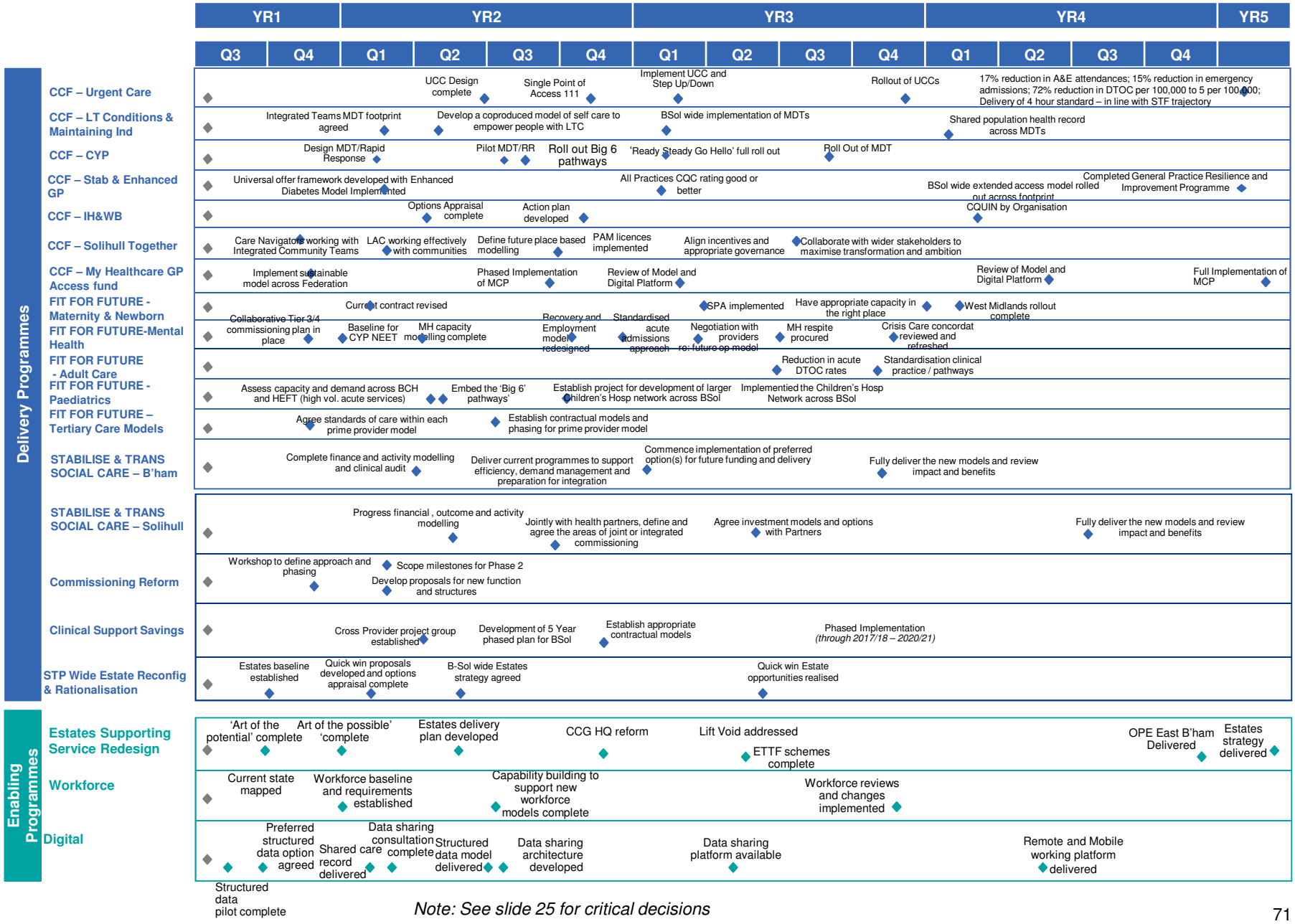
Guiding Principles and Accountabilities

- All decisions made will be in the best interests of our citizens and patients, the impact of the health of the population and the sustainability of the system
- All decisions will support our strategic objectives: efficient and lean organisations across the footprint, transformed primary, social and community care; sustainable high quality acute, secondary and tertiary services; and an effective and affordable system.
- The Strategic Health and Social Care Partnership Board will have joint accountability for delivering the STP plan
- All organisations retain sovereignty over decisions - decisions within the STP programme need ratification within each organisations governance arrangements.
- Matters that are soley the concern of a subsidiary party will not be the business of the STP.
- Small Strategic Task Groups will co-ordinate the implementation and interdependencies of the change projects embedded within their theme.
- The Programme Director and Programme Office will be accountable to the BSol Health and Social Care Partnership Board..

The principles behind our programme management approach

WHAT?	WHO?	OUTCOME
A comprehensive activity and financial model, owned by all, embedded in our planning process that links to individual organisational requirements.	SRO – efficient and lean providers	Ability to plan scenario's and support and identify the system wide impact of change projects.
A fully owned methodology for tracking progress across the five key themes and 20 plus change management projects.	Programme Director - PMO	Consistency in reporting, early identification of issues and key dependencies.
A consistent and transparent risk management and assurance framework for each level of the governance infrastructure.	Programme Director - PMO	Ownership and clarity of risks, mitigations and those areas where the risk is accepted.
A clear business model for the PMO – including funding agreement across all the organisations, development of clear reporting standards and KPIs for the function.	Chief Executive(s).	A resilient, strong and responsive PMO function for the BSol STP.
A secretariat function to ensure best practice in terms of compilation and delivery of Board paper, minute taking etc.	Programme Director	Support good decision making through timely supply of information, comprehensive minutes and action logs.
Identify our management capacity, capability and approaches to support the change management projects within the BSol programme	Programme Director	Develop our change management capacity across the BSol health and social care system.
An agreed communication and public engagement strategy and methodology and structure to support the BSol programme.	Programme Director	Clarity and consistency of message for specific stakeholder groups (staff, citizens etc.)

High level milestone plan



Note: See slide 25 for critical decisions

Engagement and communications strategy

The STP presents a real opportunity for health and social care across Birmingham and Solihull to work together differently for the benefit of our people. By choosing to operate as a system and to take a system wide view rather than an organisational view, we will be able to put our people at the heart of what we do, plan better for the long term and ensure that any decisions that are taken are made with the agreement of all partners and the engagement of our local communities. We are committed to engaging with our stakeholders at every stage of the development process of the development and implementation of the STP

Stakeholder mapping completed

Development of overarching key messages

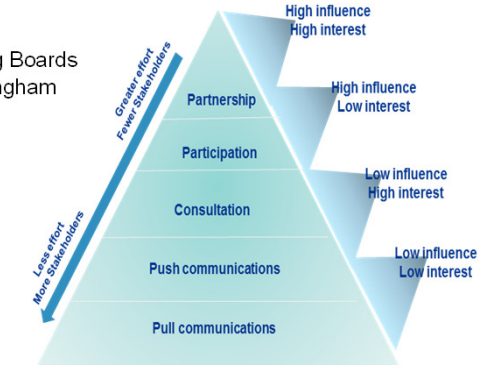
Development of the STP engagement and communications strategy

Our over-arching key messages are:

- We need to talk about our plans for better health and social care in Birmingham and Solihull, and demonstrate why we need to make a whole-scale change
- The STP is a planning tool for helping organisations to work together to make this change – it is not a separate service or organisation
- We need to work together to make sure we can continue to offer the health and social care services that you need.
- We will work with local people to help them prevent becoming ill and support them to live longer and better lives
- We are committed to working with our partners across the NHS, social care, wider public sector and voluntary sector to improve the health and wellbeing of local people.
- We continually work to improve the quality of healthcare services
- We always encourage feedback from local people and will act on it wherever possible
- We make our best efforts to use the funding and resources we have wisely, ensuring value for money

Planned activities:

- Briefings for staff and politicians
- CCGs have been regularly communicating with staff regarding a single commissioning voice for Birmingham and Solihull;
- Using social media to start conversations, including survey monkey questionnaire to baseline activities
- Create single webpage/area for hosting information
- Twitter # campaign
- Targeted Facebook activity
- Video/animation content
- Consider best use of traditional media channels e.g. organisational newsletters, different media etc.
- Ensure opportunities to take part in reference groups are shared widely
- Clinical champions
- Ensure regular, ongoing communications are provided through pre-existing communication channels
- Build relationships with local and trade media to build a positive narrative
- Secure a media partner – STP feature to engage with local people
- Respond reactively, in a timely way
- Continue to implement media protocol
- Stakeholder reference group (including wider partners - e.g. Social Housing and Fire Service)
- Creation of stakeholder bulletin
- Meetings for Birmingham and Solihull local councillors
- Specific briefings
- Attend meetings on request
- Regular engagement and updates at Health and Wellbeing Boards
- Regular meetings with GP alliance members across Birmingham and Solihull
- Communications and engagement toolkit:
  - Agreed narrative and key messages
  - Standard power-point presentation
  - Template press release/response
  - Copy for websites
  - Standard and agreed FAQs
  - Opportunities log created and maintained
  - Engagement template created and completed
  - Audit of existing communications and engagement channels
  - Case studies
- Engagement with HealthWatch
- Consultation with stakeholders and patient groups within individual workstreams



- **Stakeholder reference group meetings 27th and 29th September and 14th October**

Key risks - Individual programmes have identified their own risks, however the table below outlines key risks at BSol level:

Key Risks	Mitigating Actions
The health and care system is destabilised if BCC need to reduce social care services in response to financial pressures	Development of plan on a page and further discussion with NHS organisations and central government. **This risk cannot be fully mitigated within the system.**
Planned savings are not delivered	Programme management arrangements and internal governance processes
The planned level of transformation is insufficient to deliver the scale of results required to close the gaps	The organisations will challenge themselves to set ambitious but achievable trajectories and targets. These will be closely monitored through appropriate governance arrangements.
Plans may not be supported by local communities which could impact the timeline and the scale of transformation	The STP programme board will work with local government and local MPs to engage residents in BSol STP strategic conversations. Each work stream will be required to actively engage patients and public in co-production early on in the process. This will be supported by an effective BSol wide communications strategy and public champions.
Insufficient workforce capacity and/or capability to deliver whilst transforming to the new models of care	Development of an overarching workforce strategy based upon future requirements of STP programmes and operational models. Work with HEE and the LWAB to ensure proposals encompass best practice and proposals have been agreed with all relevant stakeholders.
Individual organisations unable to drive the change required due to localised priorities and constraints	The organisations will agree and work towards a clear vision with strategic objectives and targets are owned by all representative organisations. The organisations will establish principles around risk and reward that enable system-wide transformation.
Organisational cultures and directions not aligned with BSol wide goals	Effective system leadership to ensure full organisational involvement supported by an effective engagement strategy that captures innovative practice from staff and develop buy-in for collective transformational change. Staff OD programmes are developed as required.
Lack of resource, time, or leadership capability to deliver the required change at pace	Leadership development initiatives for aspiring directors or senior clinicians e.g. coaching, mentoring schemes. Establish an effective PMO to drive programme delivery, manage risk and monitor progress.
Resistance and lack of buy-in from staff to develop and implement the transformation, particularly service reconfigurations	Each STP sub-programme will actively engage staff in co-production early on in the transformational process Effective communications strategy and the development of staff champions in order to ensure there is a consistent message
Lack of agreement at BSol level for changes across the footprint	Effective leadership and engagement via STP programme board coupled with full organisational engagement in system redesign process. Any proposed changes will be the product of a robust options appraisal, cost benefit analysis and aligned to national and local priorities for the STP.
Inequalities will become greater as plans are implemented without detailed analysis and tracking outcomes in real time	Robust monitoring processes with a commitment to take mitigating action if current planned activities are not seen to be working.
If we fail to deliver desired outcomes demand will rise and it will be very difficult to manage	Robust monitoring processes with a commitment to take mitigating action if current planned activities are not seen to be working.
The scale, complexity and pace is so significant that it is not possible to deliver everything required at the same time	Robust STP Programme-wide planning, alignment of milestones linked to areas of identified greatest opportunity. Detailed PMO processes in place with monitoring of risks, issues and dependencies.

Immediate next steps - to end of March 2017

DATA

- Agree approach to develop a more granular demand, capacity and cost model to generate a more detailed picture to support further planning over next 8 weeks
- Develop and refine analysis on all STP programmes to enable an options appraisal on preferred models
- Establish evaluation criteria
- Support prioritisation by identifying what will make a difference

Delivery and Programme management

- Strengthen central PMO for the STP programme including additional capacity to support the future governance arrangements and further develop the STP, the delivery plan and implementation at a BSol level
- Identify and communicate working groups for STP programme and enabling workstreams
- Further develop the various STP priority initiatives into detailed project delivery plans to support programme solutions and operational planning requirements
- Develop a collective programme plan to monitor progress of key milestones
- Include 90 Day Plan for immediate delivery

Finance

- Agree the social care financial gap and the impact on the delivery of social care services, and knock on impact on other organisation
- Identify opportunities to address remaining financial gap across health and social care
- Agree finance support for the further development of plans
- Develop business cases on priority STP programmes including return on investment

Engagement

- Further develop communications strategy for the STP and commence programme of activities to support wider engagement
- Obtain feedback on proposed solutions across STP programmes
- Agree key messages for STP programmes to support wider engagement including workforce, public, and political stakeholders

Governance

- BSol leaders and other key stakeholders to develop and formalise governance arrangements
- Define governance roles, responsibilities and terms of reference
- Agree and communicate governance arrangements
- Roll out of future governance arrangements

Appendices

A. Key enablers – Estates
B. Key enablers – Digital
C. Key enablers – Workforce
D. How do our solutions address the 10 key STP questions?

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Appendix A: STP Enabler - Estates (Supporting Service Redesign)

SRO: Paul Sheriff

Relevant leads: Guy Carson (Programme Manager), John Guggenheim (Finance), Graham Seager (Acute), Mike Lyden (Primary Care) and Phil Andrews (Local Authority)

Context:

- Birmingham and Solihull is an ever expanding conurbation, with over 1.8m citizens across 446km^2. Across the BSol footprint, there are currently circa 650 properties, 1,000+ property interests, 460 care homes and 271 housing developments. There is variation between geographic areas on quality, and the use and volume of estate from which health and care services are delivered.
- Our STP provides the opportunity to re-evaluate the use of estate across the footprint – to support the delivery of high quality care and services from modern, fit-for-purpose buildings, situated in the right places to serve our local populations. This will include implementing changes to the estate that will provide flexibility and support new models of care and ways of working (including 7 day services) across primary, community, acute, and social care settings, enable more advanced use of technology to reduce reliance on physical estate, and improve the working environment to support staff health and wellbeing.
- Poor quality and sub-optimal estate will be addressed through a planned programme of rationalisation and investment; under-utilised buildings (e.g. our LIFT buildings) which provide a high quality environment will be reviewed to enhance multi-disciplinary and integrated services across primary and community care, and further opportunities to maximise the use of our estate and its efficiency across local government and health will be pursued through the One Public Estate initiative and the West Midlands Combined Authority.

Vision/Aims:

- The vision is to have an efficient, high quality estate across the BSol footprint which supports our ambition of delivering high quality services to our local populations.
- Our aims, through exploring opportunities such as One Public Estate and joint organisational working are to:
  - Reduce the known areas of estate void and dispose of unused, surplus land
  - Address the poor condition of our primary care estate in order to provide fit-for-purpose buildings to deliver care and services
  - Increase the estate utilisation and plan its use of a BSol-wide basis, including maximising the use of our LIFT buildings
  - Integrate health and social care to align the transformation of health with the ambitions for public sector reform
  - Optimising the benefits from other initiatives e.g. East Birmingham regeneration

Workstream Summary and Key Milestones: The proposed plan is:

- **Phase 1 (end Sept 16)** – System review "art of the potential" – consolidate existing data sets and analyse the scale of the deficiencies in information. This will identify the more simple solutions to be implemented asap. This will be substantially based on assumptions to underpin missing datasets. Tasks include gathering all existing data, identify gaps and deficiencies, categorising facilities, and developing initial benefits plans and next stage management plans
- **Phase 2 (Oct 16 – Mar 17)** – Programme consolidation "art of the possible" – working with the programme's 4 clinical programmes, the Estates workstream will identify the demand profile for the estate based on the planned activity levels of the clinical workstreams and calculate which properties fit within the following categories: Core, Near Core, Marginal, Redundant. Tasks include: alignment of estates thinking into clinical workstreams, identification of shortfalls in capacity and demand, and calculating gap costs
- **Phase 3 (Mar 17 – Aug 17)** – Detailed preparation "phased delivery and finance plan" – following incorporation of the suggested draft health economy strategy into each organisation's individual strategies, this stage will focus on the works required to: build system capacity, transition, and realise programme benefits. This will include development of the associated suite of documents
- **Phase 4 (Apr 17 – Mar 21)** – Implementation phase will consist of 3 work packages: Building system capacity, Transitioning, and Decommissioning and benefit realisation. Tasks include on the ground delivery of estates change. The baseline for benefits will need to be understood and fed into the clinical model so that there is alignment between these areas.

N.B. The work will need to continue in this workstream for a 10-15 year implementation cycle as following 2021 there will be a series of large redevelopments and all estate planning will need to be cognisant of these planned changes.

Key Assumptions:

- A Local Estates Forum will be repurposed to drive the Estates strategy, with a unified and system-wide view
- All organisations within the BSol footprint buy-in to the estates strategy and fully support delivery to achieve maximum benefits as quickly as possible. System-wide benefits (from estate and service) will outweigh individual organisational gains
- Any residual risks through changes to the estates portfolio will be shared across the organisations within the BSol footprint
- BSol has an over supply of buildings which are not maximised in terms of utilisation. Existing high quality long term estate will be maximised and poor quality estate will be vacated and disposed of.
- Benefits will be incremental and are likely to accelerate in later years of the programme

Key Challenges:

- Ensuring the estate supports care closer to home so that patients do not have excessive travel
- Shifting services based on estate location and the subsequent impacts on staffing
- All organisations signing up to system estates change irrespective of financial impacts and changes to foot fall
- Ensuring that any changes support legislation, regulation and policy
- Timescales to achieve the changes
- Ensuring links to other enabling workstreams support the STP delivery
- Ensuring political buy in to potentially radical solutions

Key Interdependencies:

Other Enablers

- Digital as there are technology requirements i.e. wireless access, new IT systems in support of the new estates form
- Contracting as there will be impacts on contract and commissioning requirements if new estate is needed or decommissioned
- Workforce as there will be impacts on place of work if teams move/merge
- National frameworks/guidance such as Carter, DH and Property service STP requirements, forward view and the outcomes from Vanguard sites

System

- Wider capital and revenue areas such as relevant public estate, enterprise partnerships and the potential value of these. Organisations subscribing to data/information sharing agreements and future team/resource form across the footprint i.e. duplication in resource.
- Other system projects and programmes. These need to be understood so that any potential risks and conflicts can be mitigated.

Resource Requirements:

Exact resources requirements are to be confirmed. However:

- Clarification is required on capital resources to support delivery (e.g. ETTF or other funding), and
- Phases 2-4 will also require strategic estates support to plan and deliver this work

Appendix B: STP Enabler - Digital

SRO: Paul Sherriff | **Relevant leads:** Ciaron Hoye (Digital Lead), TBC (Finance Lead) and Dr Masood Nazir (Clinical Lead)

Context:

- Digital has the ability to radically transform the way in which health and care is delivered across the BSol footprint, and the way in which citizens and patients interact with care and public health services. Despite a complex and diverse citizen landscape, the local population has become increasingly tech-enabled with over 75% of citizens having access to mobiles and internet.
- This paves the way for technology to support new care models and ways of working, enable dynamic and innovative solutions to transform and improve health, quality, and outcomes, and make access to services more convenient for both health and care professionals and citizens and patients
- Our Local Digital Roadmap sets out 3 priority areas for the BSol footprint focusing on: 1. digital maturity across the economy, 2. paper free and information flow between the economy organisations, and 3. inclusion of patients, carers and citizens in the use of digital technology
- We are already transforming the way in which services are delivered across the footprint through integrating a myriad of disparate systems to enable effective information flow which follows the patient across organisational boundaries, and through innovative use of technologies for example, our Solihull Caradigm project. "Your Care Connected", "My Healthcare", and Electronic Document Transfer are other examples of ongoing initiatives that are providing the foundation for service transformation.

Vision/Aims:

Our Local Delivery Roadmap sets out our vision for care within the economy: care unobstructed by organisational boundaries and which delivers the concepts of personalised health and care by 2020 and the Five Year Forward View. Specifically, we aim to:

- Establish a combined care record which follows patients across sectors and care settings through the interoperability of existing patient administration systems to support more efficient diagnoses, discharges, transfers of care and referrals between organisations
- Underpin the patient journey through a multi-agency single care plan, defined by population outcomes (to support reduced variation in care and improve patient experience) that can be accessed by health and care professionals from any location, and will also help to support risk stratification
- Being able to deliver technology-enhanced health innovations through the use of digital healthcare, to support:
  - Patients and citizens to access information through e.g. websites, digital apps, and to access and interact with their own care digitally, and support self-management and prevention
  - remote and mobile working for staff, and use of virtual clinics

Workstream Summary and Key Milestones:

- Shared care record – this is a live initiative with 500,000 patients and 4 acute hospitals already signed up to/able to access shared care records. Further milestones include:
  - Deployment of shared care records to remaining acute providers (subject to funding) – 6 months
  - Shared care records rolled out across the full 1.8 million local population – 9 months
- Structured data transfer
  - Pilot (commencing in Oct-16) concluded to provide an evidence base for economy-wide adoption – 1 month
  - Options appraisal, final business case, and Board approval of preferred option – 2 months
  - Preferred model implemented (subject to funding) – 12 months
- Data sharing platform
  - Clinical and public consultation on data sharing completed and outcome published – 9 months
  - Data sharing architecture developed – 12 months
  - Platform tested, implemented, and delivered (subject to funding) – 24 months
- Remote and Mobile Working
  - City wifi delivered (subject to funding) – 24 months
  - Digital signs installed – 24 months
  - Impact of digital signage measured – 30 months

Key Assumptions:

- Engagement and agreement of all organisations to the local digital roadmap and transformation
- A local footprint committee will be established to ensure all proposals for digital systems are appropriate and in line with the vision
- There will be appropriate revisions to care plans and documentation
- Funding will be available to implement and deliver the digital vision and transformation
- Shared agreements and governance arrangements can be agreed and put in place to enable roll out

Key Challenges:

- STP programmes are currently planning in silos and therefore there is a limited understanding of holistic requirements
- Clarity of requirements is also required from the STP programmes
- A whole system funding shortfall requires invest-to-save models or system efficiencies in order to progress, and clarity is required re timescales to access new digital monies. This is a potential source of delay for economy-wide initiatives.
- Consistency of messaging to citizens regarding sharing of their data, e.g. SCR, Care.Data, and Local Health Records results in citizens and patients not understanding and opting out of all schemes
- Ability to integrate over 700 disparate systems within four years whilst preserving the specific needs and requirements of individual organisations
- Discrepancies in legal mandates and requirements between partners, will require time to identify and resolve

Key Interdependencies:

- Dependency on funding – to enable the new functionality and provide an appropriate base for other activities such as use of wearable technology or interactive care plans
- Training for workforce to ensure they know how to use and access new systems and devices
- Installation of devices and connection for all estates is set up for staff to support the development of the integrated referral and information system.
- Information sharing agreements between partners to move to a universal integrated PAS on a shared platform

Resource Requirements:

- There will be a need for additional digital resources to drive forward the digital strategy
- In addition, procurement resource, technical and telephony expertise, operational expertise, digital accessibility expertise and general project support will be required to achieve the aims of this initiative
- Patient engagement support will also be required to ensure they understand and have the ability to consent or refuse to their data being shared across providers and care settings

Appendix C STP Enabler - Workforce

SRO: Tracy Taylor | **Relevant leads:** Stuart Baird

Context:

- Birmingham and Solihull is a diverse conurbation with areas of high affluence and deprivation. The footprint has a changing demography with a young population (46% are under 30) and a growing transient and migratory population.
- Our key workforce characteristics include: an ageing workforce approaching retirement particularly within primary care; supply shortages within some health and social care professional groups; introduction of new roles e.g. physician associates; changes to policy and adoption of best practice e.g. the GP and Mental Health forward views; and changes to training and education funding, all of which contribute to the need to have a collaborative approach to workforce planning and development
- There are also contributory factors such as national staff shortages and rules regarding use of agency staff and spend, and locally the ability to retain staff, high sickness levels, low numbers of healthcare professionals per 1,000 population within BSol, and challenges with specific roles such as social workers which further obviates the need for a refreshed and collaborative approach to workforce.

Vision/Aims:

- Our vision is for a healthy, competent and sustainable integrated workforce that delivers services which meet the needs of patients, service users and carers across BSol, both now and in the future
- Through the LWAB as the main driver for workforce solutions, our aims for this workstream are to:
  - Create and agree annualised programmes of work which support national and local strategy, and translate these into local plans
  - Grow a local workforce thus creating real opportunities for local residents, given the Health and Wellbeing gap
  - Develop new ways of working as a joint system and drive new workforce models such as enhanced mobile working
  - Develop career pathways and an attractive employment offer which will lead to the retention of staff
  - Increase the use of technology and integrated roles within health and social care
  - Ensure funding is placed in the most appropriate sectors through collaborative working with HEIs and other training providers

Workstream Summary and Key Milestones:

The LWAB is developing and delivering the annual work programmes. The proposed focus areas for Year 1 of our journey are:

1. Reskilling and upskilling the primary and community care workforce to support the delivery of integrated out of hospital care models
2. New role developments including enhanced roles such as community pharmacy
3. Development of an apprenticeship academy model to deliver integrated health and social care apprenticeship programmes across BSol

As the programmes are taking shape, the main milestones will be:

- Short Term actions (within 6 months): Assigning a lead to each programme area; (clinical and managerial leads would be required.) Establish multi-partner workshops to agree approach to delivery and confirm areas to focus on and more detailed areas within these i.e. to develop and launch engagement; establish system workforce information sharing agreements to gather as a footprint numbers of staff by band, age, sickness, vacancy rates; undertake gap analysis, skills assessment on data to identify specific process areas to elevate and tackle; develop year 1 PIDS; identify year 2 and 3 focus areas.
- Medium Term actions (within 12 months): Focus on capability building and clinically agree what enhanced roles would look like; test and trial changes to specific role(s); engagement with schools and university on new courses to support new workforce models, wider integration of teams and roles supporting placed based care, development of MDTs.
- Long Term actions (within 18 months): ongoing workforce reviews and new configurations
- Underpinning the above will be the following assumptions: existing projects and programmes will continue unless they are in direct competition to the STP plans; all proposed change supports wider STP outcomes such as reduced costs
- There are some early measures being identified including: reduction in agency spend and numbers; more people going into health and social care courses and roles, and reduced system sickness rates

Key Assumptions:

- The LWAB will be the Board where workforce discussions, decisions and planning will take place
- LWAB will agree the rolling programme of work on an annual basis
- All organisations will support the aims and outcomes of the LWAB and subsequent workforce programmes
- Funding decisions and impacts will be agreed at the LWAB for each provider organisation to manage both individually and as a collective
- Data and information sharing agreements will be in place so that system data can be used to direct the enabler
- Networks e.g. UEC assumptions will be incorporated into the wider workforce discussions at LWAB

Key Challenges:

- Changing patient expectations i.e. the want to be seen locally 24/7 through different mediums such as technology
- The changing landscape of the workforce e.g. an ageing workforce and reduced numbers entering the profession. There are also shortfalls in staffing both nationally and internationally and therefore increased competition to attract and retain staff
- Supply and demand e.g. ability to recruit substantive staff in order to reduce the reliance on expensive agency staff
- The need to comply with national standards and requirements, for example, 7 day services and out of hospital care
- A general reduction in system funding
- Organisational mind-sets not supporting new staffing models e.g. Joint LA/Health Reablement/Rehabilitation roles
- Changing terms and conditions of employment to support new models of working

Key Interdependencies:

Other Enablers

- Digital as there are technology requirements e.g. mobile working in support of the new workforce form
- Estates as there will be the need to understand what the future estates form will need to be in support of the workforce i.e. co-locating health and social care teams
- Contracting reform as there will be impacts on contract and commissioning requirements if new workforce structures are needed

System

- Acute providers, Primary Care, CCGs, Local Authority and Community services to understand and ensure that local workforce considerations are in annual plans, including data sharing agreements, joint appointments and role development and integration
- HEE to support workforce plans
- Finance to supply staffing

Resource Requirements:

- One of the main LWAB tasks will be to identify what resources are required to support the delivery of the workforce element of the STP
- The LWAB launch meeting, planned in October 2016 will start to work through these issues

Appendix D: How our priorities address the 10 STP questions/NHS Planning Priorities

Question	Document location
1. How are you going to prevent ill health and moderate demand for healthcare? Including: • A reduction in childhood obesity • Enrolling people at risk in the Diabetes Prevention Programme • Do more to tackle smoking, alcohol and physical inactivity • A reduction in avoidable admissions	CCF: Health and wellbeing CCF: EGMP CCF: Urgent care and care in a crisis
2. How are you engaging patients, communities and NHS staff? Including: • A step-change in patient activation and self-care • Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care • Improve the health of NHS employees and reduce sickness rates	CCF: Health and wellbeing CCF: Long term conditions Maternity and newborn programme Workforce enabler
3. How will you support, invest in and improve general practice? (Planning Priority) Including: • Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff • Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package • Support primary care redesign, workload management, improved access, more shared working across practices	CCF: EGMP Workforce enabler
4. How will you implement new care models that address local challenges? Including: • Integrated 111/out-of-hours services available everywhere with a single point of contact • A simplified UEC system with fewer, less confusing points of entry • New whole population models of care • Hospitals networks or groups to share expertise and reduce avoidable variations in cost and quality of care • Health and social care integration with a reduction in delayed transfers of care • A reduction in emergency admission and inpatient bed-day rates	Fit for Future Secondary and Tertiary Services CCF: urgent care and care in a crisis CCF Long Term Conditions
5. How will you achieve and maintain performance against core standards? Including: • A and E and ambulance waits; referral-to-treatment times	Fit for Future Secondary and Tertiary Services CCF: urgent care and care in a crisis Mental health programme Acute care programme
6. How will you achieve our 2020 ambitions on key clinical priorities? (Planning Priority) Including: • Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks • Implement two new mental heath waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity • Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries • Maintain a minimum of two-thirds diagnosis rate for people with dementia	Fit for Future Secondary and Tertiary Services CCF: Health and wellbeing CCF: EGMP Mental health programme Maternity and newborn programme

Appendix D: How our priorities address the 10 STP questions (cont'd)

Question	Document location
7. How will you improve quality and safety? Including: • Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions • Achieving a significant reduction in avoidable deaths • Ensuring most providers are rated outstanding or good– and none are in special measures • Improved antimicrobial prescribing and resistance rates	CCF: EGMP CCFL urgent care and care in a crisis Fit for Future Secondary and Tertiary Services
8. How will you deploy technology to accelerate change? Including: • Full interoperability by 2020 and paper-free at the point of use • Every patient has access to digital health records that they can share with their families, carers and clinical teams • Offering all GP patients e-consultations and other digital services	Digital enabler
9. How will you develop the workforce you need to deliver? Including: • Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values • Integrated multidisciplinary teams to underpin new care models • New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice	Workforce enabler CCF: EGMP CCG: Long term conditions Fit for Future Secondary and Tertiary Services
10. How will you achieve and maintain financial balance? Including: • A local financial sustainability plan • Credible plans for moderating activity growth by c.1% pa • Improved provider efficiency of at least 2% p.a. including through delivery of Carter Review recommendations	Executive summary Solutions and impact (page 65) BSol financial plan