



The Black Country Sustainability and Transformation Plan 2016-2021

Version 0.8

Version Control

Date	Version	Notes
15 August 2016	V0.1	Initial draft compiled from June STP submission, workstream updates and subsequent NHSI submissions
24 August 2016	V0.2	Update following review by Sponsoring Group
25 August 2016	V0.3	Annotated with further detail required from workstreams by 5 th Sept
14 September 2016	V0.4	Further detail from VI, HI and Maternity workstreams
19 September 2016	V0.5	Revised financial narrative following 16 Sept template submission and input from specialized commissioners, plus changes from review by Sponsoring Group.
03/10/2016	V0.6	Further detail from VI workstream plus Mental Health and Economic impact studies
12/10/2016	V0.7	Full revision following review by Transformation Groups and Workstreams.
20/10/2016	V0.8	Changes as agreed following review by Sponsoring Group and to align with latest financial analysis.

The Black Country and West Birmingham

In order to develop this transformational plan for our local health and care system, eighteen local partner organizations have committed to a unique degree of collaborative working for the benefit of the Black Country and West Birmingham’s 1.4 million population – 46% of whom live in the most deprived areas of England.

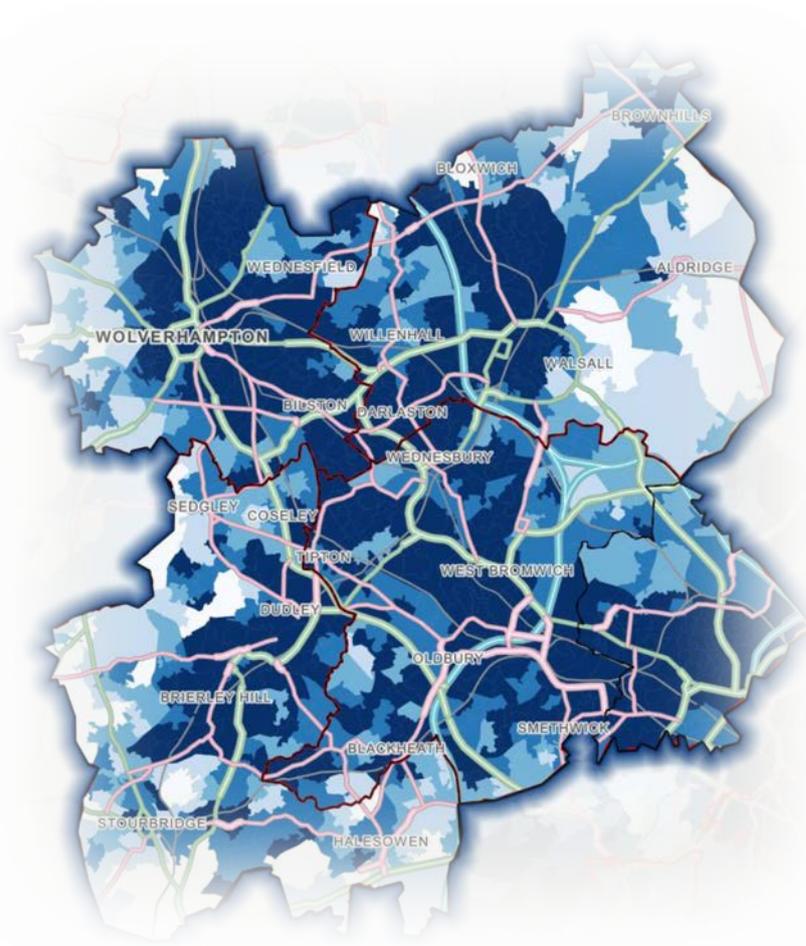


FIGURE 1 - THE BLACK COUNTRY STP FOOTPRINT (INCLUDING WEST BIRMINGHAM)

Some key principles shape our collaboration:

↪ **Subsidiarity**

We serve five distinct local communities – Birmingham (West), Dudley, Sandwell, Walsall and Wolverhampton – each with their own unique histories, strengths and challenges. We will ensure that our collaboration does not undermine the existing excellence and innovation in each area. There is a very strong sense of place across Black Country and West Birmingham.

↪ **Collective Added Value**

We believe that, through working together, we can build on our strengths, achieving a scale and pace of transformation that we cannot realise in isolation. In financial

terms, the added value to be delivered through coordinated action at STP level by NHS organisations is £413m (allowing for an additional £99m national funding). This is approximately £178m more than our NHS organisations would be expected to achieve without the STP.

Our partnership work has been advancing ahead of the formation of the STP through bodies such as the West Midlands Combined Authority, the Black Country Alliance and the Transforming Care Together partnership. Through the STP, we can now ensure that initiatives already being undertaken within Black Country and West Birmingham organisations are used to their greatest effect.

In addition:

- We have determined not to duplicate any processes or structures through our collaborative working; and
- Our functioning as an STP will not limit the way in which we liaise with neighbouring areas for patient benefit.

The following organisations have been invited to contribute to the development of this draft plan to date:

Black Country Partnership NHS Foundation Trust	NHS Walsall Clinical Commissioning Group
Dudley Metropolitan Borough Council	Wolverhampton City Council
Dudley Group NHS Foundation Trust	Royal Wolverhampton NHS Trust
Dudley and Walsall Mental Health Partnership NHS Trust	NHS Wolverhampton Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group	Birmingham City Council
Sandwell Metropolitan Borough Council	Birmingham Community Healthcare NHS Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust	NHS England
NHS Sandwell & West Birmingham Clinical Commissioning Group	West Midlands Ambulance Service NHS Foundation trust
Walsall Metropolitan Borough Council	Local Government Association
Walsall Healthcare NHS Trust	Healthwatch
Black Country Partnership NHS Foundation Trust	Health Education England – West Midlands

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Preface

This draft plan sets out an ambitious approach to transforming our local health and care system in the Black Country and West Birmingham.

Our aim is to materially improve the health, wellbeing and prosperity of the population through providing standardised, streamlined and more efficient services.

The STP's Sponsoring Group, formed of the local leaders of health and social care organisations, has prepared this draft plan to enable wider engagement. It proposes a number of critical recommendations:

- To implement **LOCAL PLACE-BASED MODELS OF CARE** for each community that deliver improved access to local services for the whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work will build on the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) approaches which are already being developed with local communities, in order to deliver an 'Accountable Care Organisation'¹ model appropriate to each of our localities;
- To create, through **EXTENDED COLLABORATION BETWEEN SERVICE PROVIDERS**, a coordinated system of care across the Black Country and West Birmingham to improve quality and to deliver efficiencies on a scale not accessible to individual organizations. This will build on existing collaborations such as the Black Country Alliance and the Transforming Care Together Partnership for **MENTAL HEALTH AND LEARNING DISABILITY SERVICES**, and it includes the development of the new Midland Metropolitan Hospital (bringing together acute services from Sandwell and City hospitals) following Public Consultation in 2007;
- To take coordinated action to address the particular challenges faced by our population in terms of **MATERNAL AND INFANT HEALTH**, and to create a single Black Country and West Birmingham maternity plan that inter-relates with Birmingham and Solihull where necessary;
- To work together on **KEY ENABLERS** that will enable us to achieve significant workforce efficiency and transformation, to deliver the digital infrastructure required for modern patient-centred services, to rationalise public sector estate utilisation, and to streamline commissioning functions; and
- To act together, and in partnership with the West Midlands Combined Authority, to address the **WIDER DETERMINANTS OF HEALTH** such as employment, education and housing.

This document summarises how we can build on existing strengths, accelerating our learning from innovation, to create a sustainable health system with improved health outcomes and a better patient experience of services.

¹ <http://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained>

How our plan could benefit people in the Black Country and West Birmingham:

- ↪ With an extra £25m invested in GP services by 2021, an extra 25,000 primary care appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- ↪ Over 1,000 people a month who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- ↪ Across the Black Country and West Birmingham, there will be at least 40,000 additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- ↪ From November 2016, by ringing one telephone number the 1.4m people who live in the Black Country will be able to book a doctor's appointment, in the evening and at the weekend, get dental advice, order a repeat prescription, or get urgent advice.
- ↪ By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- ↪ By bringing all cancer services up to the standard of the best, cancer one year survival rates will reach over 70 per cent in the Black Country and West Birmingham.
- ↪ Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E by 3,000 a week by 2021, meaning faster treatment and care for the most seriously ill.
- ↪ By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- ↪ Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- ↪ Local clinical teams involving GPs, community nurses, mental health services and social care will provide better coordinated care for our most vulnerable patients with very complex needs.
- ↪ The new Midland Metropolitan Hospital will bring hospital services in Sandwell and West Birmingham together in one place to treat over 570,000 people in a state of the art building.
- ↪ By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- ↪ Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- ↪ The NHS in the Black Country and West Birmingham will reduce current high levels of infant mortality to bring it in line with the national average, avoiding the death of 34 babies a year - the equivalent of one child every eleven days.
- ↪ By tackling waste, improving standards and working together, we can avoid a potential increase in health costs of over £413 million per year by 2021. This will give better value to the taxpayer, equivalent to £680 a year for every household in the Black Country and West Birmingham.

Executive Summary

This document outlines our draft plans for transforming health and care services across the Black Country and West Birmingham. It is a ‘work in progress’ and we are now looking to engage and communicate effectively with our patients, public, partners, staff and stakeholders across the Black Country and West Birmingham in order to develop our plans further and to agree how to implement them in the best possible way.

The demands on health and care resources are rising year on year – people are living longer with ever more complex conditions; continuing progress in treatments and medical techniques comes with new costs and expectations; and modern lifestyle issues such as obesity are causing an increase in long term conditions. For the future, we must transform services to adapt to these rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources. We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.

Our vision is to transform health and care in the Black Country and West Birmingham. We need to bridge three critical gaps:

- **Our populations suffer significant deprivation, resulting in poor health and wellbeing;**
- **The quality of the care we offer varies unnecessarily from place to place, so not everyone has the best experience of care or the best possible outcome; and**
- **We risk not being able to afford all the services our populations need unless we take early action to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.**

It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations. Mental Health and Learning Disabilities services form part of this but are also identified as a discrete strand to reinforce parity of esteem, the necessity of which is confirmed by a study we commissioned that shows the much reduced life expectancy of mental health service users. Maternity and Infant Health is also an essential focus for us given our challenges around maternal health (in particular, maternal smoking) and its impact on neonatal death rates and other infant

outcomes. Maternity and neonatal service capacity also needs to be reviewed.



In addition to the challenges we face in terms of health and wellbeing outcomes and of variations in the quality of care, the local NHS is estimated to face a £512m financial gap by 2020/21 as increased funding is outstripped by rising demand. There is a parallel £188m challenge faced by Social Care services. Whilst local organisations retain individual responsibility to deliver savings, we know that standard existing demand reduction and efficiency measures will not be enough to bridge the NHS gap. As an STP, we need both to support individual organisations in achieving their regular savings targets and, through coordinated STP action at pace and scale, to avoid a further future costs.

Elements of our triple challenge (health and wellbeing, care and quality, finance and efficiency) are unlikely to be addressed without taking action together on the wider determinants of health. To enable this we will be working closely with the West Midlands Combined Authority and have already commissioned a ground-breaking study on the economic impact of health spending. This study (commissioned through the Strategy Unit and ICF International) includes the economic impacts of health services defined in terms of both the economic benefits from improved healthcare and the opportunity costs of healthcare failures. It demonstrates how the NHS employs 6% of the Black Country and West Birmingham workforce and brings £2bn p.a. into the local economy, matched by an estimated similar value of informal care provided by friends and family members. It also models how improving infant mortality and mental health services could not only bring direct benefits to patients but could add c.£150m p.a. to the Black Country and West Birmingham economy. A summary of how we are taking forward our key initiatives can be found in the templates appended to this plan.

Aspects of these initiatives have been in development for some time (e.g. the Midland Metropolitan Hospital and the Dudley Multispecialty Community Provider model). Consequently they have already benefited from extensive public engagement and consultation. This plan, itself informed by the ongoing public and patient involvement by partner organisations, is now at the point at which coordinated engagement across the Black

Country and West Birmingham can be initiated, enabling the public to see (and to be able to contribute further to) how local plans relate to each other and how the benefits of working in partnership at scale can enhance the outcomes, experience and sustainability of Black Country and West Birmingham health services.

New Models of Care

Nationally, NHS England has been promoting a range of new models of care. These are designed to be locally appropriate ways of delivering the aims of its overarching strategy, the *Five Year Forward View*. The Black Country is active in developing a number of the new models:

➤ **Multispeciality Community Provider (MCP)**

Building on and strengthening local GP services, MCPs will take a more integrated view of the needs of local populations, bringing together a wide range of services (including some traditionally provided in hospitals) and providing them closer to patients' homes. We are doing this in Dudley and in West Birmingham.

➤ **Primary Care Home (PCH)**

Similar to MCPs, PCHs offer a different approach to strengthening and redesigning primary care, centred on the needs of local communities of around 50,000 people, and tapping into the expertise of a wide array of health professionals. This is the preferred model for most of Wolverhampton.

➤ **Primary and Acute Care Systems (PACS)**

A local hospital also takes on a responsibility for local GP services. This is being developed in parts of Wolverhampton.

➤ **Acute Care Collaboration (ACC)**

This is a model for NHS organisations offering acute care to share staff, services and resources. The Black Country is part of the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT), focusing on seven day working in acute services, crisis care and reduction of risk, and recovery and rehabilitation.

As we move towards a more sustainable, healthier and higher quality 2021, it is clear we already have a range of transformation initiatives underway across our patch. We will learn the lessons of these initiatives together. Through a programme of evaluation, we will reap vital learning from the seeds of innovation we have sown. This learning will be shared across the Black Country and West Birmingham and, where appropriate, across the NHS. We want to build a local health system that constantly improves itself and adapts as new learning emerges or needs change.

Public sector organisations are sometimes criticised for not doing enough to evaluate and learn from their new initiatives. In the Black Country and West Birmingham we are committed to making the sharing of knowledge and learning a powerful and accessible resource for our staff and patients. Empowering our staff, backed up with the right technology, we can make healthcare in the Black Country and West Birmingham a self-improving system that is constantly learning from what it is doing. Each aspect of our plan sets out to experiment – to test approaches, uncover effective practice, codify and spread it. Moreover, each of these initiatives is being evaluated and supported to varying degrees by the nationally regarded NHS Strategy Unit, based in the Black Country and West Birmingham, bringing a consistent discipline to both qualitative and quantitative measurement and understanding.

The Black Country and West Birmingham has the potential to transform its healthcare services and outcomes more quickly and more effectively than many other areas. Key areas of practical learning might include the following:

Local Place-based Models of Care

- There are two types of issue in this area -
 - Are there differences in the benefits that are delivered by the different models of care (MCPs, PCHs and PACS)?
 - What are the most effective ways for integrated local teams to deliver improved access, continuity and coordination of care to populations of 30,000 to 50,000? This could include evidence relating to the most effective Public Health interventions locally.

Extended Hospital Collaboration

- What level/type of joint working best enables the removal of unwarranted variation in care and outcomes?
- Does it help key hospital specialties to improve the benefits they bring to patients if they are provided in a joined-up way across more than one hospital?
- What are the key things that could most improve the quality of care in residential and nursing homes?

Mental Health & Learning Disabilities

- How can we best support service users to avoid crisis and manage their own care, improving health, social and economic outcomes?
- What level/type of specialist services can be sustained within the Black Country instead of further afield?
- Which interventions are best able to reduce unnecessary acute hospital usage by mental health service users?

Maternal & Infant Health

- What are the key things that would help us to reduce the number of unnecessary infant deaths in the Black Country?
- What mix of maternity services across the Black Country will best meet the needs of local mothers in the future?

Our 'Transformation Logic Model' overleaf sets out our rationale for why we believe that the things we are proposing to do will bring the benefits our patients and our communities need.

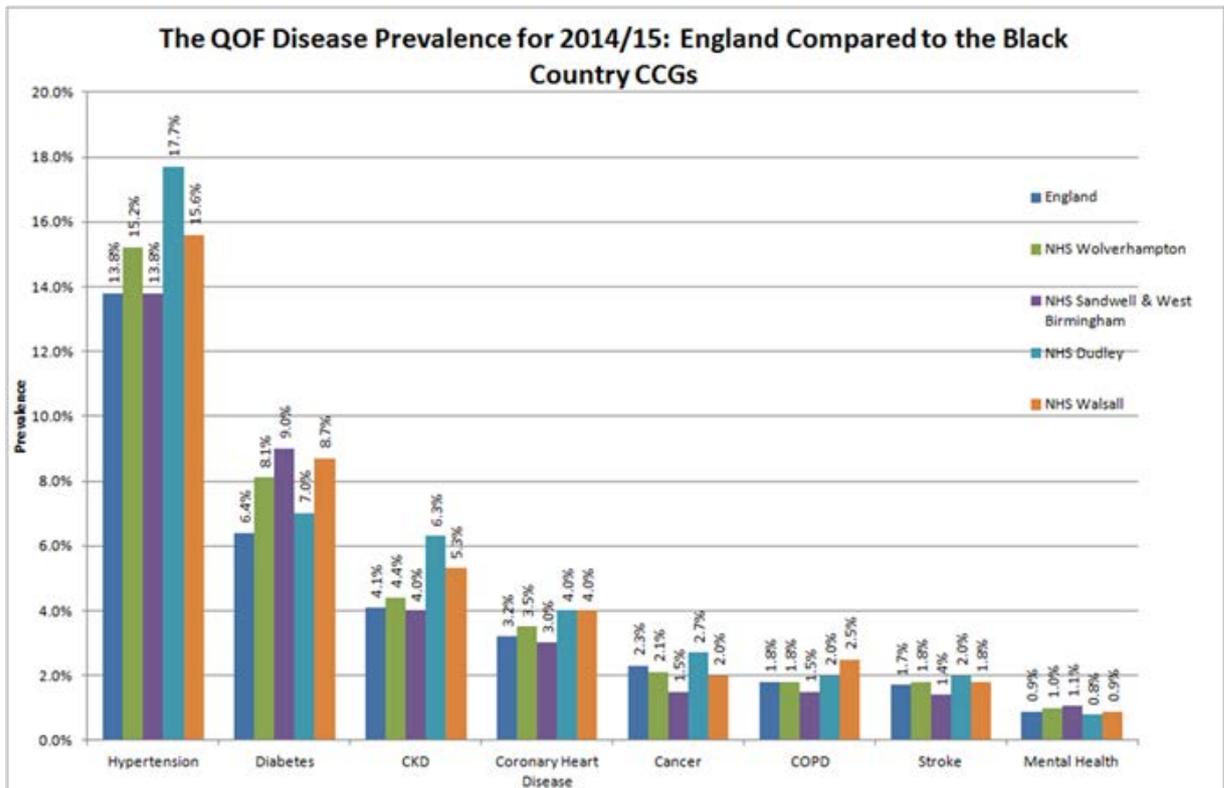
Our Transformation Logic Model

Rationale	The Black Country and West Birmingham health and care system faces significant challenges. Some of these challenges are a function of changes in population need; others are a function of the way we organise and provide services; others grow from the way we engage with patients and the public. We face resulting gaps in care quality, health outcomes and financial sustainability. We must therefore act on multiple fronts. The STP provides us with a framework for doing this. It is an opportunity to act systematically and in concert - to agree upon and address common challenges in a way that we could not as individual constituent parts.
Inputs	<ul style="list-style-type: none"> • In-kind contributions of all BC partners (including clinical and managerial resource) • Analytical inputs • Programme infrastructure • Additional funding allocations (including £99m Sustainability and Transformation Funding)
Activities	<ul style="list-style-type: none"> • 'Local Place-based Models of Care': Develop standardised place-based Integrated Care Models commissioned on the basis of outcomes; Promote the prevention agenda and build resilient communities; • 'Extended Collaboration between Service Providers': Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Commission for quality in care homes; Deliver Cost Improvement Programmes; • 'Mental Health & Learning Disabilities': Become one commissioner for NHS services, Build the right support for Learning Disabilities in association with Council commissioning functions, Improve bed utilisation and stop out of area treatments, Deliver the WM Combined Authority Mental Health challenges, Deliver extended efficiencies through TCT partnership; • 'Maternity & Infant Health': Develop standardised pathways of care for maternal/infant health; Review maternity capacity • 'Enablers': Systematically evaluate and learn from process of implementation and evidence based practice; Undertake workforce transformation and reduce agency use; Implement BC Digital Strategy; Rationalise public sector estate; Consolidate back office functions; Develop and implement future commissioning functions • 'Wider Determinants': Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact
Outputs	<ul style="list-style-type: none"> • Proactive and efficient model of place-based care codified and commissioned • Pathways codified and streamlined / standardised • Back office / estates / supporting functions consolidated • Digital Strategy implemented • New workforce roles developed • Lessons from implementation and from the evidence
Outcomes	<ul style="list-style-type: none"> • Reduced unwarranted variation in care quality and outcomes • Improved patient experience (and reduced variation in) • Increased proportion of care provided in out of hospital settings • Integrated service delivery • Reduced per capita expenditure • More proactive and risk stratified care, and reduced unplanned care • More engaged and productive workforce • Better use of available public sector infrastructure • Increased use of intelligence and insight
Impacts	<ul style="list-style-type: none"> • A more sustainable local health and care economy • Improved quality & experience of care for the population of the Black Country and West Birmingham • Improved population health: greater quality and quantity of life • A more capable local economy, equipped for self-improvement • A happier, more sustainable workforce

The Scale of the Challenge

Better Health

Directors of Public Health have examined data contained in local Joint Strategic Needs Assessments, STP data packs and Public Health England information in order to assess the Health and Wellbeing Gap in the Black Country and West Birmingham. This analysis demonstrates that not only are there gaps between STP and England averages but that there is also significant variation within the Black Country and West Birmingham. For example, there is a wide inequality in both disease prevalence (see chart below) and life expectancy.



Our Public Health departments are already working with partners to narrow these gaps by focusing resources on ensuring that prevention services are targeted at groups and areas of greatest need:

- Black Country and West Birmingham **depression** rates (7.4%) are higher than the England average (7.3%), and are recorded at 8.6% in Dudley.
- **Diabetes** prevalence is much higher in the Black Country and West Birmingham compared to the rest of England, with Sandwell and West Birmingham reaching over 9% (England 6.4%). The percentage of physically inactive adults is 32.6% (England 27.7%).
- The **Infant Mortality** rate is much higher in the Black Country and West Birmingham compared to England rate of 4.0 deaths per 1000 - Walsall 6.8, Sandwell & West Birmingham 6.9, and Wolverhampton 6.8.

- The **Smoking in Pregnancy** rate across the Black Country and West Birmingham (linked to infant mortality) is similar to the England average (11.1%) but Wolverhampton has a rate of 15.8%.
- The **Premature Mortality** rate for Respiratory Disease in the Black Country and West Birmingham is higher than the England average rate of 28.1 per 100,000 - Sandwell & West Birmingham has a rate of 38.1 and Wolverhampton 40.9. The estimated smoking prevalence level in the Black Country and West Birmingham (20.3%) is higher than the rest of England figure (18.4%). Walsall and Wolverhampton rates are 21.5% and 20.7%, respectively.

To achieve a step change going forward, we will implement a standardised, evidence-based approach to our prevention activities across the transformation areas we have identified.

This includes:

- Co-ordinated action with all partners with a focus on improving healthy life expectancy;
- Embedding critical prevention activities in place-based models of care and outcomes specifications;
- Designing common acute care pathways that focus on broad health improvement not just narrow condition treatment; and
- Tackling the rising challenge of Mental Health problems for communities through building resilience and promoting wellbeing, leading to health, social and economic benefits;
- Increasing our focus on the wider determinants of health and the impact the health and social care system can have on shaping the development of healthy, supportive environments

We have formed a Public Health Reference Group that has been focused on two key tasks:

a) Developing a common prevention framework

A common prevention framework is currently in development for use by STPs and the WMCA workstreams. For consistency this is being developed by the Association of Directors of Public Health Network (ADPH) for the West Midlands and Public Health England. The prevention framework aims to support STPs focus on prevention and early intervention to address variation and reduce the health and wellbeing gap. The framework is an enabler with a specific focus on the following three areas:

- **Changing Population Health Outcomes at Scale.** To address how to keep people healthier for longer and prevent the development of health risks;

- **Managing Individual Health Risks.** Focusing on early intervention to prevent health risks turning into ill-health and prevent escalation of existing health problems to the point where they require significant, complex and specialist health and care interventions; and
- **Better well-being by putting people at the centre of their care.** Improving quality of life and enhancing individual control by focusing on helping people to maintain good, happy, independent lives rather than being condition-focused.

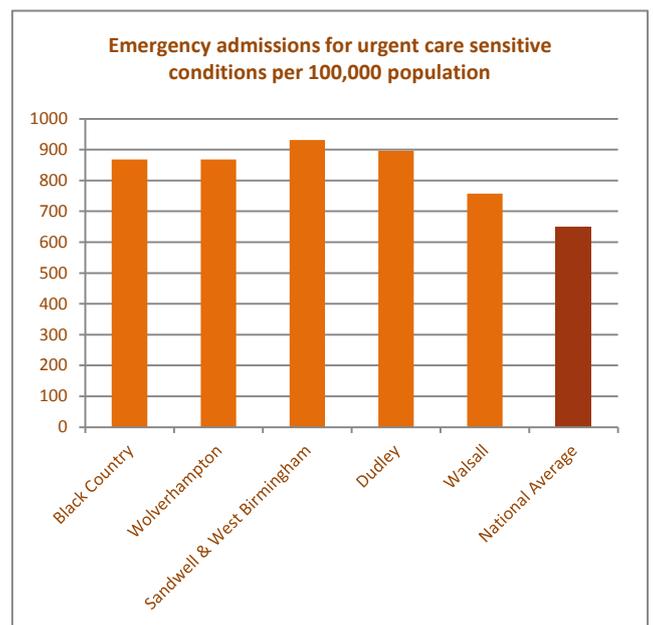
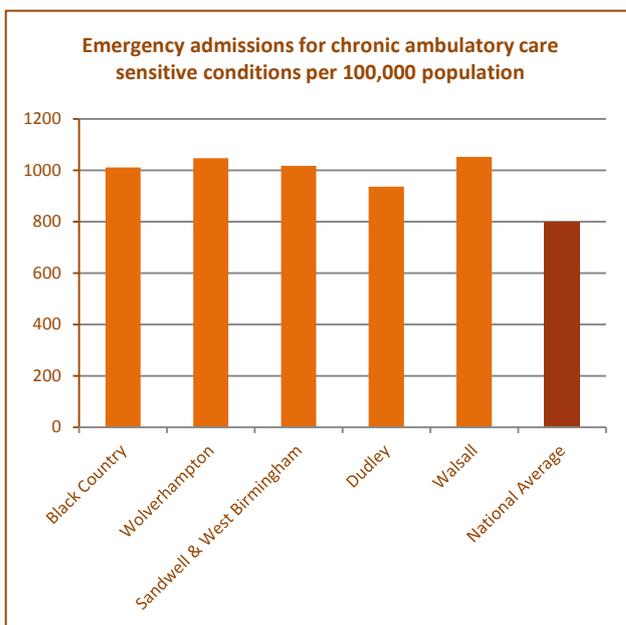
b) Providing advice and challenge across the Transformation Groups

The Public Health Reference group is closely aligned to the Health and Wellbeing workstream of the West Midlands Combined Authority (WMCA) and directly links into the STP’s Clinical Reference Group. In addition, it will also be closely linked to the Maternal & Infant Health and Mental Health Transformation Groups and to our joint work to address the wider determinants of health.

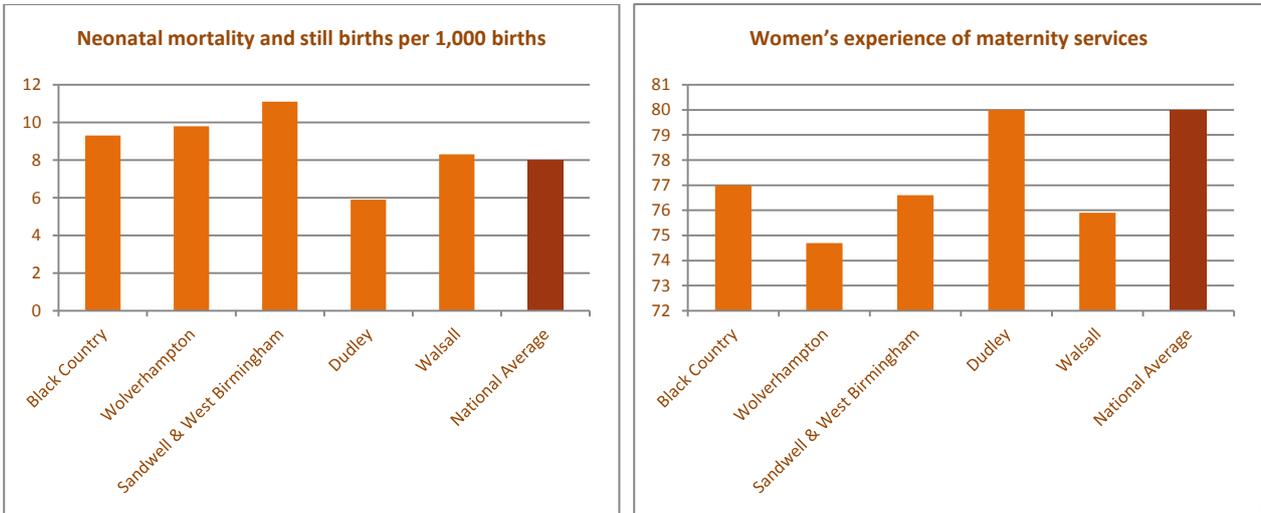
Better Care

Our analysis of Care and Quality data indicates that there is unwarranted variation both between Black Country and West Birmingham performance and national performance, and also within our area.

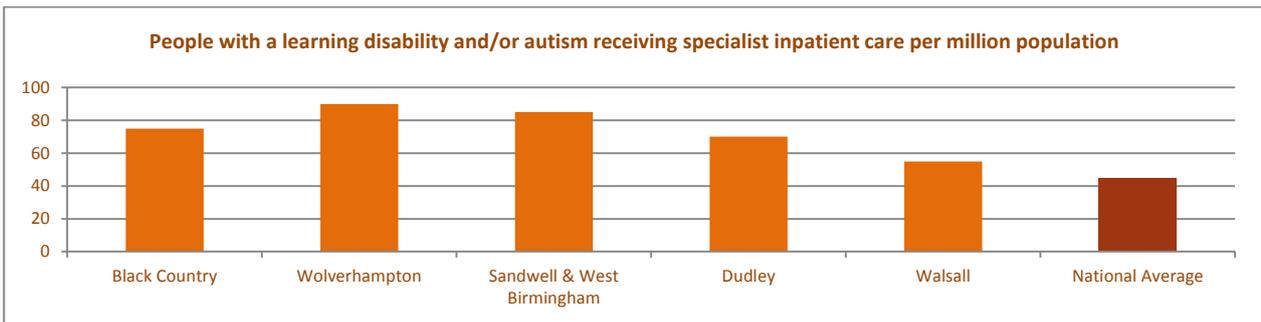
In terms of urgent and emergency care, for example, there is a 10% variation across our providers in terms of meeting the four hour waiting time target, with Black Country and West Birmingham performance in the 3rd quartile nationally (as it is for the number of emergency bed days). Emergency admissions for conditions that could be better treated in another way (i.e. through urgent care or ambulatory care) are in the bottom quartile.



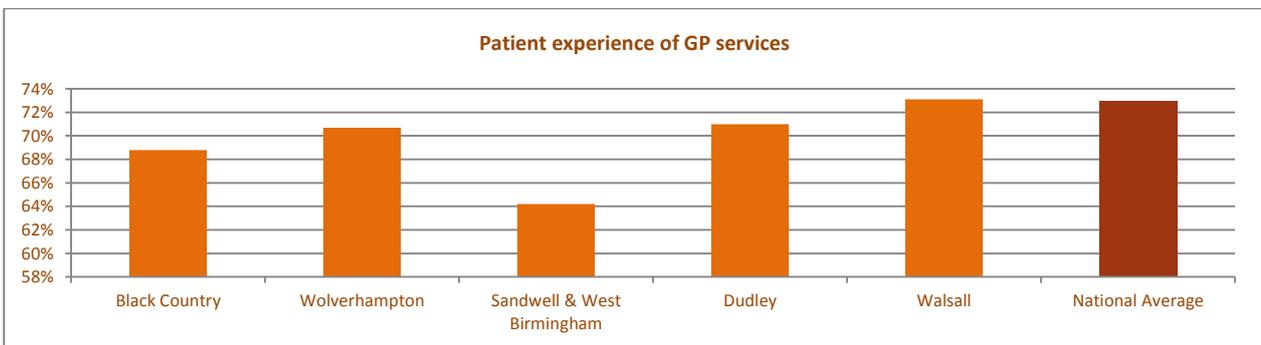
Maternity services are generally rated low in terms of mothers' experience, and the Health and Wellbeing Gap in relation to maternal smoking contributes to above average neonatal mortality. Both experience and mortality fall in the bottom quartile of STPs nationally.



In Mental Health & Learning Disability services, there are also high rates for people with LD and/or autism receiving specialist inpatient care.



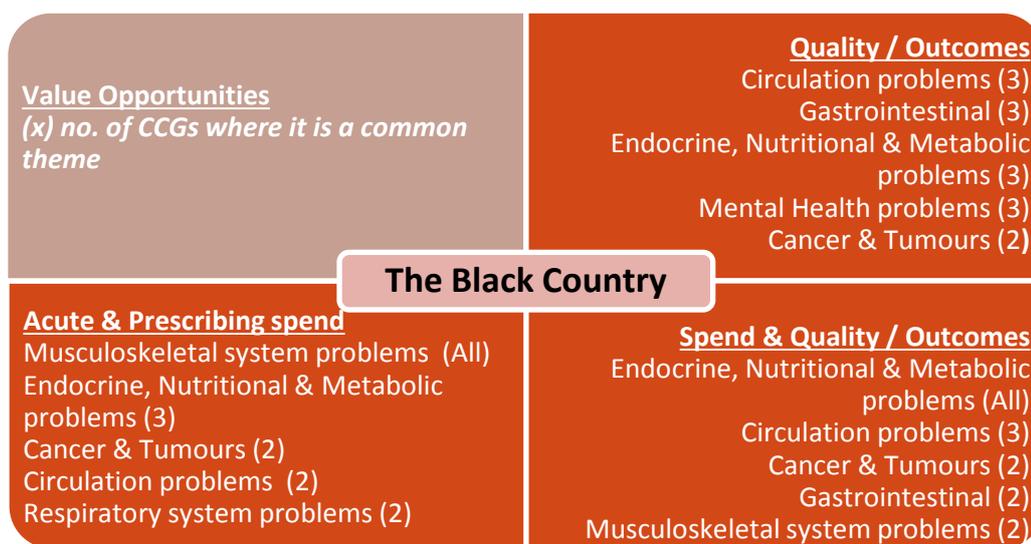
The need to standardise local place-based services is highlighted by relatively low patient satisfaction with experience of GP services.



Following this initial analysis, a Clinical Reference Group (CRG) has been formed for the STP in order to provide clinical support to our Transformation Groups in redesigning services and also to Quality Assure final clinical models, accessing external expertise where necessary. Membership of the CRG includes provider Medical Directors and Chief Nurses, CCG Clinical Leads and representatives from Public Health, Local Authorities and Pharmacists.

The CRG’s work will be guided by the West Midlands Clinical Senate’s Assurance Framework and will include the use of a standard template to facilitate a systematic and consistent approach. This will also enable integration with quality, equality and other impact assessment processes, as required by each proposal.

Following a review of Commissioning for Value (CfV) data and Public Health England (PHE) Health Profiles, the CRG has identified a number of clinical opportunities for improvement; key enablers and cross-cutting issues; and key challenges.



Comparison of Black Country CCGs (no.) with national averages	Significantly worse	Not significantly different	Significantly better
Hospital stays for alcohol-related harm	4		
Prevalence of opiate and/or crack use	4		
Recorded diabetes	4		
Obese children (Year 6)	4		
Under-18 conceptions	4		
Incidence of TB	3		1
Smoking status at time of delivery	3		1
Obese adults	3	1	
Excess weight in adults	3	1	
New STI (exc. Chlamydia <25)	2	1	1
Hip fractures – 65 and over	1	3	
Hospital stays for self-harm	1	2	1

a) Initial Focal Areas

- Avoidable emergency admissions:
 - i. Alcohol / drug related
 - ii. Frail / elderly related
- Musculoskeletal Conditions
- Long Term Conditions management

- End of Life care

b) Key Enablers and Cross-cutting Issues

- Patient engagement, activation and empowerment, and the need to help them better navigate what is often a complex health system
- Education, training & support of care home staff
- Workforce resilience & structure – use of new and/or different roles, and the potential ‘sharing’ of some workforce groups
- Information sharing between organisations
- Greater consistency and standardisation of social care referral processes
- Digital healthcare and access to records (with the need to address potential inequalities in access to technology)
- Linking with Mental Health and MCP vanguards in the STP
- Understanding costs to support sustainable changes.

c) Key Challenges

- Identifying the areas in which there are real opportunities for delivering a material improvement in the quality of care
- Defining key quality standards and the boundaries of what represents unacceptable variation
- Ensuring the robustness of proposals through evidence analysis, analytical modelling, etc.

To respond to these and other Care and Quality gaps, we are initiating a series of clinical service reviews that will, with appropriate public and patient engagement:

- Identify areas of best practice in the Black Country and West Birmingham and beyond which can inform the standardisation of care and quality both in localities and across hospital providers;
- Facilitate the development by commissioners, with providers, of consistent pathways and models of care across all care setting and locations
- Ensure the delivery of standardised enablers including common workforce competencies (especially in new roles); shared care records and other technology supportive of better care and self-management; and a common interface between health and social care across the Black Country and West Birmingham to reduce duplication, facilitate repatriation and reduce Delayed Transfers of Care.
- Focus on clinical areas with particular challenge or opportunity such as Musculoskeletal conditions, Cardiovascular Disease and Frailty.

- Support the promotion of prevention activities in all settings and facilitate patient activation and engagement.

Sustainability

The NHS currently spends over £2 billion each year to meet the health needs of Black Country and West Birmingham communities. Even with this investment and planned funding increases over the coming years, the demand for services is expected to continue growing even faster. As a result, the total financial gap relating to health service organisations is projected to reach £512m by 2020/21.

Local Authority budgets are subject to different challenges and constraints but it is estimated that, in relation to social care costs, the challenge will be around £188m. As with health services, this is likely to involve a combination of demand management, cost efficiency and service transformation.

The table below sets out what we believe would happen over the next five years if we do nothing to provide services more effectively and efficiently and to reduce demand for services by helping people to stay healthier:

The Black Country		Do Nothing					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(76,713)	(142,758)	(208,699)	(273,318)
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(89,545)	(134,744)	(183,892)	(239,238)
Footprint NHS Surplus / (Deficit)	£000s	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Indicative STF Allocation 2020/21	£000s						
Footprint NHS Surplus / (Deficit) after STF Allocation	£000s	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(67,631)	(115,428)	(155,064)	(187,698)

By contrast, if we were to successfully deliver the transformation of services described in this plan, we would not only improve the health of our populations but would also be living sustainably within our means (supported by additional Sustainability and Transformation Funds of £99m each year):

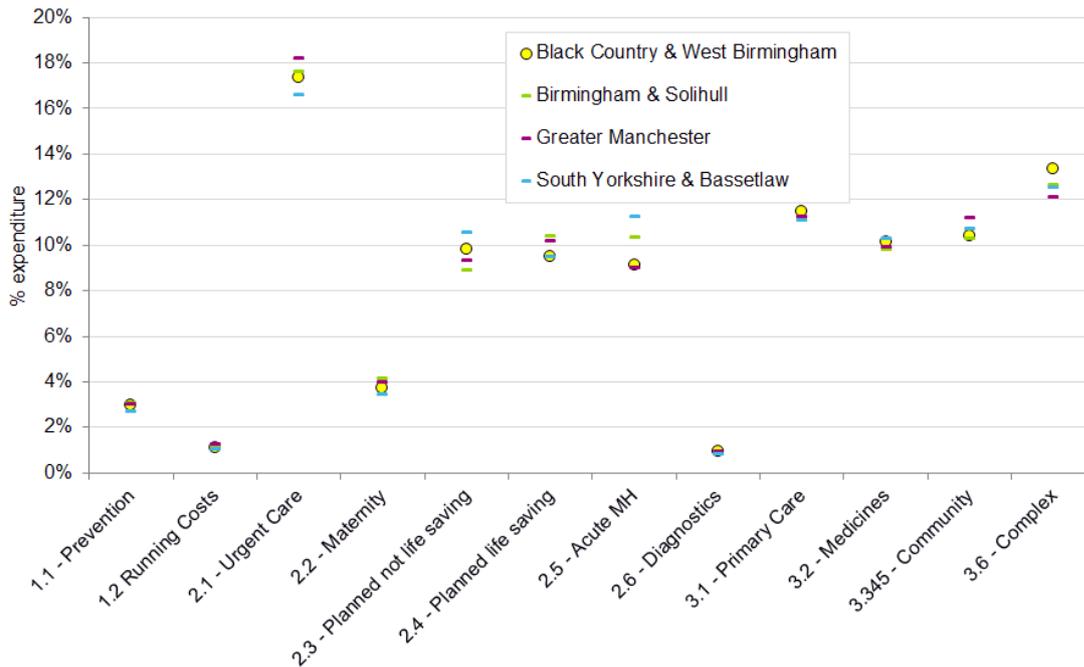
The Black Country		Do Something					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(0)	(0)	(0)	0
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(60,773)	(71,734)	(75,029)	(99,000)
Footprint NHS Surplus / (Deficit)	£000s	(7,188)	(57,090)	(60,773)	(71,734)	(75,029)	(99,000)
Indicative STF Allocation 2020/21	£000s			37,100	37,100	75,029	99,000
Footprint NHS Surplus / (Deficit) after STF Allocation	£000s	(7,188)	(57,090)	(23,673)	(34,634)	(0)	0
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(55,392)	(74,755)	(88,348)	(118,926)

We have also compared our levels of spending with other STP areas (including those with the most similar populations). This has shown us that how we allocate public funds is very similar to most other parts of the country including the most similar areas (see tables below). We will further explore this analysis in the next phase of our work – for example:

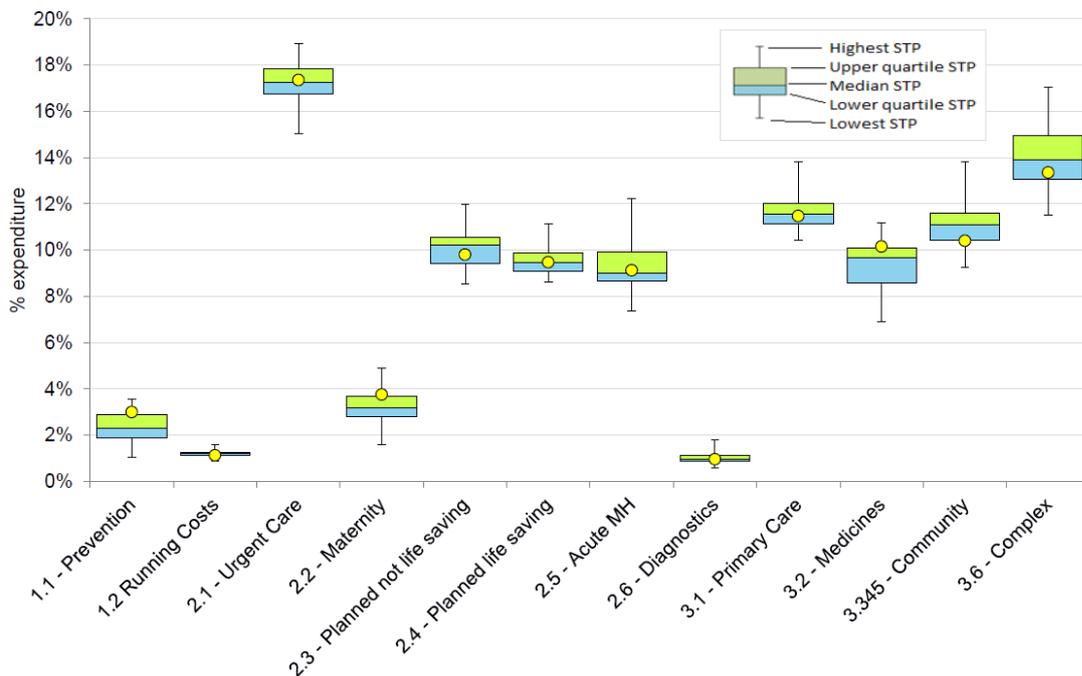
- Our administrative running costs are low;

- Our spending on complex health care needs and on primary care is high compared to our peers although we are not an outlier nationally;
- Our spending on prevention, maternity services and medicines is relatively high nationally but not unusual for our type of area; and
- Our spending on community services is relatively low, although our plans for local place-based care are expected to change this.

Distribution of Commissioning Resources 2015/16 – compared to most similar STPs



Distribution of Commissioning Resources – compared to all STPs 2015/16



When considering the sustainability of local health services, we are also very mindful that this not only relates to finance and efficiency but to some significant workforce challenges too.

- We know that a number of acute hospital specialties can be hard to recruit to across the country, and this is no different in our area. Where this is the case, we will address this as we consider how best to provide hospital services locally.
- We also know there are similar challenges faced in primary care. Delivery of the planned transformation across the Black Country and West Birmingham will provide challenges for all STP partners and success will depend upon genuine collective action. General Practice will be central to this and will play a key role designing the models for integrated delivery of services in the community and in ensuring that redesigned pathways work effectively. Current levels of manpower and capacity in General Practice increase the level of challenge. However, the STP partners are committed to an increased investment of £25m in primary care by 2020/21 to offset this challenge and to achieve the desired outcomes of the GP Forward View.

Demand Reduction through Local Place-based Models of Care

The way that health and care is provided has improved over the past fifteen years – thanks to the commitment of NHS and social care staff and, for the NHS, protected funding in recent years.

However, substantial challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatment options are emerging, and we rightly expect better care closer to home.

People across the Black Country and West Birmingham are telling us that they want:



There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. It means more preventative care; finding new ways to meet people’s needs; and identifying ways to do things more efficiently.

We plan to achieve a step change in population health & outcomes through integrated, standardised, place-based services built around the registered list, which deliver both patient-centred and population-centred care, commissioned on the basis of outcomes not activity.

Key actions we are taking include:

- The adoption of a developmental evaluation framework that will enable accelerated implementation from a robust evidence base, transferable to other STPs;
- Mapping current intentions and models in each borough to identify best practice;
- Developing standardised access to services utilising the full benefits of the new 111 service, integrated Out of Hours (OOH) services, new digital technologies and single points of access in each community;
- Improving long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;

- Creating integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community); and
- Accelerating the learning from our vanguard sites to implement new incentive and risk management models – long-term Whole Population Based (WPB) contracts that reward improvements in outcomes for patients.

Access, Continuity and Coordination Framework

The nature and scale of need is changing radically. Analytical work, alongside extensive engagement with patients, professionals and the public has shown us that different constituents of our population require different things:

1. **Enhanced access to care.** The percentage of people in the Black Country and West Birmingham ‘able to get an appointment to see or speak to someone here’ decreased from 81.8% in June 2013 to 79.1% in July 2016 (GP Practice Survey). The majority of our population wants enhanced access to care. They want more flexibility in the time and mode of access - to primary care based diagnostics and to analysis that identifies and solves problems as quickly as possible - and we need to create a sustainable primary care system to deliver this. The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems.
2. **Improved support for people with a Long Term Condition.** The Black Country and West Birmingham has a high prevalence of Long Term Conditions (LTC) compared with England and West Midlands averages, especially in relation to hypertension, diabetes, chronic kidney disease, chronic heart disease, depression and dementia:

Condition	England	West Midlands	Dudley	Sandwell	Walsall	Wolverhampton
CHD: Recorded prevalence (all ages)	3.20%	3.40%	4.00%	3.50%	4.00%	3.50%
CKD: QOF prevalence (18+)	4.10%	4.60%	6.30%	4.60%	5.20%	4.40%
Diabetes: Recorded prevalence (aged 17+)	6.40%	7.30%	7.00%	8.60%	8.70%	8.10%
Hypertension: Recorded prevalence (all ages)	13.80%	14.80%	17.70%	15.50%	15.60%	15.20%
Number of adults with dementia known to GPs: % on register	0.74%	0.73%	0.76%	0.69%	0.77%	0.82%
Number of adults with depression known to GPs: % on register	7.30%	7.60%	8.60%	6.90%	7.80%	7.90%
Stroke: Recorded prevalence (all ages)	1.70%	1.80%	2.00%	1.70%	1.80%	1.80%

Those being supported to live with a health condition (especially LTCs), need improved continuity of care. They need more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are interdependent and that change, and they expect

services to reflect these needs. As a result of these factors (both prevalence and lack of continuity of care):

- Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population were 26% higher in the Black Country and West Birmingham than the England average (1,011 compared to 800) (STP Footprint data pack); and
- By moving to the upper quartile of comparable CCGs, savings of £4.6m could be made across the Black Country and West Birmingham (Identifying Potential QIPP Opportunities, Strategy Unit, 2015)

For these patients, self-care should be supported by enhanced primary care in order to keep patients better at home for longer by helping them to understand their condition and how it may exacerbate, and what to do about it if it does. Continuity of care embraces not only primary care but also community care (designing and delivering services closer to home), acute care (enabling hospital teams to discharge patients back to community care for rehabilitation or continuing care closer to home) and mental health services.

3. Better Coordinated Care. Some, notably those with complex care needs, multiple comorbidities, those with frailty and those nearing the end of life, need better coordinated care. We know that the majority of health spending occurs in the last years of a person's life, when many have complex care needs:

- The number of people with comorbidities is set to increase in England from 1.9 million in 2008 to 2.9 million by 2018 (Long Term Conditions Compendium of Information: Third Edition, Department of Health, 2012).
- The number of people aged 75 and over is projected to increase by 10.4% between 2016 and 2021 from 105,000 to 116,000 (2014-based Subnational Population Projections for Clinical Commissioning Groups in England)
- The cost of social care and inpatient admissions in the last year of life was £18,621 (£8,649 inpatient, £9,972 Social Care) (Social care and hospital use at the end of life, Nuffield Trust, 2010).

These vulnerable people need the services that are supporting them to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it. Unfortunately, too many of these people are ending up in hospital in a crisis and being admitted to a hospital bed which potentially could be avoided with the right services in the community:

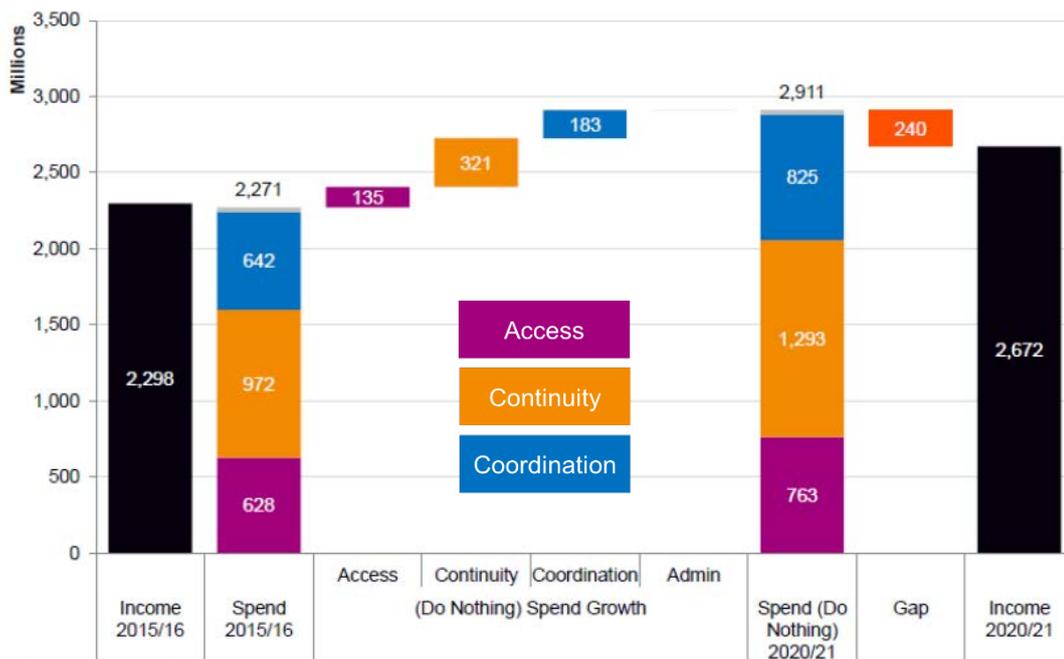
- Across the Black Country and West Birmingham Emergency Admissions for frailty and ambulatory care sensitive conditions are amongst the worst in the country.

- In 2014/15, there were 28,530 admissions for ambulatory care sensitive conditions (acute, chronic and vaccine preventable) in the Black Country and West Birmingham costing £57.6m (Identifying Potential QIPP Opportunities, Strategy Unit, 2015).

Although this is a small cohort of patients, the current ways in which services are provided results in us spending a large proportion of our resources inefficiently. Effective care planning, taking into account the whole needs of the person, is essential to ensure all individuals supporting a person’s care work effectively together and help people maximise the use of their social networks in their community, reducing social isolation and reliance on statutory care.

While the nature and scale of demand is changing, the supply of care is highly constrained and remains largely unreformed. The financial challenges facing the NHS are well documented; this places important limits on supply of care. But fundamentally, changes in the mode of provision have not kept up with changes in need. Providing care to an ageing population with multiple chronic conditions is a radically different proposition to supplying the predominantly episodic and curative interventions that typified the care of the past. Services are not configured to meet this fundamental shift. Nor are they sufficiently well integrated. With differing solutions to this problem in each place, Black Country and West Birmingham Health and Care organisations are working together to share best practice and experiences of addressing these challenges, in partnership with people who need us to address those most.

We have developed a framework that captures the scale of the local financial and activity challenge in relation to three key care areas. The following waterfall diagram sets out the challenge facing the STP’s Clinical Commissioning Groups (CCGs) in terms of these areas:



Local Place-Based Care Models

The people of the Black Country and West Birmingham are at the heart of our plans. There may be different solutions in each of the four STP areas. This is the right thing to do, working with each community to shape what those solutions are. However, our collective aim is to help them flourish: to support them when they need support; to guide them when they need guidance; and to promote independence throughout. They are individuals and citizens first, patients and service users second. Our whole approach starts with this understanding.

Key enablers are the assets of the Black Country and West Birmingham People:

- ✦ Building on self-care in a more proactive manner by engaging and activating patients not only to contribute to their own health and wellbeing but also to support others to do the same;
- ✦ Building strong, resilient communities and connecting people together, reducing social isolation; and
- ✦ Maintaining a strong Voluntary Sector.

We will reprioritise prevention, to identify and focus on issues upstream rather than tackling them at the point of demand. This will include a renewed focus on population health measures such as smoking rates, obesity and mental health.

The place based care work stream addresses the imbalances in supply and demand. It rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. Across the Black Country and West Birmingham these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organise around localities, and the services provided on referral to secondary care.

The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems. All patients accessing health whether through acute minor ailments or more complex chronic pathways should have underpinning support.

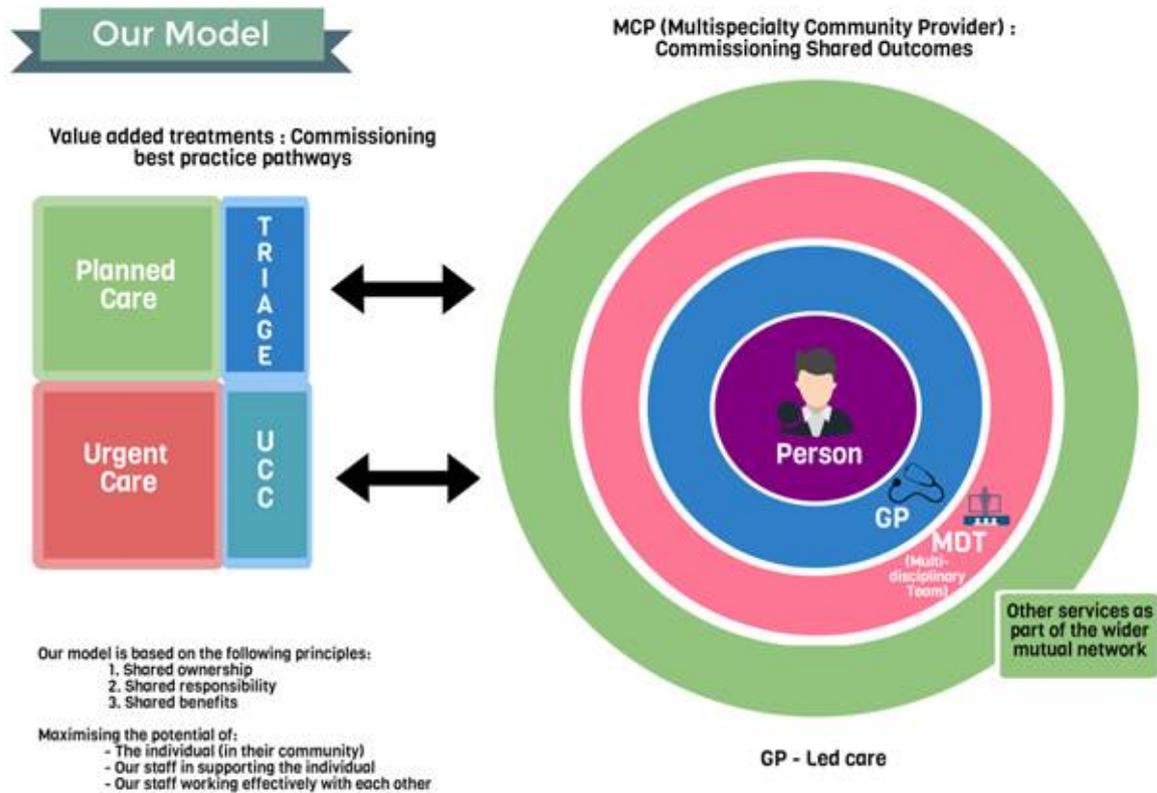
Supporting the benefits of modern hospital care, the new care models allows secondary care to focus on acute care of the unwell or injured, alongside appropriate elective activity for procedures which must be undertaken in a hospital environment. Hospital staff and teams can discharge patients back to community care in confidence of excellent local services delivering rehabilitation or continuing care closer to home.

The work stream will also tackle the variation in care, standardising pathways to best practice to deliver maximum efficiency of resources and delivering the highest quality care.

Our STP has a high density of new care model initiatives from which initial learning can be shared to accelerate implementation across the whole STP and more widely. Each model represents a locally-appropriate means of implanting an overarching, shared place-based model of care, in line with our principle of subsidiarity.

Dudley

Dudley's new care model proposes GP-led, integrated care in the community through the development of a Multi-specialty Community provider (MCP). A new approach to continuity of care and standardising access to services will provide a return on investment as it will improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve efficiency of the overall system.



Our model rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. In our model, these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley’s five localities, and the services provided on referral to secondary care. Key actions planned include:

- Develop new ways of working to support the future MCP through:
 - Successful multi-disciplinary teams across all of our 46 General Practices;

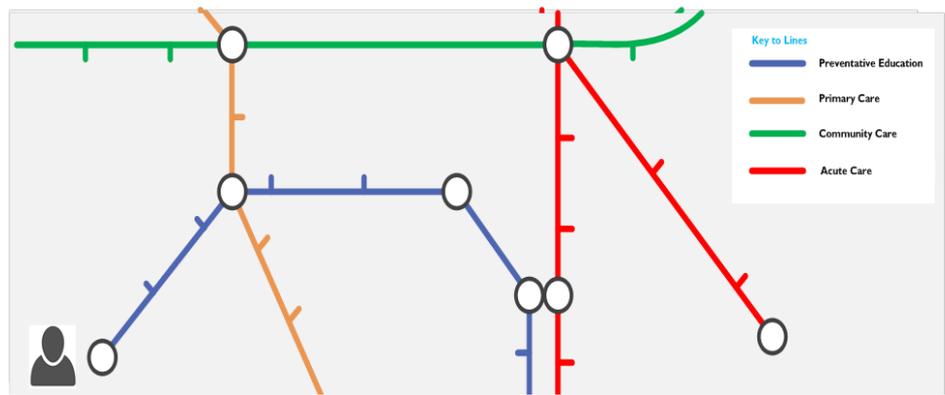
- Voluntary sector Locality Link Workers, providing access to community-based support;
- Telehealth pilots in two practices covering 34,500 patients;
- Rollout of mobile devices to all GP practices, enabling remote access to core patient systems during home visits and better coordination at MDTs;
- A new Dudley Outcomes for Health long term conditions framework;
- An IT Local Delivery Roadmap towards integrated care records by 2020;
- Scoping of services, outcomes and characteristics of the MCP.
- Award a contract for Dudley MCP early 2017/18 which includes :
 - A meaningful outcomes framework to measure improvements in population health supported by a clear and robust evidence base, transferable to other STPs;
 - Standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;
 - Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;
 - Integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community).
- Accelerate the learning from our vanguard site to implement new incentive and risk management models – long-term Whole Population Based contracts commissioning for outcomes across the STP footprint.

All of the above will be underpinned by on-going involvement and public consultation (where necessary) with local people, and we will fully engage with all staff involved in the transition to the MCP.

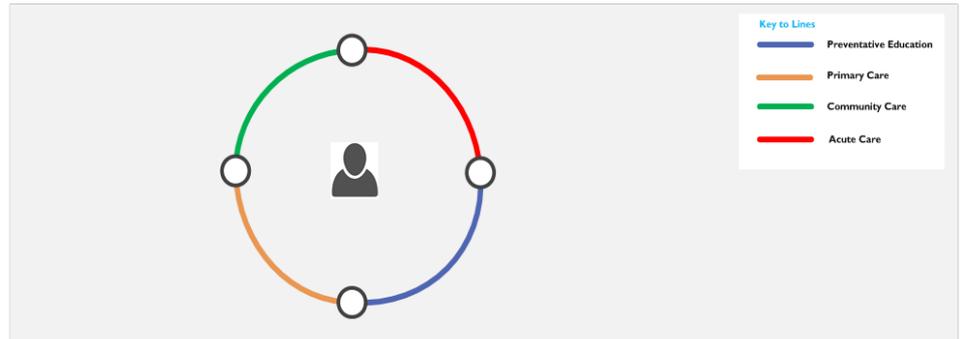
Sandwell and West Birmingham

The vision is to transition to outcomes based commissioning, which may take the form of a single, or multiple, accountable care organisations. These organisations will be accountable for both the costs and outcomes of their whole populations. The CCG will hold contracts with these organisations that will promote innovation and the delivery of effective and joined up care.

Patients travel through a system that is not designed around them, there are lots of changes and different routes and it can take a long time to the end point.



New Care Models provide the opportunity to design an approach where clinicians work together ensuring connections are made between care



Key actions planned include:

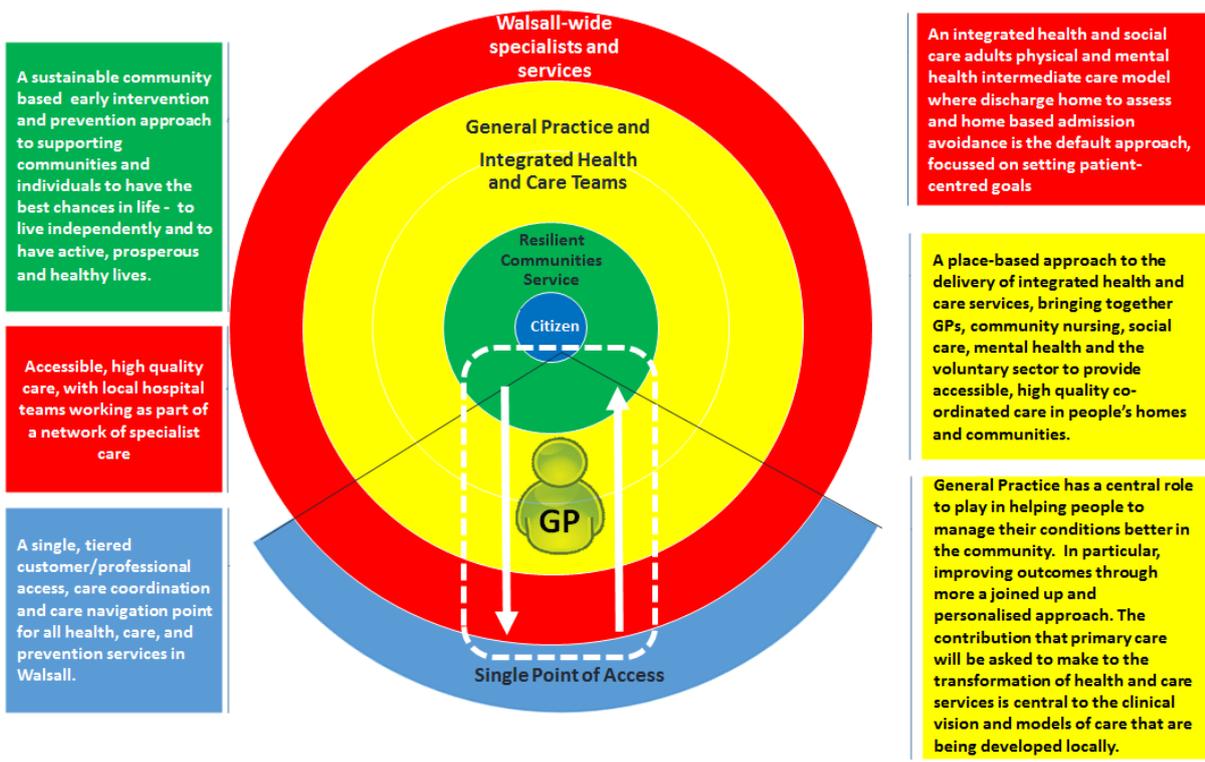
- Use the foundation of community nursing redesign and Primary Care Commissioning Framework to scope population coverage
- Develop the Whole Population Budget and the scope of services to be included
- Develop standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access
- Improve long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives
- Accelerate the learning from our vanguard sites to implement new incentive and risk management models.

Walsall

Walsall aims to develop health and care services in the community that empower children, young people, adults and older people to live happier and healthier lives. Key actions planned include:

- We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities;

- We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways. This will include urgent care services (111 service, integrated OOH, new digital technologies and single points of access);
- We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs;
- We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs; and
- We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model.



Wolverhampton

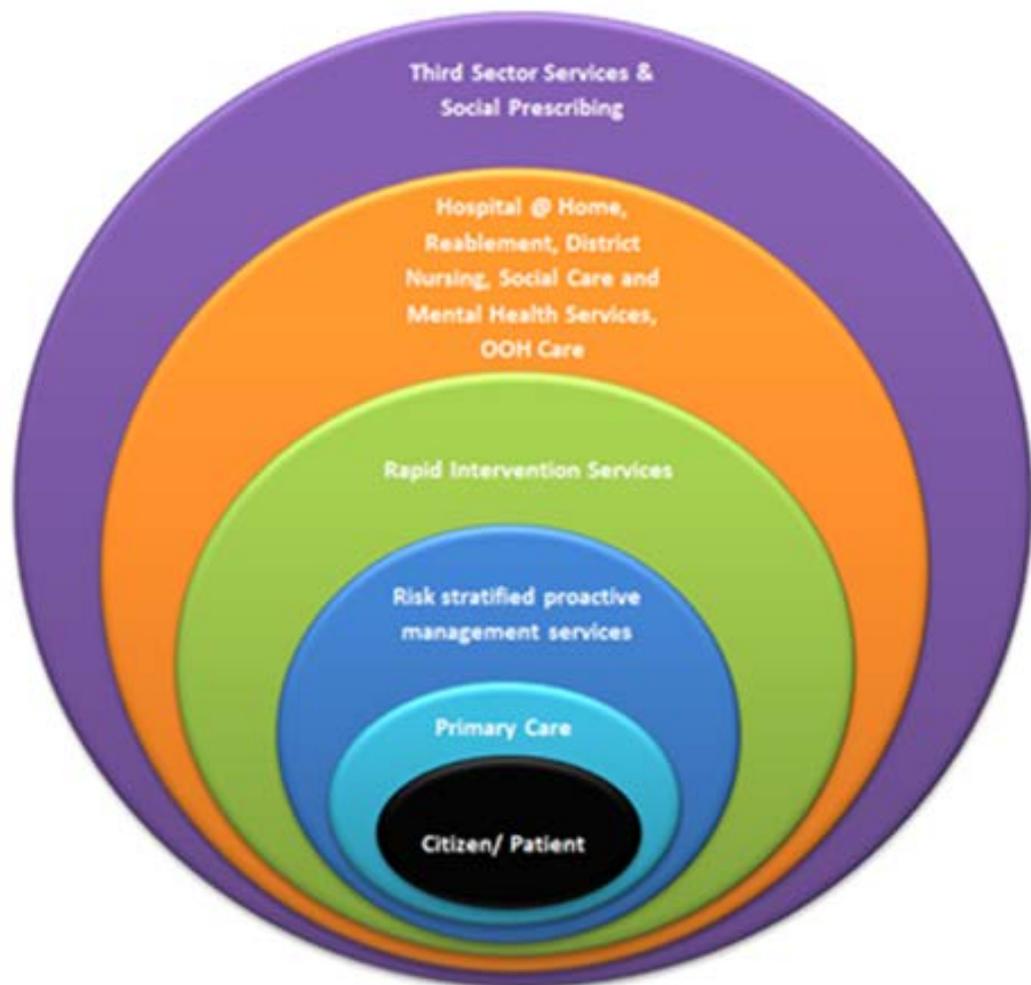
Wolverhampton CCG’s aim is to promote the health and wellbeing of our local community that is standardised & commissioned in line with the registered list(s). We will do this by learning from models of care emerging both locally and nationally – including our local Primary Care Home (PCH) test site and Primary and Acute Care System (PACS) pilot. As we move into contracting year 2017/18, it is likely that an alliance-type MCP contract will become the vehicle through which community delivered services are commissioned.

The agreed approach will focus on health and care delivery models that are in the best interests of people living in the City.

There will be a greater focus on outcomes based commissioning including those that promote independence health and wellbeing but also be responsive to the needs of individuals with deteriorating independence.

We will reduce demand on services traditionally provided in the hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment that can be achieved through shared decision making, advice and guidance and patient choice.

We will seek to ensure that our population receives the right treatment at the right time and in the right place. Care will be patient and population focused, reduce early deaths, improve quality of life of those living with long term conditions and reduce health inequalities. With Patient and GP Primary Care services at the core of the delivery model, many of the services are already in place.



Key actions planned include the development of new ways of working supported by integrated teams as the MCP or PACS model evolves, such as:

Access:

- Implement training for care navigators intercept & guide patients to the health & social care professional that best meets their needs whilst maximising social prescribing opportunities at primary care level;
- Improve access to services based in primary care including direct access to diagnostics identified through peer review, patient choice and shared decision making;
- Access to a full range of standard primary medical services during core hours and essential services 24 hours a day 7 days a week through a combination of primary care and extended out of hours service provision with access to central patient records and where feasible non face to face consultations using various media (skype, email, telephone); and
- Strengthen access to services utilising the full benefits of the new NHS 111 service, integrated out of hours, digital technologies and single points of access.

Care Co-ordination:

- Develop home based care including provision of hospital at home, community intermediate care, reablement, rapid response, therapy services and support from the third sector;
- Implementation of local strategies for Intermediate Care, End of Life, Ambulatory Care, Mental Health and Primary Care to maximise opportunities for place based care;
- Extended MDTs providing consultant outreach for diabetes, respiratory, mental health condition initially, extending a broader range of disease conditions; and
- Practices working together at scale with community neighbourhood teams that ensure coverage across the city for patients at highest risk of admission to hospital

Continuity:

- Ensure appropriate & timely support in line with our Integrated Care Strategy to support hospital discharge, prevent admission to hospital, avert potential care home admission, identify support that is suitable to meet the needs of individuals;
- Reduce demand on services traditionally provided in a hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment achieved through shared decision making, advice and guidance and patient choice; and

- Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams who are striving to achieve the same outcomes.

To support the above we will develop and implement a local Quality Outcomes Framework that seeks to achieve the highest standards of care quality, value for money & maximises opportunities for groups of practices to work at scale. This is work in progress and will be developed further with partner agencies and stakeholders.

Expected Impact

Each local area’s implementation approach will contribute to the achievement of the overall benefits required in relation to access, continuity and coordination.

To support the delivery of these benefits we have identified £34m of capital investment in primary care premises over the planning period, with a further £16m capital to support the provision of services closer to patients’ homes.

Pending confirmation of national metrics, the Black Country and West Birmingham expects its local, place-based plans to deliver the following benefits:

Category	Expected Benefit
Better Health	<ul style="list-style-type: none"> • Reduced LTC prevalence • Reduced mortality • Reduced social isolation • Increase in people dying in the place of their choice
Better Care	<ul style="list-style-type: none"> • Improved access, coordination of care, and patient experience of GP, community and other placed-based services • Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care • Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care • Minimise harm (reduce number of incident per person / per practitioner). Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation
Sustainability	<ul style="list-style-type: none"> • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Improve staff efficiency, morale, patient contact time

Efficiency at Scale through Extended Hospital Collaboration

Our provider organisations have challenging Cost Improvement Plans (CIPs) in place for 2016-17. In order to meet the ongoing provider sustainability challenge beyond 2016-17 we will enable shared learning between providers so that individual CIPs can continue to be delivered. Much more than this, however, we will deliver a scale of efficiency beyond the reach of individual providers through coordinated action to develop networked and/or consolidated models of secondary care provision. As plans continue to develop, the impact on our hospitals of any new contracting models (e.g. Dudley MCP) will also be assessed.

We recognise that improving acute hospital services may require adjustments to be made to hospital sites, and we have allocated capital investment of £35m during the planning period to support this, along with a further £3m capital relating to organisational estates efficiencies of some £10m a year.

Creating Networks of Secondary Care Excellence

Reducing Variation

We have significant opportunities to share best practice and remove variation. Our initial analysis highlighted the following service areas:

- 1) Trauma & Orthopaedics – *Better Care, Better Value* (BCBV) indicates £2.7m could be saved through reducing first to follow up ratios and £0.9m through reducing pre-procedure bed days.
- 2) CVD (Including CHD, Renal, Stroke, Diabetes Pathways) - BCBV Cardiology indicates saving up to £2.4m. BCBV Nephrology saving of £2.3m. BCBV Endocrinology saving of £0.62m.
- 3) Respiratory - BCBV Respiratory Medicine indicates saving of up to £0.9m.
- 4) Cancer – BCBV Clinical Oncology: £2.03m. BCBV Medical Oncology: £1m (specialised services changes).

We have a plan of action covering 6 phases (see table below), and these represent the sustainability challenge which is amenable to shared actions by the relevant organisations. Together they amount to a major programme of concerted change. We will build from extant clinical leadership arrangements to see it through and ensure learning from other systems that are ahead of us.

We already have networked services in a number of areas – radiology, ENT, rheumatology, vascular surgery, and stroke. By ensuring that all services supporting acute care operate to common standards we will tackle variation. By 2019 we will operate 4 A&E departments, ranging from 75k to 150k attendances in each. To succeed we may need to share expertise

and increasingly to develop rotational programmes of learning and staffing across those sites. All 4 sites will have to deliver for us to succeed.

Phase	Deliverables
A1	Develop single service plans for less-acute surgical disciplines: including plastics, ophthalmology, and urology.
A2	Complete extant work to get shared pathology vision including rationalisation of histopathology.
B1	Develop shared collaboration plans for paediatric services on a network basis.
B2	Create collaboration model of providers to support acute general surgery across 4 A&E departments
C1	Develop shared service plan for orthopaedics, based either on sub-specialised rationalisation or service relocation.
C2	Establish shared maternity and neonatal model of care to meet CQC / RCOG guidance.

Service Sustainability

In addition, we have commenced a review of specialties and/or sub-specialties that face sustainability challenges and there may be opportunities to consolidate volumes. These include:

- **Rheumatology.** We have already well advanced discussions regarding Rheumatology service, unsustainable in Walsall due to small size of service making recruitment and retention of consultant rheumatologists really difficult. As a result of our network approach, we have collectively made available short term resources to sustain the service, and have been successful in recruiting 3 consultants who will join later this year. This will lead to a reduction in locum spend in the second half of the year. RWT already provides Rheumatology services for a large part of Staffordshire as well as Wolverhampton.
- **Urology.** While all Trusts have sustainable Urology services, this is a great example of where we have moved on to consider clinical and financial sustainability at a sub specialty level. Having comprehensively mapped services at a granular level, we are now defining specialised service pathway changes to consolidate volumes in particular areas. These will maximise certain consultant interests and make the best use of out of expensive treatment platforms. Discussions are taking place to widen this work to incorporate all Trusts within the Black Country and West Birmingham.
- **Neurology.** We have established a multi-disciplinary team to explore how we might improve sustainability of neurology services across the Black Country and West Birmingham. As well as exploring joint consultant posts to sustain current services, we are exploring together how we might make better use of sub specialty skills, how we might develop workforce to increase the provision of Nurse led services (MS, Complex Headache, Epilepsy) which in turn will we believe reduce pressure and

demand for acute, consultant led FU clinics. WHC is addressing current recruitment difficulties through a joint arrangement with UHB.

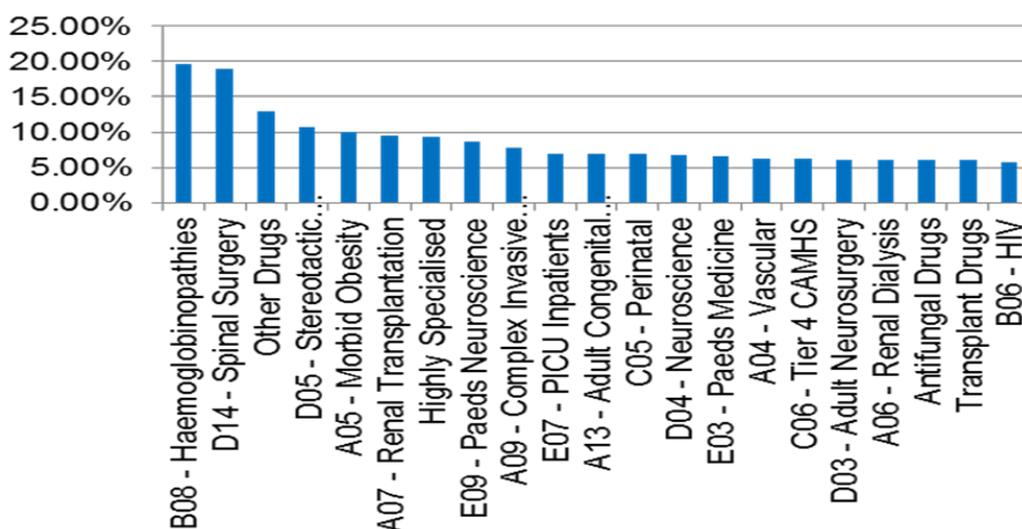
- **Out of Hours / 7-day services.** All Trusts are examining implementation of the four key standards by March 2017, RWT being an early implementer of these standards, and together we have begun to explore the opportunity to collaborate on closing 7-day service gaps and provide better out of hours cover. We have already established a joint rota for non-vascular interventional radiology (nephrostomy) and will examine extending to other areas. We will explore other areas where more specialised / lower volume services may benefit from a networked approach, for example ENT and Plastics and in particular, breast reconstruction.
- Other areas include Upper Limb Trauma, Cardiology, Audiology, Children’s and Community Services. We will also explore replicating some services across the path and scaling some services, both of which will enable improved clinical and financial sustainability.

Specialised Services

Certain services are commissioned directly by NHS England rather than through local CCGs. To support the integration of pathways and the devolution of some specialised services it is proposed that a Specialised Commissioning Board will be established for the West Midlands.

Midlands and East Specialised Commissioning will work with the Black Country and West Birmingham STP to plan for the development of new models of care to support specialised services. Over the five years of the STP this will involve looking at what is the appropriate level of planning and delivery for individual specialised services. Central to this process will be the development of networked models of care that allow geographically dependent services to be managed by Tier 1 and 2 providers.

The table below illustrates the demand and cost challenges faced in relation to fastest growing specialised services in the Black Country and West Birmingham:



To address these challenges in the current year, the West Midlands Specialised Commissioning hub has a QIPP target of £36.3 million. Schemes are split between 70% transactional and 30% transformational with 90% of these being local schemes and 10% nationally identified schemes. QIPP plans for 2016/17 are currently forecast to deliver a balanced plan. Moving into 2017/18, The QIPP target for the West Midlands in 2017/18 is: £36.9 million Schemes will be split 60% transactional and 40% transformational to reflect the national drive towards more transformational, whole system change. The proportion of this QIPP for the Black Country STP based on presumed population split is £9.23m. These plans are also expected to affect the STP’s other Transformation Groups, as indicated in the table below:

STP Transformation Group	Specialised Commissioning Transformation Project		
	National	Regional	West Midlands
Local Place-based Models of Care			Spinal Pathfinder/ Future contracting at Level 1 and 2 providers
Extended Hospital Collaboration	Cancer Alliances	Vascular Review	Neonatal Review
Mental Health & Learning Disabilities Services	Transforming Care Mental Health Service Review		Adult Secure ACO CAMHS ACO
Maternity & Infant Health			Neonatal Review

Efficiency in Clinical and Non-Clinical Support Services

Pathology

The four integrated care trusts within the Black Country STP all currently provide a full range of pathology services covering inpatients, outpatients and local community GPs, both hot & cold, that include microbiology, histopathology, blood sciences, immunology, anticoagulation and clinical haematology. All departments are CPA accredited and are currently going through the UKAS accreditation. The Blood Banks have MHRA accreditation and the mortuaries hold HTA license for scheduled activities. All Trusts have in existence or are committed to entering into Managed Equipment Service arrangements which may constrain timing of consolidation. All 4 trusts will require continued access to 24/7 hot lab capabilities regardless of any other consideration.

The Black Country STP sets out a simple triple aim to improve health outcomes, healthcare experience and make the best use of the resources we have. We have an ambition to offer a first class UKAS, MHRA, HTA accredited pathology service across the Black Country and West Birmingham that ranks in the top quartile nationally on a range of quality, efficiency and outcome measures. This will include speed of access to results for inpatients to enable

earlier decisions on treatment and so reduce length of stay (LOS), improved turnaround times for all pathology tests and appropriate out of hours coverage to reduce 7 day service gaps.

We believe that IT will be an enabler to integration of services. Currently 3 of the four trusts use Sunquest ICE for requesting and results view. A common system would allow for sharing of results across the Black Country and West Birmingham. The procurement of a common LIS would allow the laboratory services to further integrate and create a virtual laboratory, which would be an enabler for further change; however this would require significant investment. All four trusts currently provide the full range of District General Hospital (DGH) pathology services locally along with some more specialist work for a larger area. The wider STP service strategy for the Black Country and West Birmingham commits to maintaining four acute sites (five currently – four following the opening of Midland Metropolitan Hospital), and so any solution proposed must be cognisant of and consistent with this baseline.

We are examining the case for a shared molecular laboratory and explore together Digital Pathology to support specialist and sub specialist reporting, improved (virtual) multi-disciplinary team (MDT) provision and deliver efficiencies from use of latest technologies. We believe this will enable some of the work we are doing across a range of services at a sub speciality level which we believe is a core part of the route to clinical and financial sustainability.

We have already established a team comprising clinical and operational colleagues who are currently working on collaborative solutions to the sustainability of Histopathology and Microbiology services initially. Initial focus has been on service level agreements (SLAs) to stabilise services and enable some joint recruitment to reduce locum demand and improve resilience.

We have commissioned an independent expert review of our pathology services. Trust Chief Executives have identified a suitable, credible, expert (Dr Mark Newbold) who is undertaking this work, and Terms of Reference have been agreed by all four Trusts. The STP has engaged fully with the national process around pathology integration.

All four Trusts are committed to considering all options that will lead to clinically and financially sustainable pathology services. All options will be fully considered. While examining various design principles and being open minded on solution options, we will in the meantime continue to build out on extant plans and focus on the functional changes that will enable sustainable services across the patch. Our review will include examining successful models from elsewhere as well as learning from unsuccessful lab mergers. Our outline plan is as follows:

- November – December
 - Build options and assess case for each, mobilise quick win delivery
 - Determine preferred option(s)

- Q1 2017
 - Deliver quick wins
 - Build detailed plan and business case for detailed options
 - Sign off business case
- Q2 2017 – Delivery / transition

Together in addition to the ambitions outline above, we will examine the case for further development of Managed Service Contracts (MSC) to allow new technologies to be introduced and more efficient procurement of consumables. We will accelerate possible consolidation of some referred tests to enable critical mass to be achieved to drive short term savings, and we will examine opportunity for consolidation of out of hours cover, i.e. Microbiology, as a route to short term benefit.

In seeking to move at pace and scale to realise maximal efficiencies in clinical support services, we are also mindful of the risks involved, including:

- The pace of change may be constrained by the financial and intellectual headroom to focus on planning and delivering the above at the same time as continuing work on STP, local vanguards, CIP and of course, seeing & treating ever increasing numbers of patients;
- As in other examples across the country, rushing to consolidate services may create more problems than are solved;
- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change;
- Consolidation may have adverse morale impact on leaders & teams, which may lead to deterioration in service levels if colleagues leave as a result;
- Reconfiguring the use of PFI space for labs across the patch may lead to expensive change; and
- Pathology consolidation that is undertaken without full clinical engagement and without consideration of clinical strategy or which is not in alignment with patient pathways can result in (inter-provider) confusion, disruption in patient journey, delay in patient management, poor patient experience, transmission mistakes, repetition of tests with waste of resources, overall deterioration in quality of service and/or other clinical risks.

We believe we could mitigate the risks above and go further, faster if our work is supported by:

- Provision of national exemplars where consolidation was conceived, planned, delivered and sustained;
- Funding to increase project management office that can provide cohesion, grip and drive to accelerate the work;
- Funding for enablers that are identified during the assessment and planning phase of the work above. Examples being the technology to enable interoperability, digital reporting and molecular capability;
- Clarity on prioritising the sometimes conflicting requirements - short term versus long term targets; run rate reduction versus investment required to achieve; increase staffing to achieve Care Quality Commission (CQC) standards versus pressure to reduce staff to meet financial targets; quality versus value; pace versus perfection; and
- Time to make the changes in a considered way, building on extant initiatives like the Black Country Alliance, to enable change to be made in a positive way that will be sustained and deliver long term clinical and financial sustainability rather than rushing to drive short term impacts that could unwind and cause more harm than good.

Back Office Functions

There is a broad range of back office service delivery across organisations within the Black Country and West Birmingham. The CCGs have differing levels of outsourcing already in place through Commissioning Support Units (CSUs) and other providers (particularly for payroll), alongside in-house provision; and Providers and Local Authorities largely have their services delivered by in-house teams and, in some cases, themselves deliver services to other organisations.

It is recognised that this will primarily focus upon the health partners of the STP, although Local Authority partners are active in the discussions and may contribute to some of the solutions which may be considered. Discussions already taking place across organisations have identified enthusiasm for delivering transactional excellence, driving efficiencies and sharing best practice to enable improved resilience and reduce reliance on temporary staffing. The trusts have been transparent in indicating that the delivery model for those services is open to determination, and are similarly clear that the journey of improvement and any new collaborative delivery model – in-source, joint-venture or out-source - has to start with resolving and aligning extant processes, procedures and their underpinning systems. Out-sourcing a problem will simply add to costs. Rushing to consolidate may simply incur transactional costs and raise concerns among those impacted without having a clear route to value.

By working at scale across the STP, there is significant potential to integrate the non-clinical support services across both provider and commissioner organisations. Building on the early work of the Black Country Alliance (BCA), we will review key back office functions to verify the level of efficiency that is achievable. We believe (supported by the Carter Review and the experience of CIP schemes in individual local organisations) that there is greatest potential in the following areas:

- Payroll services
- Support Staff employment models
- Procurement, Human Resources (HR), telephony and legal services
- Common call centres
- Licensing of telephones, IT applications etc.
- Hotel services.

Our ambition is to move swiftly to identify which services may benefit from further collaboration, including an assessment of which service may be consolidated in 2016/17. In April 2016 the BCA Board established a comprehensive programme of work covering all back office functions across the three trusts. We are now devising a broader STP programme plan for services in 2016/17 and over the coming years (as some services are already under contract terms).

We have agreed the following principles:

- The efficiency we need by 2019 goes beyond what any part of the STP currently delivers, simply being among the current best is not good enough;
- Aggregation is not guaranteed to drive value - to get 'value' we know we need to know what we want and we will use a variant of our triple aim to guide us;
- Local employment matters and pay rates matter, we are not simply seeking the lowest possible cost model or we would, typically, outsource abroad;
- We recognise the potential to work towards a single 'virtual organisation' should the evidence support that but, first, we aim to build more securely on existing partnerships whilst keeping under review the opportunity for further consolidation;
- We approach this with a view to exploring closely the benefit of having strategic leadership across some of our functions, and in terms of opportunity to share transactional services. However, we are also mindful of the transactional costs associated with transitioning to shared service models, and the risks of impacting outcomes & experience of the service through disruption;

- We believe local business partnering and presence will continue to be a feature of most services; and
- We will seek where possible to ensure all organisations have an opportunity in this area, which enables broader engagement, capacity and will to take the work forward.

The first six-month wave of projects, mobilised in April, is reviewing potential for collaboration on a range of HR enabling processes including our use of Electronic Staff Records (ESR). We plan to reduce agency spend by working together on temporary staffing and administration, moving toward consistent admin, systems, processes and rates to establish a Black Country and West Birmingham Bank which will we think significantly reduce Agency spend. We are reviewing Clinical Coding, Information Governance, Legal Services, Research Governance, Contract Management and Procurement. Second phase will begin in October and will cover energy procurement, complaints handling, medical illustration / communication, emergency planning, mandatory training, disciplinary and conduct investigations, debtors and claims, safeguarding and recruitment.

As we mobilise a broader STP-wide programme to explore options, we will consider the merits of various delivery models, but will continue to focus in function rather form as we do so. Forms we may assess include but are not limited to:

- Use of CSUs to deliver across both CCGs and Providers
- Creation of an entity owned by the NHS bodies to deliver services to all partners
- Use of multiple providers to deliver services to NHS bodies

The quality and operational benefits will be assessed over the coming months but the following benefits are expected:

- Consistently high quality levels of service and improved resilience for those services, reducing the demand for temporary staff.
- Standardisation of service leading to fewer errors and improved efficiencies associated with fewer systems and economies of scale.
- Opportunities for more specialised level of service to be financial viable across a wider range of bodies
- Standardised ledger will lead to efficiencies in organisations, e.g. annual accounts process
- Potential for improved career opportunities for staff working in larger functions.

In advancing these plans, we are mindful of a range of issues and risks:

- Existing contract arrangements may be an impediment or delaying factor. CCGs in particular have recently entered into contracts with CSU providers. Consolidation may require termination payments, degrading the value for money case;
- In order to minimise risks of service disruption, a phased approach will need to be developed. Potential for consolidation may have adverse impact on morale that may lead to deterioration in service levels;
- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change.

These risks would benefit from the same mitigations proposed in relation to clinical support services.

Midland Metropolitan Hospital Development

This project develops a new acute hospital and A&E department, merging two District General Hospitals into one – with associated community infrastructure – by October 2018.

Existing acute services are not sustainable: 60% of ED consultant roles remain vacant, and 50% of SWBH acute physicians; and Two-site services are not able to meet Keogh standards. Half of the Unitary Payment for the new hospital will be met through single-site efficiencies in staffing, including rotas. The Trust will be able to eliminate much of its medical agency bill which is one of the highest in a metropolitan area in the country. Acute bed capacity in the STP will then be within a range of 2.0-2.75 per 1,000 resident population. According to the NHS Confederation², the UK has 2.8 hospital beds per 1,000 people in 2013, compared to 8.3 in Germany, 6.3 in France, 3.1 in Denmark, 3.0 in Spain and 2.8 in New Zealand. Key to succeeding will be flexible capacity in intermediate care through existing arrangements and through our work on nursing home provision.

Capital investment will be required for additional ED attendances expected following the catchment changes of Walsall when MMH opens. The capital, which forms part of the Trust's investment planning, will be required to upgrade ED facilities on the Manor site together with additional inpatient facilities.

Commissioning for Quality in Care Homes

We have identified a number of opportunities for improving the commissioning of care home services across the Black Country and West Birmingham.

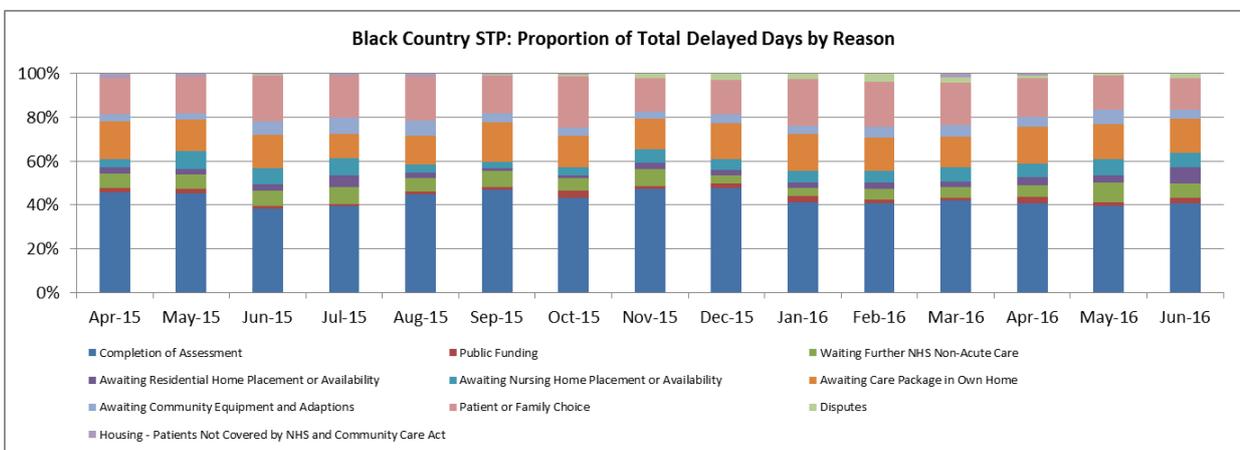
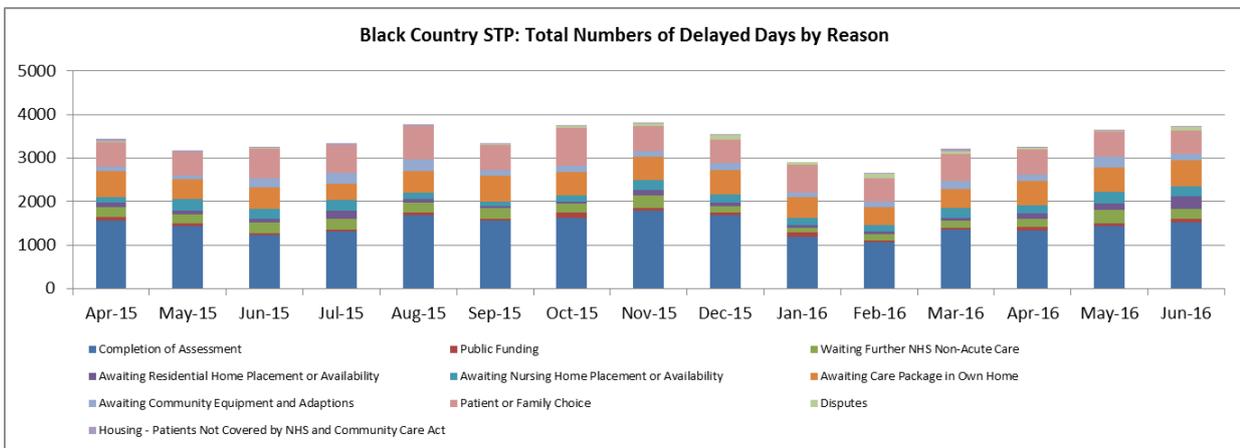
In their role as lead commissioner, Local Authorities will work with CCGs to explore how commissioning, such as enhancing primary care, can enhance the quality of services. This will

² <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>

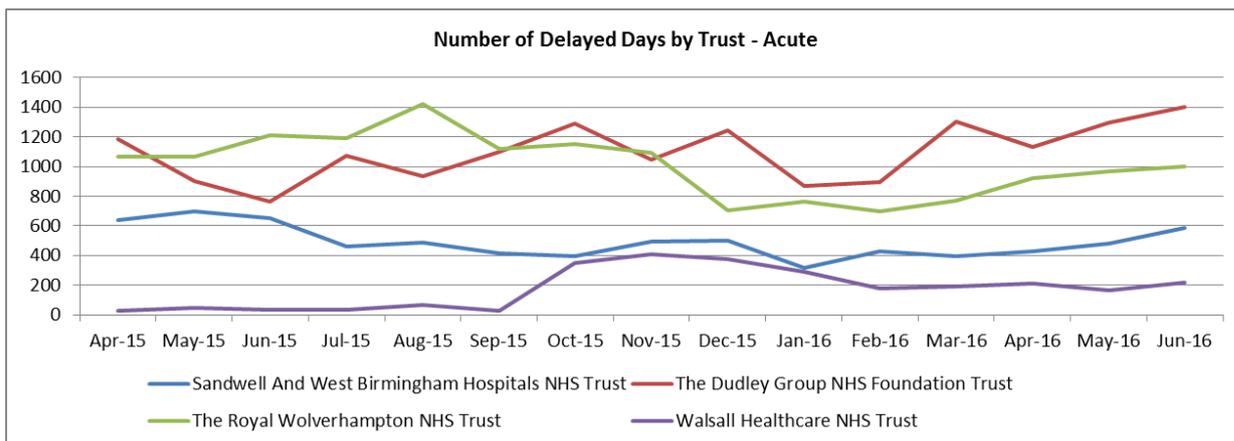
build on work initiated by the West Midlands Association of Directors of Adult Social Services (ADASS) which is completing a region-wide analysis of residential and nursing home provision. The WM ADASS has undertaken a West Midlands-wide analysis of residential and nursing home provision. Data analysis can be made available on an STP-footprint and will be commercially sensitive. Councils already have responsibility for market-shaping and a workstream is underway. This will help us improve our health and social care system.

This will cover a wide range of care and support that adult social care commissions, such as residential and nursing care, care in the home, personal assistants, day opportunities, and more. It is important that, as care and health commissioners work closer together through this plan, we understand the impact of commissions on the market place so that we are moderating the costs of care across the boundaries of health and care, and across geographical areas. At present each commissioner will pay differential rates for the types of “placements” that they purchase. We can maximise the ability of new opportunities to commission and procure together for the best outcomes for people and for the value of the public purse.

There are also opportunities to reduce delayed transfers of care (DTOCs) from acute settings through improvement in the provision of care home services. The following tables summarise the causes of these delays:



An analysis by acute provider demonstrates variation across the STP:



In addition, we have modelled the potential for reducing spells and costs for Black Country and West Birmingham Patients aged 65+ who are in receipt of packages of care (residential or nursing home plus CHC services). By extrapolating detailed analysis undertaken for Dudley CCG across the Black Country and West Birmingham, we estimate that standardising models of care in relation to care packages could save around 3,000 spells and £7m p.a. (acknowledging the likelihood of double counting across areas of care).

Estimated Avoidable Activity and Costs	Spells	Cost
Readmissions within 30 days of discharge	660	£1,851,240
Falls related	660	£1,628,790
Frail Elderly - Usually managed elsewhere	544	£1,192,482
Ambulatory Care Sensitive - Vaccine Preventable Conditions	218	£699,049
Frail Elderly - Occasionally managed elsewhere	232	£655,449
Ambulatory Care Sensitive - Chronic Conditions	251	£593,175
End of Life Care long	104	£348,880
Ambulatory Care Sensitive - Acute Conditions	99	£209,548
End of Life Care short	101	£187,308
Zero length of stay, no procedure, discharged alive - adults	344	£174,036
Medicines related	55	£133,893
Medically unexplained symptoms	58	£69,355
TOTAL	3,324	£7,743,205

The main key to improving care home provision lies in the re-design and enhancement of community-based provision. This model can be complemented by effectively improved services across a continuum from re-ablement, ‘step down’ and care home services. Effective commissioning of community-based services is a first principle which needs to underpin the approach to use of care homes.

Effective Delivery of Cost Improvement Programmes

In order to deliver the existing Cost Improvement Programmes of our organisations (including Carter efficiencies, LOS reductions, and workforce re-design), we have agreed a set of key actions;

- Ensure PMO arrangements within Trusts are robustly supported;
- Align extant CIP plans with emerging QIPP delivery plans to re-confirm no double-count positions;
- Ensure STP programme office familiar with local schemes to avoid risk of re-counting planned local supply side efficiencies; and
- Track demand side efficiencies to ensure income impact is matched by real costs change.

Three quarters of our hospital-linked providers delivered surplus plans in 2015-16. Each has a CIP programme for 2016-17 of 2-4.5% for coming years, and has agreed STF financial control totals. Explicitly co-operating at scale will deliver added savings value beyond changes in organisational form.

We plan to:

- Scope a commercial offer to GP practices and other 3rd parties
- Explore NEWCO employment models
- Contract out provision through bulk STP-wide opportunities
- Model benefits of merging call centre functions (including LA on-call)
- Software licence definitions and license pooling opportunities
- Mobile phone & pager contracts
- Examine the distribution, cost profile and funding of hotel services; opportunities for joint sourcing or supervisory opportunities; and benefits of single pan-Black Country and West Birmingham provider etc.

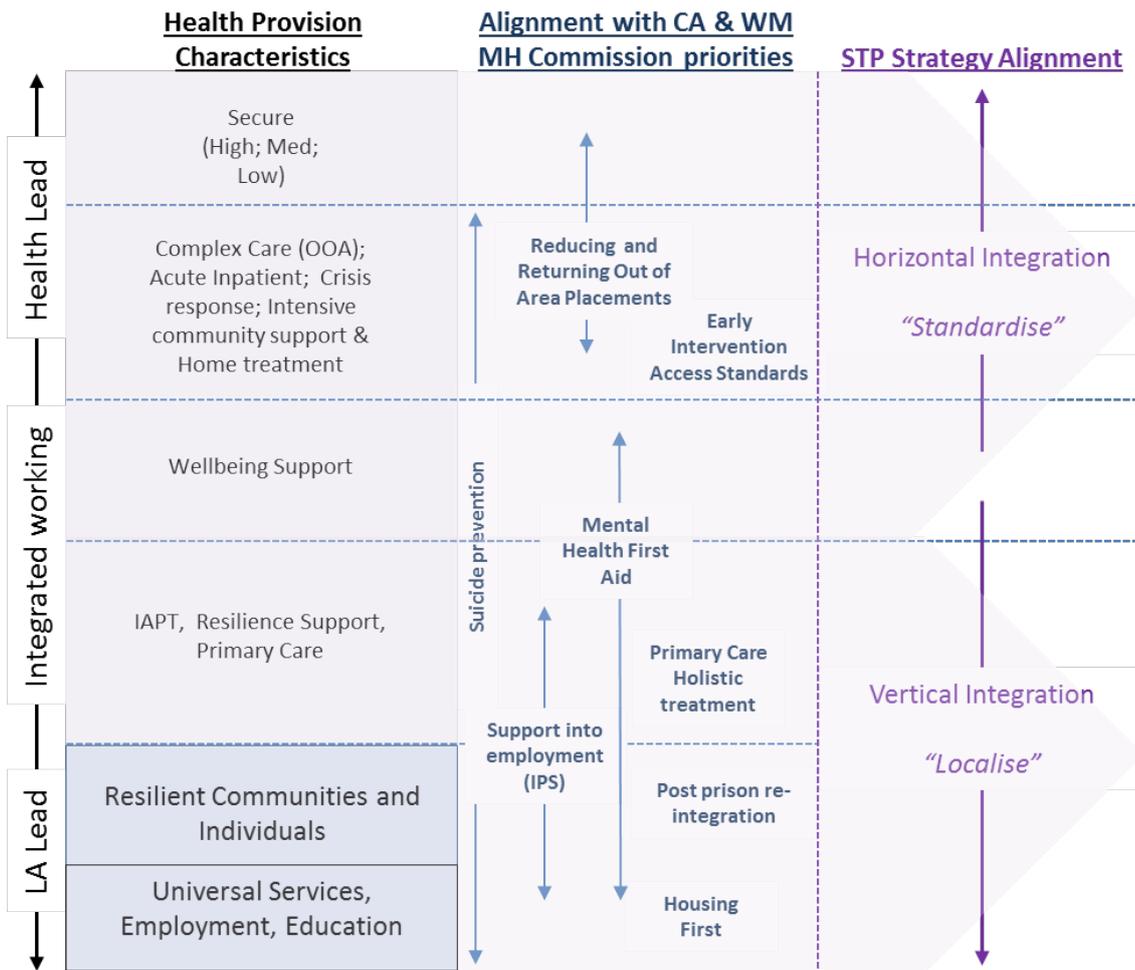
Improving Mental Health and Services for Learning Disabilities

Become One Commissioner

Our CCGs propose to operate as ‘one commissioner’ across the Black Country and West Birmingham, leading to a substantial reduction in the current unwarranted variations in the quality of care, standardised services, and the creation of an environment in which our providers can maximise resources and workforce through better skill mix utilisation. This will build on the Transforming Care Together (TCT) partnership vision to create synergies and improve the experience of Black Country and West Birmingham residents affected by Mental Health and Learning Disabilities (MHLD). By sharing best practice *and* aligning to the work of other agencies we will reduce variation; improve access, choice, quality and efficiency; and collaborate to develop new highly specialised services in the Black Country and West Birmingham (e.g. Children’s Tier 4, secure services and personality disorder services).

By agreeing common specifications and models we will develop standardised and potentially more cost effective solutions, and minimise service variation, including putting in place a recovery model that supports people to avoid crisis and manage their own care as much as possible, whilst supporting them at times of need. This will reduce role duplication, streamline service management and allow investment in front line staff development and up-skilling. Additionally, there are opportunities to develop this across the West Midlands through the work in the MERIT vanguard (Mental Health Alliance for Excellence, Resilience, Innovation and Training). Overall, this approach to harmonization and standardisation will:

- Simplify access to services improving health and wellbeing for users, families, staff and communities;
- Put in place common, responsive and standardised all age Early Intervention services;
- Combat variation in care and service delivery across the Black Country and West Birmingham;
- Ensure clear, simplified pathways for users, ensuring most effective use of resources;
- Achieve economies of scale for providers and reduction of duplication; and
- Improve utilisation in front line services through better skill mix usage and reduction in temporary and locum costs.



Principles

- Parity of esteem for mental and physical health
- Collaboration/partnership
- Co-production
- Standardisation of core specifications: single model/pathway/specification: specialized and acute services
- Locally designed community services based on a core model/pathway
- Evidence based commissioning
- Maximise resource use: financial/workforce/estate

Build the Right Support for Learning Disabilities

The Black Country and West Birmingham Transforming Care Partnership (TCP) is a partnership of local authorities, CCGs and NHSE (Specialised Commissioning) working together to deliver the vision set out in Building the Right Support and the National Service Model. The partnership enables the TCP to build on existing collaborative commissioning arrangements, facilitate improved local health economies of services for people with a learning disability and/or autism, and to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for relatively small numbers of people whose packages of care can be very expensive and difficult to procure and monitor in isolation.

We aim to deliver ‘Building the Right Support’ (the National Plan) across the STP footprint, to reduce reliance on inpatient care by 62% within 3 years, to improve quality of outcomes for people with learning disabilities and/or autism through the development of standardised outcome measures, care pathways and clinical services.

To date, as part of meeting the vision of TCP, ten inpatient beds have been decommissioned, with consultation currently taking place regarding the proposed closure of one Assessment and Treatment hospital; dependence on inpatient services has reduced by thirteen 13 beds (12%) across CCG and NHSE commissioned beds over the last six months; an Intensive Support Service has been commissioned as a pilot in Wolverhampton (2016) with a view to sharing learning across the footprint (January 2017); and revenue funding has been awarded from NHSE (£380,000).

Improve Bed Utilisation and Stop Out of Area Treatments

Inpatient provision is a key part of the whole system in support of people’s mental health and wellbeing. It is resource heavy, but is only appropriate for a minority of people in contact with mental health services. Our ambition is to ensure that patients receive hospital care only when their health needs require it by commissioning appropriate consistent crisis services across the Black Country and West Birmingham. When admission is required it is (where possible) within the Black Country and West Birmingham ensuring that links are maintained with local support networks. We will determine the optimum bed requirement for existing services provided by NHS providers, which should support development of new highly specialised services.

We aim to retain Black Country and West Birmingham funding in the STP to deliver the right care in the right place for service users, working across current NHS providers, ensuring the right capacity of beds to meet the demand (numbers and service type). Although bed day costs are unlikely to deliver savings, efficiency should be delivered through reduced length of stay from strong local partnerships with social care, housing and family. This should reduce cost for Commissioners through existing out of area placements (savings only for services that can be provided from existing skilled staff). It will improve sustainability to existing providers by improved utilisation and profitability of inpatient units.

Deliver the West Midlands’ Combined Authority Mental Health Challenges

Mental Health is an important issue nationally and in the Black Country and West Birmingham. The level of employment for individuals with mental health issues is significantly lower than the employment rate in the population.

In the Black Country and West Birmingham, the rate of employment for people with mental health issues is lower than the national average, and is particularly low in Wolverhampton.

Assuming the Black Country and West Birmingham could achieve the employment rate for people with mental health issues achieved in England (adjusted for the overall lower employment rate in the Black Country and West Birmingham) then an additional 4,000

people with mental health issues would be in employment in the Black Country and West Birmingham. At average full-time employment wage rates in the Black Country and West Birmingham, this would equate to an additional £100m of income less reductions in benefits.

Employment of individuals with mental health conditions, 2015³

	Number of people with mental health issues employed	Employment rate for people with mental health issues	Employment rate for whole population
Dudley	4,000	23.3%	69.5%
Sandwell	5,900	39.5%	70.2%
Walsall	4,200	28.2%	63.0%
Wolverhampton	2,600	21.7%	66.3%
Black Country	16,700	28.3%	67.5%
England	1,088,433	39.1%	74.2%

Labour Force Survey, Taken from the HSCIC indicator portal

Data is available for the number of people claiming Disability Living Allowance (DLA). This is presented below and shows that the percentage of the population claiming DLA in the Black Country and West Birmingham is similar to the national average. Using an average DLA payment of nearly £75 per week, the annual payments in the Black Country and West Birmingham are estimated to be nearly £44 million.

Disability Living Allowance claimants and payments for mental health issues in the Black Country, 2015

	No. of claimants (16-64)	% of population	Weekly value of benefits (£000)	Annual value of benefits (£000)
Dudley	2,615	1.4%	196	10,172
Sandwell	3,358	1.7%	251	13,060
Walsall	2,633	1.6%	197	10,240
Wolverhampton	2,618	1.6%	196	10,181
Black Country	11,223	1.6%	839	43,653
England	550,760	1.6%	41,199	2,142,333

ONS mid-year population estimates, DWP benefits claimant data

³ This uses quarterly data. Data for 2015 Q2 was unavailable for Walsall and Wolverhampton, therefore the 2015 average is an average of Q1, Q3 and Q4 for all areas

Research suggests that employment and work is beneficial to mental health (Waddell and Burton, 2006). This improvement in health has a positive impact on the health service (as patients require fewer treatments) and can also help to move people off welfare payments, which is beneficial to the Government. If more people with mental health can return to employment then it will also improve the productive capacity of the Black Country and West Birmingham area.

The West Midlands Combined Authorities Mental Health Commission, chaired by Norman Lamb, has identified a series of 'Health delivered' interventions for the Combined Authority's regeneration programme. Just as economic success underpins Mental Health, good Mental Health ensures employability and underpins regeneration. For the programme to be successful, the strong relationship between these drivers needs to have firm foundations, working collaboratively across the Health and Local Authority Commissioning and Provisioning organisations.

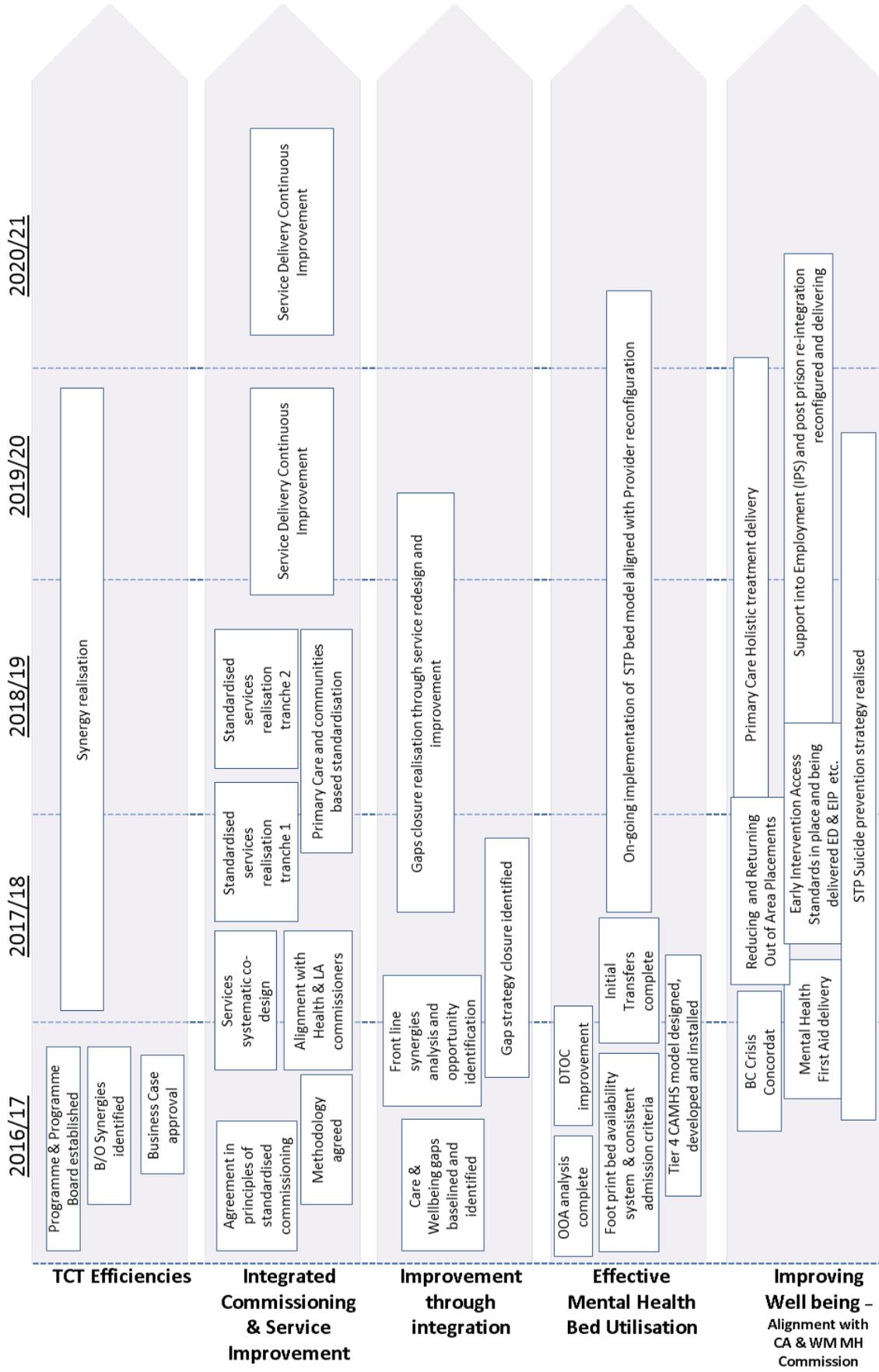
Deliver Extended Efficiencies through Transforming Care Together Partnership

Our vision for the Transforming Care Together (TCT) partnership is based on harnessing the strengths of three high performing NHS organisations, with uniquely aligned services (mental health, learning disability and children & families), to create synergies that will benefit our communities, our staff and our stakeholders. This specific opportunity will focus on harnessing efficiencies, best practice and sustainability by streamlining corporate and back-office services and infrastructure (IT and estates in particular).

By combining our corporate and back office functions, we hope to achieve significant efficiencies to support our future plans for clinical service transformation. The rationale is based around achieving economies of scale, reducing duplication, better management of pan-partnership roles and harmonising of policies and procedures.

Our overall delivery plan for Mental Health and Learning Disability Services is shown overleaf. It will be supported by £10m in capital investment to enable the changes to our estates required for service transformation.

MH STP Delivery Timeline

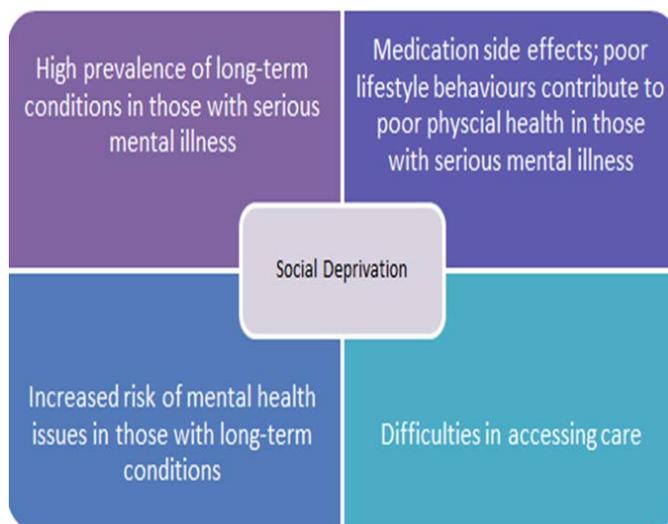


Identifying and Addressing the Physical Health Needs of Mental Health Service Users

In addition to our established Mental Health and Learning Disability projects, the STP has commissioned analysis of how mental health service users’ experience of physical healthcare services may vary from that of the rest of the population. That analysis is summarised below and we now aim to work with partners (service users, carers, and the West Midlands Combined Authority) to identify how best to respond to the challenges identified.

The health outcomes of individuals with mental health problems often fall short of the outcomes of the background population. Furthermore there is evidence that mental health service users present at acute hospitals in times of crisis. There are a number of factors that help to explain this:

In 2011 the Government launched its mental health strategy, *No Health Without Mental Health* (HM G, 2011) setting out its vision for mental health services to deliver on par with those for physical health. Building on this strategy the Mental Health Taskforce developed *The Five Year Forward View for Mental Health* (NHS England, 2016) which identified three key priorities;



- A 7 day NHS – right care, right time, right quality
- An integrated mental health and physical health approach
- Promoting good mental health and preventing poor mental health

New analysis commissioned by our STP from the Strategy Unit has found the following:

- The life expectancy of men in contact with mental health services in the Black Country and West Birmingham is 17 years lower than the rest of the male population. For women the gap is 14 years. This life expectancy gap, consistent with other international studies, is long standing and has closed only marginally since 2006.
- Mental health service users experience higher mortality rates across all major disease groups. Whereas cancer is the leading cause of death for the population as a whole, circulatory disease is the most common cause of death for mental health service users.
- Approximately 1 in 5 of all A&E attendances and emergency admissions relate to mental health service users whose A&E attendances and emergency hospital admission rates are three times those of the rest of the population.

- Outpatient DNA rates run at almost 15% for mental health service users; considerably higher than other patients and rates of diagnostic imaging are almost twice as high among mental health service users as the rest of the population.

The analysis also identifies opportunities for improving care for mental health service users:

- The STP could save up to £1.9m in A&E attendances and up to £17.7m in inpatient care, by reducing mental health patients' hospital activity, in subgroups which may be amenable to commissioner based QIPP schemes, to the same levels as the rest of the population. In practice, reducing acute healthcare utilisation of mental health service users to that of the rest of the population may not be wholly attainable, and clinical advice will be required concerning what is realistically achievable for each condition.
- Compared to England, the STP overall has higher utilisation for many of the opportunity subgroups. Patients conveyed by ambulance to A&E but discharged following no investigation and no treatment, frequent A&E attenders and patients admitted for self-harm are the exceptions to this.
- The overall mental health cohort had higher utilisation for each opportunity than the non mental health cohort. Almost without exception, those with cognitive impairment have the highest relative use of acute services of all mental health patients for all sub-groups of activity.
- The largest single potential saving (£16.7m) for the Black Country and West Birmingham is estimated to come from reducing admissions for those attending A&E with a primary diagnosis of mental health. The extension of psychiatric liaison services may impact on multiple opportunities – e.g. reducing admissions for mental health issues, self-harm and medicines adherence.
- These potentially avoidable hospital admissions represent an opportunity cost. Targeted investment in evidence-based interventions could release acute hospital costs whilst improving the physical health of mental health service users.

The following developments could help us to grasp these opportunities for users of mental health services, working in partnership with service users and carers:

- Mental health services could enhance annual health checks and make them effective as part of the individuals overall health care plan, review all prescribed medication for toxicity and side effects, work with partners to very significantly increase health improvement /risk reduction interventions (e.g. exercise on prescription, use of third sector community building opportunities) and staff in mental health services could develop a better understanding of physical health needs.

- Liaison and joint working between mental health and acute services could be strengthened (would a mental health service know if a services user had presented four times in the last week at A&E, and what would the mental health and the acute service do jointly about it?). Joint work between care homes, social care, voluntary services, mental and physical health could also be beneficial.
- Psychiatric liaison services are developing across the country but the outcomes achieved (and resource used) could be reviewed. For example, are integrated models for jointly managing the mental and physical implications of long term conditions and medically unexplained symptoms being developed?
- To enable an outcomes based approach to be implemented, there will need to be co-production of service models and feedback loops involving staff, users and carers. This could not only add knowledge and understanding but also make a real difference to the duration and quality of the lives of many Black Country and West Birmingham people.
- Local arrangements for integrating primary and community services on a place basis should always include mental health, social care and voluntary services. This represents the ideal opportunity to consider how this integrated team can develop innovative, locally sensitive options to address the physical health needs of their population in receipt of mental health services.

Getting the Best Start - Improving Maternal and Infant Health

The infant mortality rate in the Black Country and West Birmingham is much higher than the national average. Only Dudley has a rate lower than the national average, while the other local authorities in the Black Country and West Birmingham have a higher rate than the national average.

Annual infant mortality in the Black Country, 2011-13

	Number of infant mortalities per year	Infant mortality rate (deaths per 1,000 live births)	Best rate in England
Dudley	14	3.7	1.1
Sandwell	34	6.9	1.1
Walsall	26	6.8	1.1
Wolverhampton	24	6.8	1.1
Black Country	98	6.1	1.1
England	2,729	4.0	1.1

Public Health England Health profiles 2015, ONS Birth Summary tables

There are high levels of deprivation, teenage conceptions and smoking at the time of delivery which contribute towards some of the poor maternal, infant and child outcomes. A coordinated maternity pathway alongside the provision of universal and targeted support will improve the quality of maternity care and prevent lifelong disability arising from poor outcomes at birth. In addition, if the infant mortality rate in the Black Country and West Birmingham can be reduced, this will provide an economic benefit to the Black Country and West Birmingham (through productive capacity in the future) and to society (the human costs of the Value of a Statistical Life).

Value of a Statistical Life, WebTAG

Element	Value (£000)
Productivity	591
Human Cost	1,126
Medical services	1
Total	1,718

Department for Transport, WebTAG databook, 2016; HM Treasury, GDP deflators

A reduction in Black Country and West Birmingham infant mortality rates to those achieved in England would deliver 34 fewer deaths, and an economic saving of £58m. However, improving infant mortality rates is also likely to have a positive impact on the number of children born with serious health conditions (through better screening and treatment of pregnant women and new-born children). The total economic saving from these measures is likely to be higher therefore.

We aim to improve maternity care and infant health outcomes across the Black Country and West Birmingham through the development of standardised pathways of care and quality improvement, involving:

- Implementing the recommendations of the Cumberledge report including improved cross boundary working and post/perinatal mental health services across the Black Country and West Birmingham;
- Public Health departments working together to provide evidence based recommendations of effective interventions to improve outcomes and to develop an STP-wide network for sharing intelligence and best practice on maternal, neonatal and infant health;
- Local and strategic partners developing a Black Country and West Birmingham Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes; delivers integrated maternal and neonatal health services, providing accessible care tailored to needs; improves the quality of care provision via Maternal and Neonatal networks reducing variation and standardising best practice; and ensures multi professional working and learning across frontline professionals caring for women and their babies;
- Identify opportunities for system wide action on the wider determinants of health; and
- Model maternity capacity projections across the Black Country and West Birmingham and develop options for delivery.

To support the review of maternity services across the Black Country and West Birmingham, we have commissioned the Strategy Unit to develop, in partnership with neighbouring STPs, local estimates for the volume and type of inpatient birth episodes, maternal bed days and associated costs that might be expected in future. This work is due to complete by the end of Q1 2017/18.

The outcome of the West Midlands Neonatal Review has identified that capacity and demand is mismatched between maternity and neonatal services. Alongside the STP, NHS England specialised service commissioners will rebalance capacity across the footprint which is likely to lead to changes in capability and capacity within a number of units.

Three key themes have been identified:

- Infant mortality (health gap)
 - Defining a set of agreed metrics to support improved performance outcomes
 - Maternal mental health pathway
- A sustainable model for maternity and neonatal services (sustainability gap)
 - Effective pre-conception care
 - Healthy pregnancy pathway
 - Neo-natal pathway
 - Normalisation agenda for delivery
- National Better Birth agenda (quality of care gap)
 - Sustainable options for future delivery of standardised care
 - Reflective of national direction - Better Births: access, choice and empowerment.

Addressing the Wider Determinants of Health

We will build on existing partnerships with individual Local Authorities and the West Midlands Combined Authority to support the delivery of appropriate Local Authority efficiencies (the plan assumes application of the Social Care Precept and of the net Better Care Fund increase), to take effective action together on prevention and the wider determinants of health, to maximise the impact of health spending in the Black Country and West Birmingham and, as set out above, to implement the recommendations of the Mental Health Commission. The STP Plus agenda agreed by WMCA covers:

- The Mental Health Commission (see Improving Mental Health section)
- Best Start in Life (see Maternal and Infant Health section)
- One Public Estate (see Key Enablers – Infrastructure section)
- Place Based Regulation (see Future Commissioning section).

Reducing the Prevalence of Long Term Conditions

The healthy life expectancy of residents across the Black Country and West Birmingham is generally lower than the England average, indicating a considerable number of years is spent living with disability resulting from long term health conditions (LTCs). Care of people with LTCs accounts for 70% of the money spent on health and social care in England. Population projections predict an increase in residents over the age of 75 years across the Black Country and West Birmingham, with longer life expectancy but a high likelihood of increasing demand for health and social care services within this, and younger, population groups. Poor health outcomes are the result of lifestyle choices such as smoking, alcohol misuse and unhealthy eating, which significantly contribute to the development of LTCs. The prevalence of LTCs can be reduced by focusing on primary prevention to halt the occurrence of LTCs and extend healthy life expectancy by addressing lifestyle factors. Secondary prevention will support optimal management of LTCs, slow disease progression and reduce the demand for services.

We aim to improve the healthy life expectancy of Black Country and West Birmingham residents by achieving a significant reduction in the prevalence of long term conditions (LTC) through promotion of the prevention agenda and building resilient communities. Public Health departments will work together to:

- Provide evidence based recommendations to support the prevention agenda; and
- Develop an STP-wide network of best practice and identify prevention resources & self-help tools.

Local partners will work together to:

- Deliver ambitious programmes across the Black Country and West Birmingham to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count. This will include promotion of workplace health initiatives across health, social care and local business;
- Support the development of social capital to address social isolation and improve resilience, enhancing local knowledge of community resources and support whilst creating a culture where communities and groups can themselves identify gaps and develop solutions for local people;
- Promote independence through personalisation;
- Develop place-based models of care to improve management of LTC;
- Improve employability and skills development; and
- Encourage a wellbeing focus across all health and social care policies, planning and departments.

Maximizing the Impact of the Health Pound

One of the major drivers of the financial gap in the Black Country STP is projected increases in demands for health and care over the planning period. There is a clear evidence base to demonstrate that the wider determinants of health and wellbeing lie mainly outside of the health and care system and relate to employment, wealth, education and housing.

Our STP commissioned a unique economic study through the Strategy Unit and ICF International in order to provide:

- ↪ An indicative assessment of the economic impacts in the Black Country and West Birmingham, that flow from spending by the NHS on health services
- ↪ A framework for assessing the wider impacts of changes in the scale and/or type of health services spending.

The study tracks healthcare expenditure and the subsequent effects on the demand for goods and services (through procurement) and for labour (skills and wages). The economic impacts associated with treating the population, especially, the working age population, with subsequent effects on levels of labour market output and productivity, have also be added. In both cases the focus is on the patients, health sector workforce and procurement located in the Black Country and West Birmingham. There is also brief analysis of services that have the potential to have significant economic impacts; informal care, infant care / mortality and mental health services. The more effective healthcare services are, the greater the economic as well as health benefits. The analysis seeks to distinguish between patients according to age and economic activity. The study has aimed to:

- Quantify the health and wellbeing benefit of the economic redevelopment proposals associated with the Combined Authority’s proposals;
- Address through the Combined Authority the wider determinants of health including employment, housing, welfare and education; and
- Identify the contribution that the STP plan can make to the Combined Authority’s goals through reduced welfare dependency, employment and procurement, recognising health as a major industry sector in the West Midlands.

Key findings to date include:

↪	The NHS spends some £2 billion in the Black Country and West Birmingham each year.
↪	The additional income (Gross Value Added) as a result of this NHS expenditure is £1 billion each year. This represents 5.5% of the GVA of the sub-region (representing £1 in every £17).
↪	The multiplier effect of NHS spending (when NHS staff and suppliers spend money in the Black Country and West Birmingham) is estimated to be 1.43, increasing the total NHS-generated GVA to £1.53 billion.
↪	The value of informal care undertaken by some 16% of the Black Country and West Birmingham population is estimated at a further £2 billion each year. The majority of carers provide between one and nineteen hours of care per week, rising to fifty hours for the economically inactive.
↪	The Black Country and West Birmingham operates a small export surplus on NHS services with more non-Black Country residents treated in the Black Country and West Birmingham than local residents treated outside the area.
↪	The NHS in the Black Country and West Birmingham also spends £1 billion on the purchase of goods and services, some supplied by local businesses.
↪	The NHS is the largest single employer in the Black Country and West Birmingham. NHS expenditure supported 30,800 full-time equivalent (FTE) jobs in 2015, of which 24,000 FTE jobs (and some 29,000 people) were directly employed by the NHS. This represents 6.3% of total employment in the sub-region (1 job in every 14). Additional employment of 10,000 FTE jobs results from NHS spending on goods and services.
↪	The NHS workforce is highly skilled, with average wages of the NHS workforce some 26% higher than the average wage for the Black Country and West Birmingham workforce.
↪	The NHS in the Black Country and West Birmingham occupies 23 acute (hospital) sites, covering 125 hectares and over 511 million square metres of floorspace, with a notional land value of £188m. GP practices in the Black Country and West Birmingham were estimated to occupy 61 hectares of land, with an estimated value of £70 million.

Other work undertaken local to examine the economic impact of social care has found the following:

- Based on work undertaken in the City of Wolverhampton, the economic value of adult social care alone in the Black Country STP area is over £1 billion a year based on direct and indirect spend;
- Each locality's Director of Adult Social Services is accountable for the quality of the whole commissioned workforce in their area and there are approximately 30,000 staff in paid care roles working with adults in the Black Country STP area; and
- No calculation currently exists for the local or regional economic contribution of services supporting children, young people and their families but the economic value of social care services more broadly could be as high as £2 billion.

The second phase of the NHS study begins in November when the STP will seek to identify opportunities through which NHS spending could be used to further enhance the associated economic impact.

The following table identifies possible areas for discussion:

	Current activity	Discussion
Recruitment	With a direct workforce of over 24,000 the NHS is the largest employer and recruiter of labour in the BC. It is also one of the most skilled.	How can this recruitment activity be leveraged in support of wider recruitment plans? For example, offering incentives to the spouses of NHS applicants currently resident outside the sub-region
Training	Significant investment is made in the training of NHS staff, one of the largest training programmes in the BC	The training offered to the local NHS workforce, whilst specific to NHS occupations, offers a well-developed training infrastructure. How could this infrastructure be utilised for other employers, especially in the area of transferable skills?
Improved services to reduce the need for unpaid care	12% of those in employment provide some level of unpaid care, with an opportunity cost based on the value of (leisure) time of £0.6 billion each year	Providing informal care services has potential costs to carers in employment and employers. One possible option could be to mobilise the voluntary sector to take on some of this care. Is this feasible and what other options are available?
Adjustment to out-patient services	Half a million hospital out-patients from the local working population receive treatments each year	Even small reductions in the time taken off-work could have significant cost savings to local employers / employees. Transferring some out-patient treatments to primary care might be one approach, is this possible and what other options are available?

	Current activity	Discussion
Procurement	Over a £1 billion is spent each year. Much of this on employment services, pharmaceuticals and IT systems, but a wide range of goods and services are procured	The need for transparency and economies in procurement prevent any positive discrimination in favour of local firms. However, assistance for local firms to participate in NHS procurement procedures could be considered. How might this be achieved?
NHS estate management	The NHS occupies 125 hectares of land in the sub-region, with over 500 million m2 of floorspace. GP practices occupy (but do not necessarily own) some 60 hectares of land	NHS sites tend to be highly accessible and have limited development constraints compared to available development sites. Are there any opportunities for improving NHS services through reorganisation of the NHS estate, including sale/lease and relocation to non-NHS sites, and improving the supply of development land?
NHS resource management	Of total purchases (£1bn in the BC) 3% (£30m) is spent on energy, and 4% (£40m) on waste management and repair services Based on national figures half of purchases (£500m in the BC) are made on goods, mainly pharmaceuticals and computer equipment, but also including a wide range of other goods.	Given the scale of spending, there is the possibility of substantial savings from improved resource efficiency. Social benefits might also be realised from the recycling of pharmaceuticals, and the reuse of unwanted computer equipment. How can these opportunities be identified and what support can be provided to the NHS to realise benefits?

Key Enablers

Workforce

Aim

Our aim is to ensure that we provide the workforce, now and in the future, that can ensure patients receive safe, sustainable, high quality care in the right place and at the right time. This will require us to be bolder and braver than before about how our workforce is shaped, provided and developed.

We want the Black Country and West Birmingham to be a great place to work and grow, with workforce transformation a core element of service transformation. New skills will be developed alongside new types of roles. We will have a reshaped workforce, working across professional boundaries, with proven competencies to ensure safety and quality of care.

A key driver for our staff will be providing a shift from treatment to prevention, from reactive to proactive care, and to steady state rather than crisis care. This will reduce the cost of delivering care by equipping and uplifting skills across the health and care system, moving care closer to home, and encouraging staff to move to and remain in the Black Country and West Birmingham.

Context

Delivering the Forward View: NHS planning guidance states that:

Planning by individual institutions will increasingly be supplemented with planning by place for local populations [and] success depends on having an open, engaging and iterative process that harnesses the energy of clinicians, patients, carers, citizens, and local community partners including independent and voluntary sectors and local government.

It is clearly evidenced that high performing organisations have integrated workforce planning. There are 5 benefits to strategic workforce planning:-

- 1. Supports the budgeting process – good workforce planning, good understanding of the system needs*
- 2. Supports the strategic/business planning process – it needs to be an iterative process*
- 3. Identifies shortage of qualified talent to fill critical roles – good planning helps highlight talent gaps*
- 4. Serves as a mechanism for identifying critical talent – improves the ability to identify and retain the most important talent*
- 5. Identifies skills gaps in workforce*

We know that system workforce planning is easier said than done. However, the Black Country and West Birmingham has embraced the workforce opportunities provided by the STP. The Black Country Local Workforce Action Board (LWAB) is in place and will be the enabling mechanism. The STP has agreed that the majority of workforce efficiencies will be sought from the priorities ensuring there is no double counting or duplication of work.

The Health Education England (HEE) national data pack details a significant workforce across the Black Country and West Birmingham delivering health and care. This information does not include the unpaid workforce of carers and volunteers. The data pack reflects a Black Country and West Birmingham workforce of:

- c.30,800 FTE NHS staff including primary care
- c. 16,300 FTE social care.

Key Workforce Challenges

As we seek to better meet the needs of our patients, we also recognise that we are faced with same real challenges in terms of maintaining and developing the workforce patients need:

- We have an ageing workforce across the whole system (a significant proportion of the workforce are aged 55+ (15% in healthcare, 17% in social care, 11% in primary care);
- There are supply challenges as a result of the comprehensive spending review and also the implications of seven day services and out of hospital provision;
- There are a number of hotspot areas across the system including public health provision, social workers, adult nursing, Speech and Language Therapists, Operating Department Practitioners (ODPs), paramedics, sonographers, Primary Care both GPs and practice nursing, and the utilisation of enhanced and advanced role development across the system.
- We face financial challenges such as the delivery of the apprenticeship levy, living wage cost impact, changes in the LBR and tariff; and
- The provision of an integrated STP workforce plan requires data sharing agreements and also a common language, understanding and processing of the different “types” of workforce across the whole of the health and care services.

Workforce Strategy

Although currently in draft this strategy identifies five key strands for implementation:

1	<p>Engage sustainability and transformational leads to consider and implement workforce implications of system transformations</p> <p>Within each of the transformational and sustainability plans people are the most important resource to ensure full implementation of the system change. The identification of the workforce implications, the mechanism for engagement and the full understanding of the proposed change is critical to the success of the priorities. It is the aim of the Workforce strategy to support and lead the detailed analysis of implications for each of the priorities. Early consideration of the workforce implications will ensure that the workforce enabler of transforming roles is connected into system change for programme development.</p>
2	<p>Support and lead system leadership across organisational structures and professional boundaries</p> <p>Collaboration across the whole system is the only possible and effective way to ensure better outcomes for people within a sustainable financial envelope and it is the strategy of the workforce leaders to ensure that the system will have the skills, knowledge and ability to lead, motivate, guide and support staff through the system change. The system leadership programme will work with regional and national partners across health and social care to:</p> <ul style="list-style-type: none"> ➤ identify system leadership development programmes; ➤ Identify system leaders with experience of leading across boundaries; ➤ Develop system leadership skills through co-learning and a learning and reflective system of development
3	<p>Develop and deliver a workforce development plan across each of the sustainability and transformational programmes to achieve the aims of the priorities</p> <p>Robust workforce data is essential in leading system change and redesign. Through detailed workforce data and intelligence across all partners will enable a full development plan for each of the transformation themes using the 5 step programme for workforce development. Workforce planning will include reviewing Skill mix, supply pipeline for future workforce and transforming roles. This will be fully supported by the agenda of the Local Workforce Advisory Board (LWAB)</p>
4	<p>Ensure staff across all levels of the organisations are aware of the system changes and the reasons for change to enable positive responses to change</p> <p>Working in full collaboration and partnership with the communications transformational programme to ensure all staff are educated, engaged and informed of the system changes and the rationale for these changes.</p>
5	<p>Manage the system risk of people change management programmes to ensure sustainability programmes are delivered within timescales and ensuring continued high quality and safe patient care</p> <p>To ensure successful implementation, staff must be identified as the most precious resource, ensuring their resilience to system change is maximised across both organisational and sector boundaries. The workforce strategy will oversee, manage and mitigate where possible the system risks of change management, providing advice, skills development and system solutions where possible.</p>

Moving Forward

1. **A focus on bank and agency efficiency.** The HEE national data pack highlights that there is a vacancy proxy based on workforce plans submitted 2016 of 9.3%. The bank and agency (excluding locum) reflects a % of staff in post of 13% this indicates that there are some efficiencies to be made from this within the priority work stream. The Black Country Alliance (BCA) has already started to undertake work specifically around bank and agency and this will now be expanded to include other parts of the system. The group will start to look at the opportunities around consistency, negotiated fees, sharing resources and using technology to streamline the work (such as an app for bank staff to book directly on line).
2. **A focus on supply and demand challenges.** The HEE national data details student output versus organisational leavers for adult nurses reflects a -14 supply (on average the Black Country and West Birmingham has 271 leavers and the proxy value of students for the Black Country and West Birmingham is 257). The leavers' data does not include retirements which we know are significant in this particular staff group. Therefore we can conclude that the supply is not available with the commissioned education system so we do need to give careful consideration to placements, fast track routes for education, and recruitment and retention practices. Investing in training of a more readily available workforce which would support changes to team skill mix whilst maintaining safe care (e.g. Physicians' Associates, Band 4 Associate Nurses, Care Coordinators). There are also significant opportunities to continue building on the voluntary sector's contribution to effective patient care.
3. **A focus on standardisation.** We will also seek to move towards more standardised processes including recruiting and retaining staff for the Black Country and West Birmingham. Our Transformation Groups are working up the detailed workforce implications which will start to inform and develop a place based system for population system workforce plan.
4. **Utilisation of the LWAB.** The LWAB will be the driving mechanism for the workforce challenges and opportunities and will utilise the resources developed by HEE WM both via the STP offer, the transformational themes as well as connections with best practice across the health and care architecture.

To achieve this we are:

- Utilising the LWAB to lead and drive workforce development across the STP making extensive use of HEE resources;
- Using research and recognized evidence base to embed the principle that investing in developing our people will improve health outcomes, the experience of healthcare and make better use of our resources;

- Ensuring baseline data is collected from STP to inform forward planning and performance management;
- Adopting and spreading best practice across the system on managing turnover and reduction in bank/agency/locum;
- Considering the use of a single Black Country and West Birmingham Bank/Agency/Locum delivery function – to reduce costs and ensure consistency;
- Utilising the principles of the six step methodology to integrated workforce planning, we will employ a systematic and practical approach that supports the delivery of quality care, productivity and efficiency. It is both a scalable approach and joined up with social care; and
- Adopting and spreading best practice across the system.

Black Country and West Birmingham Digital Strategy

Digital enablement – both for services and for patients – is a key enabler of service transformation leading to sustainability. There is an evidence base which supports the triple aim benefits of digital initiatives.

- **Person-Centred Digital Health**
Digital solutions must be ‘person-centred’; based on the needs of the end user and must be able to demonstrate measurable health and/or economic benefits.
- **Interoperability**
‘If you’re known to one of us, you’re known to all of us’. Solutions must be capable of ‘sharing by default’ through the use of interoperability standards while at the same time respecting trust and confidentiality. Citizens and Users need to be confident that information is accurate, up to date and only shared legitimately.
- **Big Data**
Used properly, Big Data leads to meaningful information and so to insight, action and results and further data. We will create this virtuous circle for our STP.
- **Prevention through digital enablement**
Risk stratification to target proactive interventions; remote monitoring and telemedicine to improve adherence to treatment, manage LTC closer to home and prevent crisis; move knowledge from specialists to those responsible for care (including patients).

Our plan is to:

- Accelerate production and convergence of Local Digital Roadmaps, aligning existing plans;

- Form Black Country and West Birmingham Digital Transformation Board to lead, drive and own delivery;
- Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20);
- Accelerate and support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise 'risk of regret' & maximise triple aim benefits; and
- Rapidly identify & deliver 'quick wins' such as ePrescribing, ToC (electronic correspondence), network rationalisation, and procurement efficiencies. ePrescribing alone is expected to generate annual savings of £24m, supported by an initial capital investment of £5m.

One Public Estate

The Black Country and West Birmingham has invested heavily in new capital assets over the past decade and has a variety of capital asset funding models in place, included several Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) facilities, which have comparatively high occupation costs. We see two streams of opportunity in this cost area. Firstly, there may be opportunity to leverage the £3.8bn 'Sustainability & Transformation Fund' on a non-recurrent basis, to buy-out elements of PFI or LIFT. Secondly, we see opportunities in the better utilisation of the estate that currently exists. As noted in relation to our hospital collaboration plans, we have allocated a one-off capital investment of £3m to this work in order to realise efficiencies of £10m each year going forward. A further £3m annual savings are expected in relation to voids in the primary care estate.

The evidence base for this project includes the Carter Review, Private Finance Unit (PFU) Forum survey and studies and Dudley CCG place-based assessments. We aim to ensure that the estates infrastructure required for service delivery and supporting functions is configured, financed and utilised in the most efficient way, contributing to a 10% reduction in STP estates costs through:

- Survey of current estate – LIFT & PFI – VOIDS
- Health & Local Authority opportunities
- Refinancing opportunities including Local Authority or Independent Trust Financing Facility (ITFF) borrowing
- Unitary payment reduction opportunities (lifecycle, Risk buy back, etc.)
- Elimination of void space
- Challenging planned developments 2017/18 to 2020/21
- Best use of most expensive estate (PFI/LIFT etc.)

Future Commissioning

The future shape of service commissioning within and across the Black Country and West Birmingham needs to be aligned with the evolving nature of service provision. What is set out here reflects initial exploratory work by a number of our commissioning bodies. We will now test and refine our approach with all our commissioning partners.

The Black Country and West Birmingham is currently served by ten commissioning organisations across health and social care. This is likely to lead to:

- Duplication of activity and cost;
- Unnecessary complexity in models of care and in commissioning procedures (including procurement);
- Unwarranted variation in service delivery and outcomes.

Working together within the STP presents us with real opportunities to address these challenges and to look more strategically at the provision of services across the Black Country and West Birmingham, including how they interact with services in neighbouring areas. This work will be led through an STP commissioner group including NHS and Local Authority partners.

New ways of working together as commissioners are required to support the delivery of our local Accountable Care Organisation models, so we aim to simplify and standardise commissioning mechanisms across the Black Country and West Birmingham in order to support Better Health and Better Care, and to remove duplicated costs by:

- Identifying priority areas for streamlining and standardisation – both quick wins and major opportunities; and
- Identifying and evaluating alternative mechanisms through which streamlining and standardisation can best be enabled.

In addition, we aspire to invest an additional £82m annually in developing local healthcare services, subject to achieving an equivalent level of additional savings from our work to reduce demand.

The current NHS planning guidance requires NHS commissioners to agree two-year contracts with providers for 2017/19. This will not only create some medium-term stability for the system but will also afford the opportunity to review our commissioning arrangements in preparation for commissioning services for beyond April 2019.

Our STP sets out two main structures for the delivery of health and social care transformation across the Black Country and West Birmingham:

1. Local Place-based Delivery of Care

This includes the implementation of the new care models such as the Multispecialty Community Provider (MCP) models in West Birmingham (Modality) and in Dudley Wolverhampton has implemented the Primary Care Home (PCH) model across the majority of practices and has also a Primary and Acute Care System (PACS) type model with the remainder of its practices. As set out above, each of our local areas will have its own locally-appropriate model for delivering place-based care.

2. Extended Provider Collaboration

This includes the MERIT vanguard and Transforming Care Together Partnership for mental health services, and collaboration on service delivery and support services between the Trusts running our four acute hospitals.

There is, therefore, a clear benefit in organising commissioning arrangements across the Black Country and West Birmingham to enable and enhance the implementation of these two complementary strands. Further consideration also needs to be given to the consequential impact on CCGs once the new models of care have been fully commissioned. The key considerations for each of these issues are set out below, reflecting our core principles of subsidiarity and collective added value.

Local Place-based Commissioning

Each local place-based model shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local

population delivery and a priority on achieving improvements in outcomes. It will therefore be desirable to implement these new forms of contracts from April 2019. We are already actively engaged in supporting the development of these new contractual models, providing one of the six national test sites via the Dudley MCP. This creates a further opportunity to use local learning from Dudley to establish a shared understanding and capability across Black Country and West Birmingham CCGs so that, subject to local determination on timing and methodology, we are able to progressively implement these new contractual models in each local system from April 2019.

Black Country and West Birmingham System-wide Commissioning

Earlier sections of our plan set out a clear need for collaboration between our acute service providers. In addition, our Clinical Reference Group (CRG) has reviewed the national [Right Care evidence](#) and determined that there are a number of services which would benefit from a strategic clinical review in order to determine the model of service delivery best placed to optimise patient outcomes, the quality of care, and efficiency in service delivery. Those services may include the following (subject to further analysis):

- Cardiovascular Disease (e.g. heart attacks, stroke);
- Endocrine conditions (e.g. Diabetes)
- Genito-urinary conditions (e.g. Chronic Kidney Disease)
- Musculoskeletal conditions (e.g. hip replacement); and
- Cancer.

Our shared objective is to commission acute service delivery so that everyone across the Black Country and West Birmingham can be assured that they will receive the same high quality standard of care regardless of which local hospital they attend. Consequently it will be important for the Black Country and West Birmingham CCGs to collaborate in commissioning these services to the same standards, particularly as our providers are themselves increasingly collaborating on service delivery. This approach will also help to provide a collective commissioning approach to the realisation of efficiencies across our system.

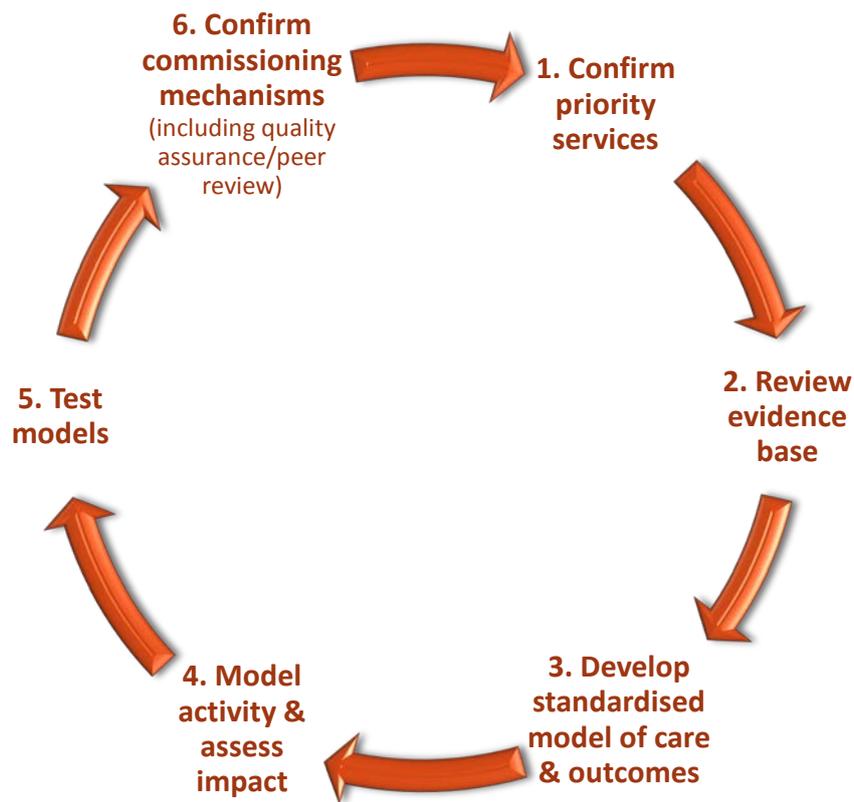
The first stage in this process would be to initiate the proposed clinically-led strategic review. This would be followed by establishing a shared approach to commissioning those services across the four Black Country and West Birmingham CCGs, so that from April 2019 the services can be commissioned through a single shared process across the whole of the Black Country and West Birmingham. The review process is expected to begin in early 2017 and is likely to be an iterative process (see diagram below).

In addition to our local-initiated work, NHSE Midlands and East's Specialised Commissioning Strategic Framework develops a vision to deliver services such as chemotherapy and renal dialysis through networks of provision based around larger specialist providers supporting local services. Specialised Commissioning teams will be working with providers and STPs to

identify opportunities for consolidating services and developing networks. In the Midlands and East region, the larger specialist providers can be categorised into two tiers:

- Tier 1 providers are those that have a large and diverse specialised commissioning portfolio and provide a number of level 1 national services; and
- Tier 2 providers are those which have a large and diverse specialised commissioning portfolio and are a sub-regional specialised centre for a number of services, or a Major Trauma Centre.

OUR CLINICAL REVIEW PROCESS



Although a substantial range of specialist services is provided in Black Country and West Birmingham hospitals, there are no resident Tier 1 providers (patients travel to Birmingham hospitals) and the Royal Wolverhampton NHS Trust is the only Tier 2 provider. This creates the need for a network of acute collaboration across the Black Country and West Birmingham. The framework specifies thirty-six specialised services which could be devolved through the West Midlands Specialised Commissioning Board to a Black Country and West Birmingham commissioning footprint.

Key drivers for commissioning at greater scale include where:

- Outcomes could be improved through service consolidation (e.g. to secure the appropriate clinical competencies)

- Services have interdependencies with other STP footprints (e.g. the configuration of specialist networks including emergency services, trauma care, PPCI)
- Services may not be sustainable as separate local entities (e.g. due to workforce shortage and/or high agency costs)
- Equity of access to high quality care can be improved.

This offers the opportunity to align a Black Country and West Birmingham CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider – to create an integrated Black Country and West Birmingham approach to the commissioning of all major acute services. Our intention would therefore be to work with NHS England to create a joint capacity and capability to commission all of these services from April 2019 on the basis of a single acute network of provision across the Black Country and West Birmingham working to the same standards of care.

This work will also include an independent assessment of the potential impact of the Midland Metropolitan Hospital on services across the Black Country and West Birmingham and, where necessary, the development of plans to address any adverse impact.

Impact of New Care Model Implementation

One aspect of the new care models programme is the opportunity for providers to take on responsibility for providing care to a whole population (e.g. through ‘accountable care’ type arrangements or Whole Population Budgets). This raises questions about the opportunities for CCGs to contract out some of their functions to providers in a way that has not been possible before. Whilst the details on what is appropriate will be different for each local system and will be dependent upon the preferred model of care, each CCG Governing Body and its constituent members will need to consider the potential benefits this offers for enhancing the capabilities of local providers and the implementation of the new care models to drive better outcomes and efficiency.

As we move towards outcomes based commissioning and contracting which these new care models afford, the skills and capabilities of commissioners will also need to change. As the component parts of the commissioning system of the STP are addressing these challenges at different paces and with differing timescales, there exists the opportunity for greater collaboration between CCGs to facilitate and accelerate the adoption of new models.

As CCGs evolve to maximise their future effectiveness, it will also be important to consider opportunities for integration of some functions with the regulators, particularly NHS England and the Care Quality Commission, such as service assurance activities. As well as supporting the standardisation of care and the resulting improvement in patient outcomes, this may also enable additional cost savings through a reduction in the tiers of performance management and assurance processes.

A key area in which local commissioners have already been actively collaborating is in relation to urgent and emergency care. This work is summarized below.

Urgent and Emergency Care

The partners in the Black Country STP are committed to ensuring that high quality urgent and emergency care services are provided for patients. We have been working with the organisations that provide urgent and emergency care to make sure that these services are available when they are needed, from facilities as close to home as possible.

The provider organisations have been working together to identify ways to make sure that patients get treated in the right place by the right people. For those people with more serious or life threatening emergency needs we will develop a robust service offer to ensure they are treated 24 hours per day, 7 days per week in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

This work is going on across the whole of the West Midlands and the Black Country STP is playing a lead role. We have been focusing upon improving access to patient's records so that clinicians can be better informed when making decisions about treatment. In addition we have established NHS111 as a single point of entry into urgent care services and are also developing central points where calls from patients can be taken by doctors and other health professionals including pharmacy, dentist and mental health services. We want to clearly identify which services are available and from where and our work aims to make it as simple as possible for patients to find and get treatment from the service that they need 24 hours per day, 7 days per week.

We are aiming to reduce the need for patients to be transported to hospital by ambulance and we are doing this by making more advice and treatment available at the scene including in patients' homes.

There is developing work involving the providers of mental health services to make sure that patients receive consistent services and that those services are as close to home as possible.

We also want to encourage and support patients to manage their own conditions and to give them more information to help them understand what they can do to avoid the need to see a doctor or go to hospital.

Significant work has also been done to ensure that patients can get urgent treatment from their GP, dentist or pharmacist.

Patients and their carers have been heavily involved in the development of our work on urgent and emergency care from the beginning including co-design events, participation in the Urgent and Emergency Care Network and involvement in procurement processes.

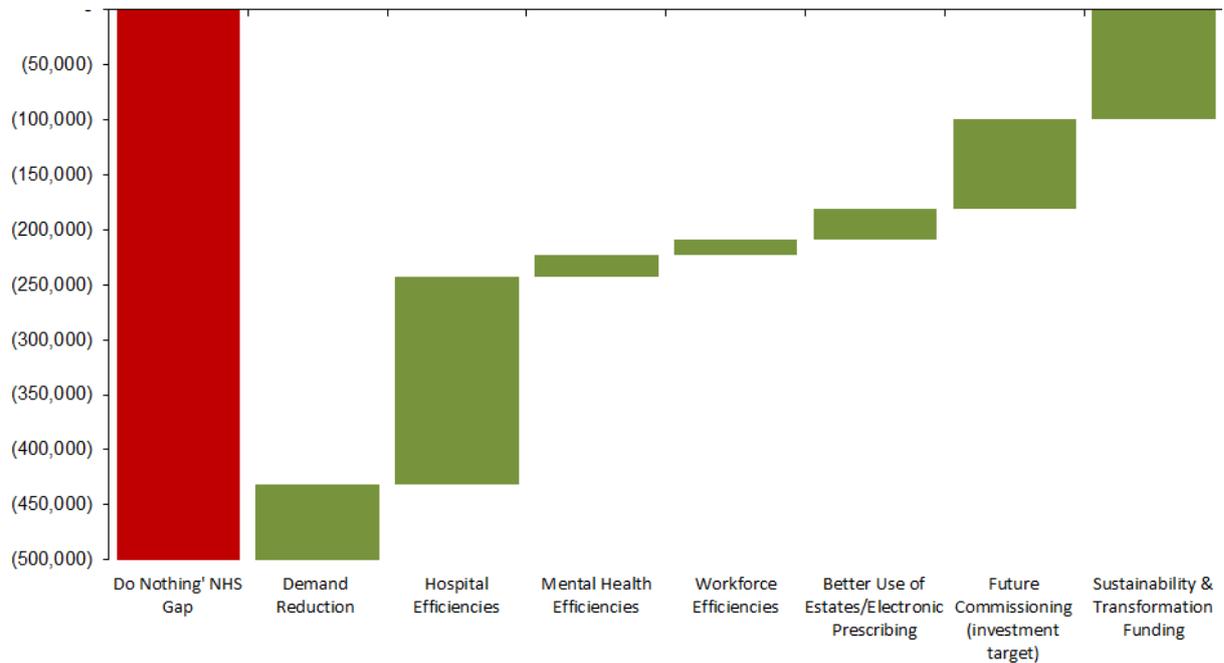
Financial Sustainability and Investment in Transformation

To achieve sustainability in local health services, the Black Country STP needs to take significant action to reduce both the projected growth in demand and the costs of the services provided. The challenge equates to avoiding spending of £512m by 2020/21. With an indicative national Sustainability and Transformation Fund allocation of £99m in 2020/21 that leaves a local challenge of £413m. The table below summarises how our transformation plans will contribute to building a financially sustainable healthcare system for the Black Country and West Birmingham. To be updated

The Gap		The Solutions
£700m 2020/21 STP 'Do Nothing' Gap	£512m Health £413m savings + £99m STF	£81m Demand Reduction through Local Place-based Models of Care
		£189m Efficiency at Scale through Extended Hospital Collaboration
		£20m Improving Mental Health and Learning Disabilities Services
		Getting the Best Start - Improving Maternal & Infant Health
		£14m Workforce Enabler
		£27m Infrastructure Enabler (estates and technology)
		£82m Future Commissioning
		Addressing the Wider Determinants of Health
	£188m Social Care	Local Authority Investment & Savings Plans

Individual organisations retain responsibility for delivering annual savings and efficiency targets, albeit with the increased mutual support available through STP structures and processes. There is currently a requirement for providers to deliver a 2% CIP and for CCGs to keep demand 1% under the average annual growth of 2.3%. Achieving against these challenges will deliver £235m out of the local £413m challenge. This makes it clear that we need the added value of increased collaboration through the STP to avoid future costs of a further £178m.

The diagram below sets out how sustainability will be achieved for Black Country and West Birmingham health services by 2020/21.



In order to achieve this, we will need to make some targeted capital investments. Our plan proposes the following allocations beyond what features in the separate investment plans of each of our organisations:

- ↪ £34m for primary care premises
- ↪ £16m for premises changes to support other closer to home services
- ↪ £35m to support networks of acute care excellence
- ↪ £10m for estates changes required to deliver Mental Health and Learning Disability services transformation
- ↪ £3m to enable the release of £10m annual efficiencies relating to estates
- ↪ £5m to enable the release of £24m annual efficiencies relating to prescribing.

Transformative Impact through Rapid Cycle Learning

We wish to become one of the most innovation-aware and adoption-ready health and care economies in the country. Our existing innovations (such as our Vanguard models of care) and the developments set out in this plan would give us the ability to systematically study and compare different approaches, to harvest and codify good practice and to actively support its adoption.

The single most important change in the NHS... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.

Berwick Report, 2013

We intend to demonstrate the power of this approach to the wider NHS and to make practical learning central to what we do.

Maximising the value of knowledge exchange relies upon defining the right focus and questions. For example:

- ↪ Dudley is developing an MCP under the New Care Models programme (other areas have plans for them) and Wolverhampton is adopting PCH and PACS models. Marrying international and national evidence with local experience, we will be able to examine the arguments for the adoption of each model, the component parts of them, the practicalities of implementing them and the effects that result. In effect, we would treat the Black Country and West Birmingham as a microcosm of the New Care Models programme, with a rapid route to adoption;
- ↪ Whilst on one level there is a choice between types of new care models, it is likely that their component parts will be similar. Each typically includes some form of enhanced / scaled up primary care; each features community based teams over populations of thirty to fifty thousand; each makes use of more intensive multi-disciplinary teams focused on higher risk patients. This provides opportunities for cross-model learning. We will be able to select a common component and focus knowledge exchange on its design and operation. For example, how do we provide community based teams with the information they need to effectively manage 'their' populations?
- ↪ We, like most areas of the country, need rapidly to learn how best to take advantage of the unrealised opportunities for efficiency at scale and how best to deliver increasingly specialized services across a population of 1-2 million people. Should a service area focus be taken – urology has been identified as an example – this would allow knowledge exchange activity to use clinical peer review as a mechanism. Again,

involvement of clinicians would provide for rapid adoption of identified improvements;

- ↪ We have already identified the need to make rapid improvement in relation to MHL and maternity services. In addition to learning about how services are best configured and operated, we also need to understand the potential impact of wider system drivers such as public health measures and the role of voluntary organisations, employers and the public. Such a breadth of approach is necessary given the wider determinants of problems as complex as infant mortality and mental health. Our approach here is likely to be more place-based, asking (for example) what each local area does on public mental health, what seems to work well and where improvements are needed.

Exploring questions such as these is no abstract exercise without urgency. In order to build a transformed and sustainable health and care system that makes an increased contribution to local wellbeing and prosperity, we need to learn rapidly from what we do. Every year, the NHS in the Black Country and West Birmingham has some nine million patient contacts undertaken by over 30,000 healthcare staff. This provides us with a vast live evidence base and a huge team of learners. With the right mechanisms in place we believe we can make the Black Country and West Birmingham a health and care system that quickly and continually adapts itself as a result of what it learns day by day.

The mechanisms we will be exploring include:

- Structured peer review cycle across the STP (e.g. between integrated community teams or acute specialty teams);
- ‘Living Review’ function (building on the current provision for the Dudley MCP Vanguard) to help our workforce learn from research and practice in a timely way. It would keep staff up to date with new evidence as it emerges, distilling key messages and translating them into a local context;
- How to use technology to enable the rapid spread of learning across both front line teams and the system as a whole. For example, it is feasible to envisage integrated community team members equipped with portable devices that:
 - Provide access to a shared care record;
 - Enable activity recording; and
 - Facilitate social media type comments about how services are working for patients and staff (new ideas, positive or negative feedback on developments, identification of system blockages).

Potential benefits might include near real-time peer-to-peer learning for operational staff, ability for strategic evaluation through in-depth analysis of qualitative feedback,

cross-referenced to any changes in activity patterns and feedback from evaluation both to front-line staff and to other STPs/regulators for wider learning.

- Targeted local analytical reports designed to respond to identified team priorities with built in loops to measure improvement.

Communications and Engagement

Our Strategy outlines our plans on engaging and communicating effectively with our patients, public, partners, staff and stakeholders across the Black Country on how we will work with them to improve the health and care of people of the Black Country and west of Birmingham.

We recognise what people and communities want from their local health and care services and could do for themselves and by reorienting and reshaping health and other services to support them. This shift from a clinically and managerially led process to a coproduced approach to health and care is at the heart of our plans around communication and engagement.

Communication and engagement need to be at the heart of how we move forward if we are to transform local services in order to make them sustainable for the future and more responsive to the needs of the people we serve. In other words, the voice of the patient needs to be central to everything we do.

The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff and protected funding in recent years. However, some challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatments options are emerging, and we rightly expect better care closer to home.

There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

Two levels of activity are planned:

- STP programme level – high-level communications activity in support of the Programme, and the management of communication and engagement interfaces with contiguous strategic work programmes (including the Health Care Review; NHSI Financial Improvement Programme.)
- STP work stream level – supporting specific STP work streams to develop and implement a detailed, operationalised communications and engagement plan (or plans) to support their specific work programmes.

STP partners have committed to ensure all of our communications support local people to understand all of the issues which the programme seeks to balance. There will be many

different interests and only by working together, to discuss and debate the relative needs of local people, as well as the safety and quality of services proposed, can we fully ensure all interests are properly represented.

We will ensure we promote ways of working together which are in the interests of local people, who will remain at the heart of the development of this programme.

We will commit to communicate in a way that is:

- Open and transparent – our communication will be as open as we can be, ensuring that when the information cannot be given or is unavailable, the reasons are explained
- Consistent – There are no contradictions in the messages given to different stakeholder groups or individuals. The priority to those messages and the degree of detail may differ, but they should never conflict
- Two-way – There are opportunities for open and honest feedback and people have the chance to contribute their ideas and opinions about issues and decisions
- Clear – Communication should be jargon free, to the point, easy to understand and not open to interpretation
- Planned – Communications are planned and timely rather than ad-hoc and are regularly reviewed to ensure effectiveness
- Accessible – Our communications are available in a range of formats to meet the needs of the target audience
- High quality – Our communications are high quality in relation to structure, content and presentation at all times.

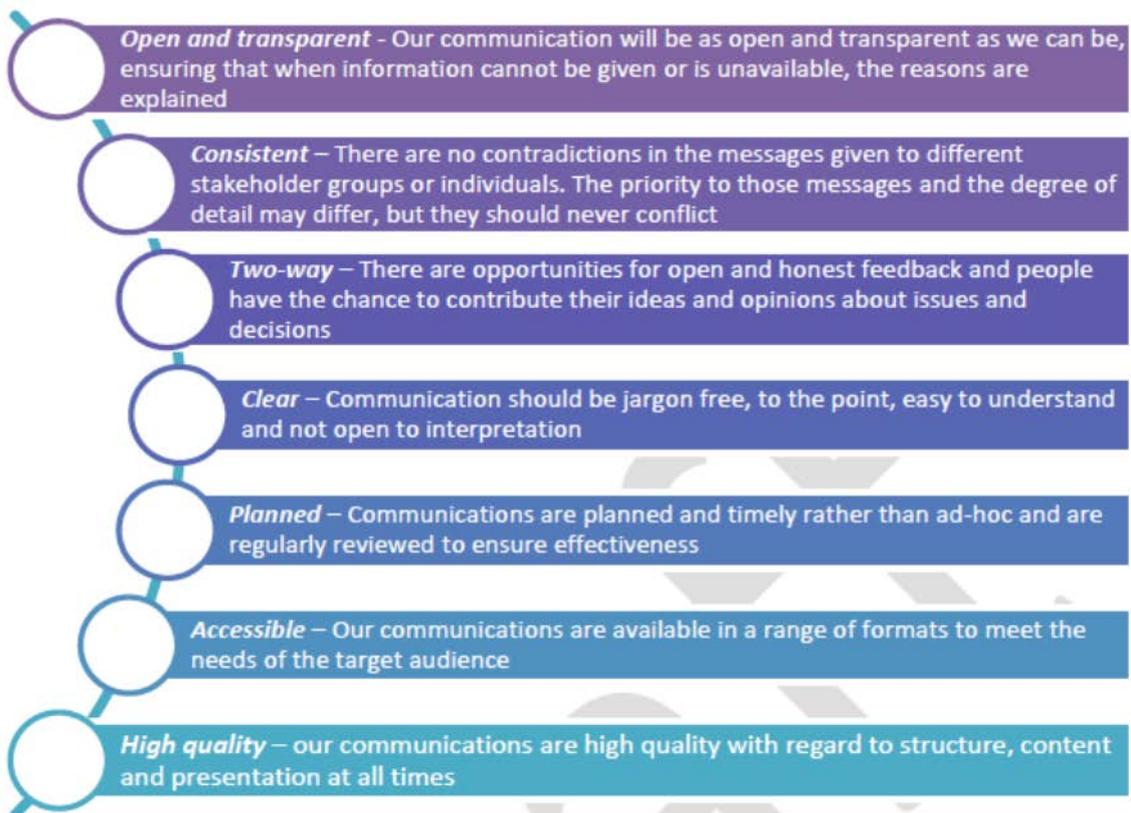
We will actively provide the following channels for communication, sharing, learning and strategic advice:

- Communications Concordat
- Local communications and engagement networks
- Communication and Engagement leads on each transformation work-stream
- Communications and Engagement lead to attend/report into the Operational Group
- Communications and Engagement lead to attend/advise Sponsoring Group

This concordat makes a commitment to publish a quarterly statement of programme progress as a minimum.

The five community empowerment dimensions above are helpful in thinking about how we work with people. Empowerment is not just about the people and communities, it is also about organisational structures and processes being empowering. When developing new ways of working we will take an empowering approach to engagement.

- By ‘confident’, we mean, working in a way which increases peoples skills, knowledge and confidence – and instills a belief that they can make a difference.
- By ‘inclusive’, we mean working in a way which recognises that discrimination exists, promotes equality of opportunity and good relations between groups and challenges inequality and exclusion.
- By ‘organised’, we mean working in a way which brings people together around common issues and concerns in organisations and groups that are open, democratic and accountable.
- By ‘cooperative’, we mean working a way which builds positive relationships across groups, identifies common messages, develops and maintains links to national bodies and promotes partnership working.
- By ‘influential’, we mean working in a way which encourages and equips communities to take part and influence decisions, services and activities.



Over the summer we have been working with partner organisations to refine our plans. During this time we have continued with a programme of communication and engagement events involving staff and other key stakeholders, to build understanding and support for our rationale and approach to change. Key aspects of our plans had themselves been subject to previous public engagement and, in some case, formal public consultation.

This engagement will continue and intensify following the publication of this plan, in a format that is accessible to our patients, public staff and wider stakeholders. We will be in a position to articulate the benefits for our patients in a way that they can understand and relate to through the publication of a document that gives the public a good understanding of the need to change. Throughout the Autumn we will be taking our plan through our partner organisations' governance processes. We will be presenting our plans to a wide range of key stakeholders, including:

- Health and Well-being Boards
- Overview and Scrutiny Committees
- Local Professional Committees, for example LMCs
- Healthwatch
- Patients and their carers through existing mechanism such as PPGs, FT Governors, Patient Advisory Groups etc.
- The public - through in-reach into Libraries, local housing forums, Citizen Forums etc.
- Reaching out through the local voluntary and community sector infrastructure organization to local community based organisations
- Utilising existing channels to communicate and engage staff and clinicians

We will take advantage of existing systems to capture patient and public insight, experience data in order to fully understand and inform the specific plans for change arising out of the workstreams. We will adopt a co-design and co-production approach to ensure that our plans for transforming the health and care of people across the Black Country and West Birmingham are sustainable and achieve real change.

It is important that we make best use of existing communication channels and build on place based relationships. We have undertaken a stakeholder analysis to understand who our stakeholders are and how we best communicate with them. For example we will continue to communicate with our patients, people who use our services, their carers and their communities by using existing forums, such as citizen panels, patient networks, patient participation groups, community events. Social media will also continue to feature in respect of how we get our messages out.

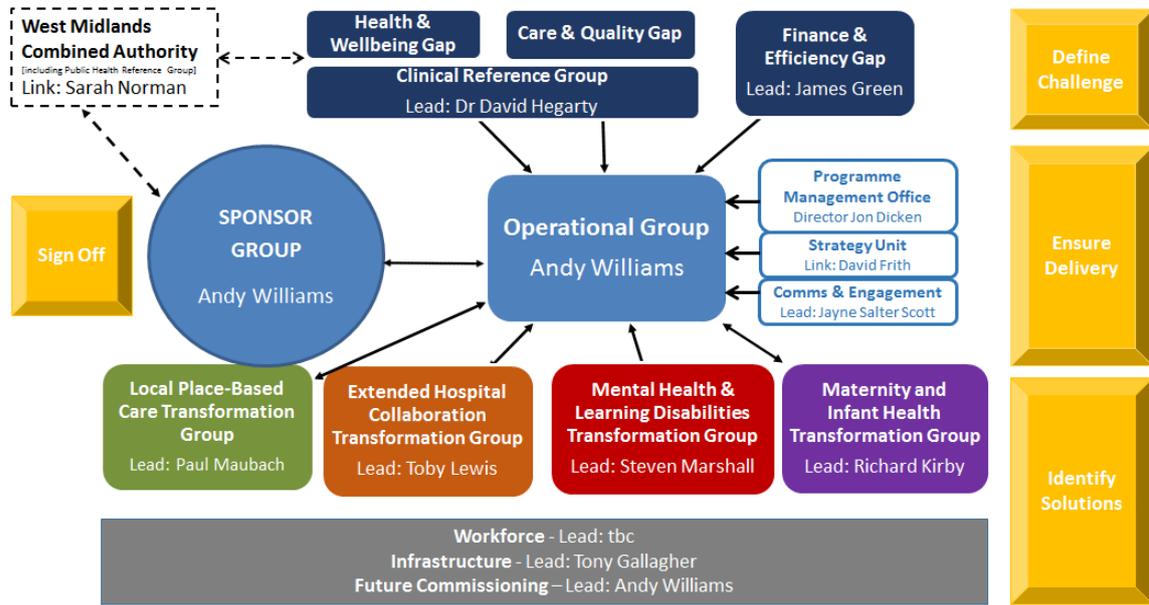
The success of our STP also relies on our relationship with our patients, people who use our services, our staff and clinicians. We will take an engaging and co-production approach to our STP by getting patients, people who use our services, our staff and clinicians to lead change. Taking decisions together, we will ensure that collective action can make a positive difference to the health and care of people across the Black Country and West Birmingham.

Ten Priority Questions

1	How are you going to prevent ill health and moderate demand for healthcare?	Our plans for local place-based models of care address the need for better health and will also serve to moderate demand.
2	How are you engaging patients, communities and NHS staff?	The communications concordat makes a commitment to publish a quarterly statement of programme progress as a minimum. Engagement with patients, communities and NHS staff will continue to be led by partner organisations in ways appropriate to local circumstances.
3	How will you support, invest in and improve general practice?	The development of place-based models of care, building on local Vanguard, will strengthen the resilience of primary care services and enable re-design appropriate to each locality.
4	How will you implement new care models that address local challenges?	New models of care are already active within and across the four Black Country and West Birmingham boroughs, and each area will implement a model which addresses access, continuity and coordination challenges. Our local evaluation methodology will enable rapid learning across all areas.
5	How will you achieve and maintain performance against core standards?	Our plans for standardised best practice in place-based models of care will reduce the pressure on the urgent and emergency care system; and our analysis shows significant potential to reduce first: follow-up ratios, improving RTT.
6	How will you achieve our 2020 ambitions on key clinical priorities?	Standardisation of acute pathways will improve cancer survival; prioritisation of Mental Health transformation will improve access & outcomes; standardisation of maternity pathways will improve experience and outcomes; and Strategy Unit analysis will inform improved intervention along the Dementia pathway.
7	How will you improve quality and safety?	Improvements will be achieved through standardisation of place-based care models and of priority acute pathways. A system-wide ePrescribing system will support antimicrobial resistance through reducing inappropriate prescribing.
8	How will you deploy technology to accelerate change?	Our digital strategy will enable benefits in vertical and horizontal integration initiatives. These will both drive digital requirements and be partially shaped by digital potential (e.g. collaboration, analytics, big data, infrastructure).
9	How will you develop the workforce you need to deliver?	Our horizontal integration work will drive a new scale of workforce efficiency (including around agency spend). We are also initiating a discrete project to develop new roles (e.g. physicians associates, nursing associates, assistant practitioners, integrated health and social care apprentices) to underpin new models of care.
10	How will you achieve and maintain financial balance?	Balance will be achieved by 2020/21 through partner organisations delivering against their regulatory or statutory duties with an additional scale of savings delivered through collective opportunities at STP level.

Programme Governance

The sponsor organisations of the STP have agreed the following governance structure:



Oversight of the plan’s development and implementation lies with the Sponsoring group which is constituted as follows:

Chair/Lead: Andy Williams

Organisation	Named Lead	Named Deputy
Black Country Partnership NHS Foundation Trust	Tracy Taylor	Tracey Cotterill
Dudley MBC	Sarah Norman	Matt Bowsher
Dudley Group NHS Foundation Trust	Paul Harrison	Anne Baines
Dudley and Walsall Mental Health Partnership NHS Trust	Mark Axcell	Mary Bytheway
Dudley CCG	Paul Maubach	Matt Hartland
Sandwell MBC	Jan Britton	David Stevens
Sandwell & West Birmingham Hospitals NHS Trust	Toby Lewis	
Sandwell & West Birmingham CCG	Andy Williams	
Walsall MBC	Paul Sheehan	
Walsall Healthcare NHS Trust	Richard Kirby	Daren Fradgley
Walsall CCG	Paul Maubach	Tony Gallagher
Wolverhampton City Council	Keith Ireland	Linda Sanders
Royal Wolverhampton NHS Trust	David Loughton	Mike Sharon

Organisation	Named Lead	Named Deputy
Wolverhampton CCG	Trisha Curran	Steven Marshall
Birmingham City Council	Alan Lotinga	
Birmingham Community Healthcare NHS Foundation Trust	Tracy Taylor	Lorraine Thomas
NHS England	Alison Tonge	Alastair McIntyre
West Midlands Ambulance Service	Anthony Marsh	Mark Docherty
Local Government Association	Joe Simpson	
Healthwatch	Jayne Emery	
Health Education England	Della Burgess	

Workstream and Transformation Group leads together form the Operational Group:

Transformation Group/Workstream	Named Lead	Named Deputy
Sponsoring Group	Andy Williams	
Local Place-based Care	Paul Maubach	Jo Taylor
Extended Hospital Collaboration	Toby Lewis	
Mental Health & Learning Disabilities	Steven Marshall	Mary Bytheway Sarah Fellows
Maternity & Infant Health	Richard Kirby	Sally Roberts
Workforce	tbc	Della Burgess
Infrastructure	Tony Gallagher	
Future Commissioning	Andy Williams	
Link to WMCA on Wider Determinants	Sarah Norman	Karen Jackson
Health & Well Being	David Hegarty	Jim Young
Care & Quality		
Finance & Efficiency	James Green	
Communications & Engagement	Jayne Salter Scott	
Programme Management	Jon Dicken	

A quality assurance function (QA) will be exercised by our CRG that will:

- Provide robust clinical assurance to each transformation group and workstream, supported by patient engagement;
- Be based on an evidence-based methodology developed in the Black Country and West Birmingham for the West Midlands Clinical Senate (and now endorsed by National Senate Chairs);

- Complement and provide evidence for any external assurance processes that may be required for aspects of our plan from time to time.

The partners to the STP have all worked collaboratively over recent months and have contributed to the development of the content of the plan for the Black Country and West Birmingham setting out aspirations for transformative and sustainable developments. The next stage will be to formally engage and consult with stakeholders on the plan. This will then facilitate formal sign off of the plan over the coming months.

Programme Plan

The STP has established a dedicated Programme Management Office which has developed a detailed programme plan and is monitoring workstream activity against this. The following table summarises key milestones for the STP during 2016. Summary plan templates for each main area of activity can be found in the appendix.

Subject to sign off and approval of the plan by the national sponsoring bodies we will move to implementation, this will see a review of our governance and leadership of the STP. Our intention is to place clinicians at the head of our governance so that the STP is a clinically led managerially supported process. It is essential that we build upon the advice and guidance provided through our Clinical Reference Group and effectively engage the clinical (and non-clinical) workforce.

Our clinical leaders will enhance the credibility of our plans when we consult and engage with patients and wider stakeholders as our plans mature and the implementation gathers momentum during the coming weeks, months and years.

The implementation of the STP rests firmly upon each of the localities and the constituent partners including patients, providers and commissioners. This approach recognises the principal of subsidiarity which has been central to the STP since its inception, it also recognises the wealth of existing work taking place across the Black Country and West Birmingham and ensures continuity whilst recognising the opportunities for further and wider collaboration and integration through the STP.



THE BLACK COUNTRY

Sustainability and
Transformation Plan
Summary

October 2016



SUMMARY



The local NHS wants to make some common sense changes so people in the Black Country and West Birmingham get the treatment they need as quickly as possible. This will mean more money going into GP services – creating more appointments, giving doctors and nurses more to time to go and visit patients at home, and linking up GPs with hospital specialists. Patients can expect to see a number of changes happening in their area.

- With an extra £25m invested in GP services by 2021, an extra 25,000 primary care appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Over 1,000 people a month who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- Across the Black Country and West Birmingham, there will be at least 40,000 additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- From November 2016, by ringing one telephone number the 1.4m people who live in the Black Country will be able to book a doctor's appointment, in the evening and at the weekend, get dental advice, order a repeat prescription, or get urgent advice.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- By bringing all cancer services up to the standard of the best, cancer one year survival rates will reach over 70 per cent in the Black Country and West Birmingham.
- Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E by 3,000 a week by 2021, meaning faster treatment and care for the most seriously ill.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- Local clinical teams involving GPs, community nurses, mental health services and social care will provide better coordinated care for our most vulnerable patients with very complex needs.
- The new Midland Metropolitan Hospital will bring hospital services in Sandwell and West Birmingham together in one place to treat over 570,000 people in a state of the art building.
- By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- The NHS in the Black Country and West Birmingham will reduce current high levels of infant mortality to bring it in line with the national average, avoiding the death of 34 babies a year - the equivalent of one child every eleven days.
- By tackling waste, improving standards and working together, we can avoid a potential increase in health costs of over £413million per year by 2021. This will give better value to the taxpayer, equivalent to £680 a year for every household in the Black Country and West Birmingham.

SUMMARY



Partnership Working

This plan is a 'work in progress' to which partners from across local health and social care organisations have contributed collaboratively over recent months. It sets out aspirations for transformative and sustainable developments. The next stage will be to formally engage and consult with stakeholders on the plan so that it can be further developed before formal approvals are considered.

Progress to Date

We drafted an initial outline plan in June. Since that time we have taken substantive steps forward (see over for detail) so that our plans now set out:

- ✓ Further detailed analysis that has been undertaken to understand the challenges we face in health, care and resourcing, supported by a review of priorities by our own newly established Clinical Reference Group;
- ✓ A year by year (and organisation by organisation) breakdown of how we will deliverable a sustainable local health economy;
- ✓ More granular project plans for the actions we will take going forward to address those challenges;
- ✓ The specific benefits that we expect our plans to deliver, not least in terms of patient outcomes; and
- ✓ A clear sense of what we can achieve together at pace and scale (an additional c.£90m avoided cost) beyond what could be delivered through business as usual.

Stakeholder Engagement

Over the summer we have been working with partner organisations to refine our plans. During this time we have continued with a programme of communication and engagement events involving staff and other key stakeholders, to build understanding and support for our rationale and approach to change. Key aspects of our plans had themselves been subject to previous public engagement and, in some case, formal public consultation. This engagement will continue and intensify post submission with the publication of our full plan in a format that is accessible to our patients, public, staff and wider stakeholders. We will be in a position to articulate the benefits for our patients in a way that they can understand and relate to through the publication of a document that gives the public a good understanding of the need to change. Throughout the Autumn we will be taking our plan through our partner organisations' governance processes, and we will be presenting our plans to a wide range of key stakeholders.

Next Steps

Subject to sign off and approval of the plan by the national sponsoring bodies we will move to implementation, this will see a review of our governance and leadership of the STP. Our intention is to place clinicians at the head of our governance so that the STP is a clinically led managerially supported process. It is essential that we build upon the advice and guidance provided through our Clinical Reference Group and effectively engage the clinical (and non-clinical) workforce. Our clinical leaders will enhance the credibility of our plans when we consult and engage with patients and wider stakeholders as our plans mature and the implementation gathers momentum during the coming weeks, months and years. The implementation of the STP rests firmly upon each of the localities and the constituent partners including patients, providers and commissioners. This approach recognises the principal of subsidiarity which has been central to the STP since its inception, it also recognises the wealth of existing work taking place across the Black Country and ensures continuity whilst recognising the opportunities for further and wider collaboration and integration through the STP.

Priority Area	Progress since June	Key Benefits Expected
Local Place-based Care	An overarching framework has been defined for our local model of care to deliver improvements in access, continuity and coordination of care. Each of our areas has set out a locally-appropriate implementation model for improving care and reducing demand, including the outcomes to be achieved.	<ul style="list-style-type: none"> • Urgent Care. From November 2016 Black Country patients will have easier access to urgent advice and treatment 24/7 from a range of clinicians via a single phone number. • New Models of Care. Benefits in our localities will include: <ul style="list-style-type: none"> • Same day GP access for under 5s and over 75s • Telehealth pilots for 34,500 patients in Dudley • Increasing community contacts by approx. 25,000 • Create new integrated Health and Care Teams covering 30k-50k populations • Access to a full range of standard primary medical services during core hours and essential services 24/7.
Extended Hospital Collaboration	Plans to deliver efficiencies in support services and to make high-locum specialties more sustainable are now set out. Detailed analysis has been undertaken to map the activity, cost and performance of a range of specialties that may most benefit from collaboration; to identify opportunities for reducing admissions from (and delayed transfers to) care homes; to verify that CIPs are addressing BCBV opportunities; and to clarify the system impact of the MMH development.	<ul style="list-style-type: none"> • Patients getting the very best care through a shared network of expertise • Improve patient outcomes through standardising how hospitals provide care – for example, heart attack, stroke, diabetes, kidney disease • Complete development of a new acute hospital serving 570,000 patients
Mental Health & Learning Disability Services	A route map and delivery timeline have been developed, supported by an extended governance structure and detailed plans for sub-projects. We have also developed a deeper understanding of the physical health needs of mental health service users and how we can better address them.	<ul style="list-style-type: none"> • Reduce the number of patients who have to travel out of area to receive their care – for example, specialist children’s services • Simplify access to services improving health and wellbeing for users, families, staff and communities • Improve all age Early Intervention services; • Reduce variation in care and service delivery across the Black Country
Maternal & Infant Health	A plan of action has now been defined to reduce infant mortality, agree a sustainable model for maternity and neonatal services and to address the Better Birth agenda. A capacity review has been initiated. We now also have a detailed understanding of the human and economic impact of poor maternal health and poor infant outcomes.	<ul style="list-style-type: none"> • Avoiding the unnecessary death of an infant every 11 days through reducing Black Country infant mortality rates to the England average • Options for how to access maternity services and where to birth your baby, developed with local mums • A range of health and care support tailored to mothers and families needs during pregnancy
Future Commissioning	We have now set out an approach for streamlining and standardising the commissioning of services to improve quality of care, patient outcomes and system efficiency.	<ul style="list-style-type: none"> • Commissioners will ensure that patients get the best care wherever they receive it in the Black Country • We will maximise our spending on services by removing unnecessary administrative costs
A Learning System	We are determined to use real-time learning from our range of local innovations to drive change, not just to implement new models and trust they will deliver. We have set out a range of approaches that we will consider, and identified some of the questions we will want to explore to maximise learning from our initiatives.	

Our Transformation Logic Model



Rationale for our STP

The Black Country and West Birmingham health and care system faces significant challenges. Some of these challenges are a function of changes in population need; others are a function of the way we organise and provide services; others grow from the way we engage with patients and the public. We face resulting gaps in care quality, health outcomes and financial sustainability. We must therefore act on multiple fronts. The STP provides us with a framework for doing this. It is an opportunity to act systematically and in concert - to agree upon and address common challenges in a way that we could not as individual constituent parts.

Inputs

In-kind contributions of all BC partners: clinical and managerial resources

Analytical inputs

Programme infrastructure

Additional funding allocations (including £99m Sustainability and Transformation Funding)

Activities

- 1: 'LOCAL PLACE-BASED MODELS OF CARE'**: Develop standardised place-based Integrated Care Models commissioned on basis of outcomes; Promote prevention agenda & build resilient communities;
- 2: 'EXTENDED COLLABORATION BETWEEN SERVICE PROVIDERS'**: Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Commission for quality in care homes; Deliver Cost Improvement Programmes;
- 3: 'MENTAL HEALTH & LEARNING DISABILITIES'**: Become one commissioner for NHS services, Build the right support for Learning Disabilities in association with Council commissioning functions, Improve bed utilisation and stop out of area treatments, Deliver the WM Combined Authority Mental Health challenges, Deliver extended efficiencies through TCT partnership;
- 4: 'MATERNITY & INFANT HEALTH'**: Develop standardised pathways of care for maternal/infant health; Review maternity capacity
- 5: 'ENABLERS'**: Systematically evaluate and learn from process of implementation and evidence based practice; Undertake workforce transformation and reduce agency use; Implement BC Digital Strategy; Rationalise public sector estate; Consolidate back office functions; Develop future commissioning functions
- 6: 'WIDER DETERMINANTS'**: Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact

Outputs

Proactive and efficient model of place-based care codified and commissioned

Pathways codified and streamlined / standardised

Back office / estates / supporting functions consolidated

Digital Strategy implemented

New workforce roles developed

Lessons from implementation & from the evidence

Outcomes

Reduced unwarranted variation in care quality and outcomes

Improved patient experience (and reduced variation in)

Increased proportion of care provided in out of hospital settings

Integrated service delivery

Reduced per capita expenditure

More proactive and risk stratified care; reduced unplanned care

More engaged and productive workforce

Better use of available public sector infrastructure

Increased use of intelligence and insight

Impacts

A more sustainable local health and care economy

Improved quality & experience of care for the population of the Black Country

Improved population health: greater quality and quantity of life

A more capable local economy, equipped for self-improvement

A happier, more sustainable workforce

Sustainability Solutions



£700m 2020/21 STP 'Do Nothing' Gap

£512m Health (£413m savings + £99m STF)

Demand Reduction through Local Place-based Models of Care £81m	<ul style="list-style-type: none"> Eliminating unwarranted variation and improving access to primary care through standardised outcomes and model of delivery. Achieving integrated continuity of care for the 1/3 of the population with Long Term Conditions – improving management and reducing admissions for chronic conditions. Delivering better coordination of care to reduce unscheduled admissions.
Efficiency at Scale through Extended Hospital Collaboration £189m	<ul style="list-style-type: none"> Creating Networks of Secondary Care Excellence Efficiency in Clinical and Non-Clinical Support Services Midland Metropolitan Hospital Development Commissioning for Quality in Care Homes Effective Delivery of Cost Improvement Programmes
Improving Mental Health and Learning Disabilities Services £20m	<ul style="list-style-type: none"> Become one commissioner for NHS services Build the right support for Learning Disabilities with Council commissioning functions Improve bed utilisation and stop out of area treatments Deliver the WM Combined Authority Mental Health challenges Deliver extended efficiencies through TCT partnership
Improving Maternal and Infant Health	<ul style="list-style-type: none"> Closing the Infant mortality gap Developing a sustainable model for maternity and neonatal services Delivering National Better Birth agenda
Workforce Enabler £14m	<ul style="list-style-type: none"> Workforce Efficiency & Transformation (additional to individual provider savings)
Infrastructure Enabler £27m	<ul style="list-style-type: none"> Black Country Digital Strategy - £24m (ePrescribing) One Public Estate - £3m (additional to individual provider savings)
Future Commissioning £82m	<ul style="list-style-type: none"> Strengthen collaborative commissioning to support local services Undertake clinical service reviews of key services across the Black Country Seek to achieve stretch target savings of £82m to enable further investment in service developments
Addressing the Wider Determinants of Health	<ul style="list-style-type: none"> Reducing the Prevalence of Long Term Conditions Maximizing the Impact of the Health Pound

£188m Social Care

Local Authority Investment & Savings Plans - £188m

- Additional BCF funding/Social Care Precept - £69m
- LA efficiencies (locally defined) - £119m

1. LOCAL PLACE-BASED MODELS OF CARE			Project Lead – Paul Maubach	
Project Ambition			Key Risks & Mitigation	
To address the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams that support them and the wider health and care system.			<p>Sponsor sign up is a risk due to change to system incentives. Mitigation is that plans are place-based and have a degree of accountability and autonomy for implementation. CCG leadership is required and is in place in each area.</p> <p>Risks around contractual obligations and procurement of new ways of working can be mitigated by learning from vanguard sites.</p> <p>Securing the workforce required to change skill mix, and demand for key roles such as ANPs and GPs, is supported through workstream engagement with HEE WM, universities and providers.</p>	
Key Actions		Milestones		
1	Mapping current intentions and models in each borough to identify best practice and areas of replication to speed up implementation	Apr 2017		
2	The adoption of a developmental evaluation framework will enable accelerated implementation from a robust evidence base, transferable to other STPs;	Apr 2017		
3	Developing standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;	Each area is starting from a different position. All models to be fully in place by April 2019, Dudley by Apr 2018.		
4	Improving long-term conditions and care pathways with emphasis on prevention, early detection, self-care and building community resilience, supported by Integrated Care Teams working to the same outcome objectives;			
5	Creating better coordination for our frail elderly and those with complex needs through integrated place-based teams which include social care and the voluntary sector, shared records and mobile devices, community outreach services, and advanced care planning, reducing social isolation and supporting patients dying in the place of their choice;			
6	Accelerating the learning from our vanguard sites to implement new incentive and risk management models – long-term whole population budgets /contracts commissioning for outcomes;			
Outcomes Impact			Resources Required	
Category	Type/Scale	Timing		Transformation funding. £34m capital investment for primary care premises and £16m capital to support service provision closer to home. Pace of implementation in vanguard areas is dependent on continued Value Proposition funding.
Better Health	<ul style="list-style-type: none"> Reduction in LTC prevalence, % deaths in hospital & social isolation; 	Full evaluation framework with clear benchmarks to be completed by Apr 2017		
Better Care	<ul style="list-style-type: none"> Improved access, coordination of care, and patient experience (incl. dying in place of choice) Clinical outcomes improved via MDTs, & LTC care pathways Patient experience improves through co-production & patient activation; 			
Sustainability	<ul style="list-style-type: none"> Reduction in emergency bed days, admissions for ACSC, use of acute beds, nursing and social care placements, reduction in elective and non-elective activity, reductions in repeat prescribing £81m Demand reduction 			
Governance				
Project reports to the Operational Group and Sponsor Group. Local implementation is the responsibility of CCGs working with relevant providers. Demand reduction proposals have an interdependency with the hospital collaboration work.				

Dudley's new care model proposes GP led, integrated care in the community through the development of a Multi-speciality Community provider (MCP).

A new approach to continuity of care; and standardising access to services will provide a return on investment as it will improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve efficiency of the overall system.

Actions	Milestones	Impacts
<p>Develop new ways of working to support the future MCP to improve Access:</p> <ul style="list-style-type: none"> - Increase primary care access by providing same day access to our under 5s and over 75 s population; - Telehealth pilots in two practices covering 34,500 patients; -voluntary sector Locality Link Workers, providing access to community-based support; - standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community; - Standardisation and demand management of outpatient referral pathways <p>Support for people to live with a Long Term Condition: A new 'Dudley Quality Outcomes for Health' long term conditions framework which will develop into a full-MCP outcomes framework; Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives; Extended MDT's providing consultant outreach for diabetes, respiratory and mental health conditions</p> <p>Better coordinated care for those with complex care needs:</p> <ul style="list-style-type: none"> - Successful multi-disciplinary teams across all of our 46 General Practices for patients at highest risk of admission; - Rollout of mobile devices to all GP practices, enabling remote access to core patient systems during home visits and better coordination at MDTs; - Extended MDT's providing consultant outreach for complex frail elderly and children with complex health needs - Implement the Airedale model for telemedicine support to care homes - Implementation of a fracture liaison service; <p>System wide enablers for the above:</p> <ul style="list-style-type: none"> •An IT Local Delivery Roadmap towards integrated care records by 2020; •scoping of services, outcomes and characteristics of the MCP; and developing the relationship between the MCP and other providers. •Developing and implementing the system-wide solutions on complex care (including frailty); LTC management and access •Award a contract for Dudley MCP in 2017/18 which includes : •A meaningful outcomes framework to measure improvements in population health supported by a clear and robust evidence base, transferable to other STPs; •Integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community). •Accelerate the learning from our vanguard site to implement new incentive and risk management models – long-term capitation based contracts commissioning for outcomes across the STP footprint. •All of the above will be underpinned by on-going involvement and public consultation (where necessary) with local people. •We will fully engage with all staff involved in the transition of the MCP. 	<p>Dudley is an MCP national vanguard and the overarching objective is to have a fully-established MCP operational from April 2018, holding a capitation-based outcome-driven MCP contract.</p> <p>In the intervening period the existing providers are collaborating to develop the MCP model of care; and are preparing to respond to the procurement to create the MCP in full.</p> <p>MCP development and the implementation of the current value proposition is coordinated by our Partnership Board and led by Stephanie Cartwright. Key timetables for development include:</p> <ul style="list-style-type: none"> • On-going development of MDTs (on-going since 2015/16) • Full implementation of the new primary care outcomes framework - 2016/17 • Improving capabilities in the primary care at scale component of MCP - during 2016/17 • Testing LTC 'team without walls' concept across the system with - phased development through 2016-18 • System-wide new frailty pathway – phased development through 2016-18 • Establishing full MCP Patient reported outcomes 2016/17 • Implementation of the Single Point of Access – interim development of frail elderly solution in 2016/17; full implementation including full integration with NHS 111 will be post MCP procurement <p>The MCP procurement is led by Neill Bucktin and is working to a timetable as follows:</p> <ul style="list-style-type: none"> • Public consultation on outcomes and scope of services July-Sept 2016; • Mapping of risks & mitigations resulting from the procurement Sept 2016; • PIN notice issued October 2016; • Market development on-going until Jan 2016; • Regulator gateway 1 assurance Nov 2016; • PQQ published Feb 2017; • Contract Award Sept 2017; • Full MCP mobilisation April 2018 	<p>Better Health: Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.</p> <p>Better Care:</p> <ul style="list-style-type: none"> • Improved access, coordination of care, and patient experience of GP, community and other placed-based services • Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care • Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care • Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation <p>Sustainability:</p> <ul style="list-style-type: none"> • Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements <p>Potential Headline Statements</p> <ul style="list-style-type: none"> • Delivery of Rightcare opportunities will deliver a 15% reduction in Elective activity over a 4 year period • Delivery of Rightcare opportunities will deliver a 14% reduction in Non Elective activity over a 4 year period • Improved management of Ambulatory Care Sensitive Conditions at a Primary Care MDT level will reduce the annual number of admissions by approximately 1,000 • Improved Primary Care productivity through schemes such as online booking, EPIC programme, centralised repeat prescribing and MDT working will increase the annual GP appointments by 25,000 • Multi Disciplinary Team working will improve efficiency and increase community productivity will increase community contacts by approx. 15,000 • The development of the new front end of A&E will allow an additional 4,000 patients to be triaged and seen by a more appropriate primary care clinician • The new MCP model will help to improve referrals and also encourage appropriate outpatient activity to be delivered in a community setting. This will reduce the number of secondary care outpatient attendances by 43,000, approximately 3% per year.
<p>Governance and Responsibility: There is a partnership board which represents all health and care organisations across the borough to guide the development of the MCP. There is a primary care development steering group to bring Dudley GPs together and develop the future of primary care in the model. There is a procurement project board led by the CCG to make the procurement decisions on the MCP. Dudley CCG is the lead organisation and has considered conflicts of interest to ensure that we have robust separation between functions and personnel where necessary.</p>		

SWBCCG are the commissioning organisation for the Modality Vanguard MCP, the objective of which is to have a fully established MCP operational from April 2018, holding a whole population budget, subject to public consultation. Further work is being undertaken on the Transformation Area programme to scale up the new care model- with other emerging groups taking on the NCM by model by April 2019

Actions	Milestones	Impacts
<p>Work has also commenced and is currently underway on</p> <p>New Care Models:</p> <ul style="list-style-type: none"> A New Care Models Project and programme plan has been established with a number of workstreams to ensure delivery of a new model for provision from April 2018 for Modality as a vanguard, with delivery from April 2019 in other areas. Development of existing advice and guidance services through Modality Vanguard pilot schemes e.g. Consultant Connect as a vehicle to pilot new ways of working <p>CCG Priorities</p> <ul style="list-style-type: none"> Roll out of Right Care priorities for the CCG: <ul style="list-style-type: none"> Maternity Children and Young People Infant mortality Mental Health Urgent Care Cancer Respiratory <p>By delivering new ways of working to not only reshape provision on a local level but support all future MCPs to increase</p> <p>Access, Provision and Cost Efficiency:</p> <ul style="list-style-type: none"> Standardisation of access to services through the new NHS 111 service, integrated OOH, new digital technologies and single points of access Implementing 7 day services, in conjunction with the PCCF Provision of community based services on an increasing basis, such as the recent mobilisation of direct access community diagnostic and extended minor surgery services Diagnosis and treatment of cancer with the use of a new Cancer work plan, to improve outcomes across all indicators. Positive Experience of Maternity provision by remodelling existing community midwifery services with current provider to deliver National Best Practice and working across the STP footprint on maternity and infant mortality Case finding and prevention in LTC, for example; active Atrial Fibrillation Case finding within practices and active lifestyle management of pre-diabetes to prevent development of Type 2 diabetes. Increase quality and coordination of End of Life Service provision with the mobilisation of the End of Life hub model Detailed mapping of existing children’s community service provision to identify gaps or inequity in services Mental health, which is also reflected in STP mental health work plan Prescribing of High Cost drugs- implementation and roll-out of Blu-teq 	<p>SWBCCG are the commissioning organisation for the Modality Vanguard MCP- the objective is to have a fully established MCP operational from April 2018, holding a whole population budget, subject to public consultation. Further work is being undertaken on the Transformation Area programme to scale up the new care model- with other emerging groups taking on the NCM by model by April 2019</p> <p>Governing Body Procurement decision during November 2016</p> <ul style="list-style-type: none"> Baseline model in place for full scope, and Vanguard Scope- working on appropriate scope modelling with clinical support during 2016/17 and early 2017/18. Primary Care Commissioning Framework fully implemented for 2016/17 and updates in progress for 2017/18 to deliver enhanced primary care and access and other clinical outcomes. Vanguard MDT in place and SPA with outcomes measurement through the partnership board through 2016/17 and 2017/18 MCP development and the current value proposition will be co-ordinated by the CCG partnership board and led by Claire Parker from 2016/7 onwards. Implementation of GP strategy to deliver preparedness for NCM- current consultation closed August 2016 with the final document due for approval during October 2016 <p>Public consultation to start January 2017 led by SWBCCG Engagement team</p>	<p>Better Health: Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.</p> <p>Better Care:</p> <ul style="list-style-type: none"> Improved access, coordination of care, and patient experience of GP, community and other placed-based services, such as maternity provision and end of life care services Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care Patient experience improves through co-production & patient activation; and by delivering more efficient care and preventative services to reduce the necessity for ongoing provision as time progresses Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation <p>Sustainability:</p> <ul style="list-style-type: none"> Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements <p>Potential Headline Statements</p> <ul style="list-style-type: none"> Delivery of Rightcare opportunities will deliver a 15% reduction in Elective activity over a 4 year period Delivery of Rightcare opportunities will deliver a 9% reduction in Non Elective activity over a 4 year period Improved management of Ambulatory Care Sensitive Conditions at a Primary Care MDT level will reduce the annual number of admissions by approximately 1,700 Multi Disciplinary Team working will improve efficiency and increase community productivity will increase community contacts by approx. 25,000 The development of the new front end of A&E will allow an additional 7,000 patients to be triaged and seen by a more appropriate primary care clinician

Health and care partners have established the Walsall Together Partnership to develop and implement a new Model of Care: a greater emphasis on prevention, patient activation, community resilience; creating integrated health and care services; streamlining and standardising access to services; supporting people with long term conditions; and co-ordinating care for people with complex needs.

Actions	Milestones	Impacts
<p>Develop new ways of working to transform the efficiency and effectiveness of health and care services:</p> <ul style="list-style-type: none"> We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities. We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways. We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs. We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs. We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model <p>Plans for the creation of new integrated Health and Care Teams have been agreed – 7 teams, geographically aligned, covering 30k-50k populations.</p> <p>Community nursing re-structure complete, social care staff alignment to new structures in progress, discussion on-going re mental health team alignment. Beginning discussion also with the voluntary sector.</p> <p>Workshops to be held in each locality/team area, bringing together primary care, social care, community nursing, mental health to look at how the integrated teams can work differently and better for patients, drawing on learning from national Vanguard programme.</p> <p>Task and Finish groups to develop the Model of Care for priority areas: End of Life, Dementia, Diabetes, Health of Very Young Children, MSK and Respiratory.</p>	<p>Walsall Together is currently developing the Model of Care; it is anticipated that it will begin to prototype key changes early in 2017. The scope and scale of the programme is such that this will be a multi-phase development, as the implementation of different elements of the model and the roll out to full population coverage are managed over time within the overall programme.</p> <p>The CCG and Local Authority will need, in due course, to consider the commissioning of new models of care in the light of their legal duties, including EU and UK procurement law and, for the CCG, the Health and Social Care Act. At present, however, we believe that our models of care are not sufficiently well developed to enable commissioners to determine the approach to procurement and contracting that will ensure that the best outcomes and value is achieved.</p> <p>We propose therefore that there should be a further period during which we continue to work collaboratively with existing providers to develop, refine and test the model, following which a formal decision regarding the commissioning of the new model of care will be agreed. It is anticipated that the decision will be made within a timeframe that allows new arrangements for the commissioning of the new model to be in place by April 2019.</p>	<p>Better Health: Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.</p> <p>Better Care:</p> <ul style="list-style-type: none"> Improved access, coordination of care, and patient experience of GP, community and other placed-based services Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation <p>Sustainability:</p> <ul style="list-style-type: none"> Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements

Wolverhampton's Primary Care Strategy is underpinned primarily by delivery through a Multi Speciality Community Provider (MCP) delivered by care hubs who are supported by integrated teams and through a Primary and Acute Care System (PACS).

The introduction of care hubs will enable the new care model to deliver improved access, improved care co-ordination and continuity of care in the community whereby care can be provided closer to home and in the community setting as far as reasonably practical.

Actions	Milestones	Impacts
<p>Develop new ways of working at hub level supported by integrated teams as the MCP evolves:-</p> <p>Access:</p> <ul style="list-style-type: none"> Implement training for care navigators intercept & guide patients to the health & social care professional that best meets their needs whilst maximising social prescribing opportunities at practice level too March 2017 Improve access to services based in primary care including direct access to diagnostics identified through peer review, patient choice and shared decision making. Access to a full range of standard primary medical services during core hours and essential services 24 hours a day 7 days a week through a combination of primary care and extended out of hours service provision with access to central patient records and where feasible non face to face consultations using skype, email, telephone etc September 2017 Strengthen access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access December 2017 <p>Care Co-ordination:</p> <ul style="list-style-type: none"> Develop home based care including provision of hospital at home, community intermediate care, reablement, rapid response, therapy services and support from the third sector March 2017 Implementation of local strategies for Intermediate Care, End of Life, Ambulatory Care, Mental Health and Primary Care to maximise opportunities for place based care September 2017 Extended MDT's providing consultant outreach for diabetes, respiratory, mental health conditions initially, extending a broader range of disease conditions by April 2019 <p>Continuity:</p> <ul style="list-style-type: none"> Ensure appropriate & timely support in line with our Integrated Care Strategy to support hospital discharge, prevent admission to hospital, avert potential care home admission, identify support that is suitable to meet the needs of individuals October 2016 Reduce demand on services traditionally provided in a hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment achieved through shared decision making, advice and guidance and patient choice March 2018 Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams who are striving to achieve the same outcomes March 2018 <p>Practices as Providers & Commissioners</p> <ul style="list-style-type: none"> Practices working together at scale with community neighbourhood teams that ensure coverage across the city for patients at highest risk of admission to hospital March 2017 Develop and implement a local Quality Outcomes Framework that seeks to achieve the highest standards of care quality, value for money & maximises opportunities for groups of practices to work at scale March 2017 	<p>The Primary Care Strategy in Wolverhampton spans an implementation timescale of 4 years 2016 to 2020.</p> <p>Practices have begun to work at scale and will be commissioned at scale to deliver improved Access from April 2017→ with a trajectory to improve access using a range of sources by December 2017.</p> <p>The achievements of our care hubs are monitored closely by the Primary Care Strategy Committee and Governing Body as well as the city's Health & Wellbeing Board October 2016→</p> <p>Support the PACs (Primary and Acute Care) Model and MCP (Multi Speciality Care Provider) to develop & sustain general practice through working at scale in line with both frameworks to ensure the most appropriate delivery model is adopted April 2017</p> <p>Our new strategies are being implemented across the city and will result in patients receiving care co-ordinated by their GP Practice working in close collaboration with their Community Neighbourhood Team with anticipated implementation by September 2017</p> <p>Identification, work up and launch of extended MDT's to reduce demand on service and improve long term condition management will be realised fully by April 2019</p>	<p>Better Health: Reduction in long term condition prevalence, deaths in hospital & social isolation; increase in people with long term conditions feeling supported with care closer to home.</p> <p>Better Care:</p> <ul style="list-style-type: none"> Improved access, coordination and continuity of care resulting in positive experiences of care in primary, community and other placed-based services Timely availability of a range of services at hub level 7 days a week that enable care co-ordination and continuity Improved Clinical outcomes as a result of practice groups, neighbourhood teams and other specialists working cohesively to provide patient centred care particularly for those with long term conditions & in greater need of support Continuous improvement in service development and provision through engagement with patients who have co-produced efficient & holistic care Reduced variation to improve care quality as a result of standardised pathways; improved communication across our practice groups <p>Sustainability:</p> <ul style="list-style-type: none"> Resource sustainability will be realised through implementation of the CCGs Primary Care Strategy. This will realise improvements in practice service provision, commissioning at scale, workforce, estate, IT, contracting and resilience within each group of practices. Reduction in emergency bed days, admissions to hospital and use of acute beds, nursing and social care placements A range of healthcare professionals providing timely intervention delivering the best possible care in the most effective way. <p>Deliverability:</p> <ul style="list-style-type: none"> Responding to opportunities for improved care quality for pathways included in the Rightcare Programme will realise improved clinical effectiveness Improved management of patients during their end of life phase Improved Primary Care productivity & efficiency through full implementation of a range of IT schemes that enable online booking, online consultations, centralised repeat prescribing and hub working with supporting integrated teams

2. EFFICIENCY AT SCALE THROUGH EXTENDED HOSPITAL COLLABORATION				Project Lead – Toby Lewis
Project Ambition				Key Risks & Mitigation
To deliver a scale of efficiency beyond the reach of individual providers through coordinated action to develop networked and/or consolidated models of secondary care provision.				
Key Actions			Milestones	
1	Develop shared/single service plans for acute specialities with particular opportunities/challenges			
2	Develop new models of care to support specialised services incl cancer/vascular			
3	Develop options for delivering efficiency in pathology services		Q2 2017/18	
4	Extending collaboration in back office services			
5	Complete MMH development		Q3 2018/19	
6	Commission for Quality in Care Homes			
7	Delivery individual CIPs		Annual	
Outcomes Impact				Resources Required
Category	Type/Scale		Timing	<p>£35m capital to support any premises changes required to deliver networked models of care.</p> <p>£3m capital allocated to enable £10m annual revenue savings relating to estates efficiencies as part of CIPs.</p>
Better Health				
Better Care	<ul style="list-style-type: none"> Reduced variation in care and improved outcomes 			
Sustainability	<ul style="list-style-type: none"> Delivery of >2% CIPs £189m net savings (excluding additional workforce and infrastructure savings) 			
Governance				
<ul style="list-style-type: none"> Project reports to the Operational Group and Sponsor Group. There is also a reporting line to the Black Country Alliance. Project includes DGFT, RWT, SWBH & WHT. There is an interdependency with demand reduction proposals/local place-based models, and also with demand assumptions of neighbouring STPs. 				

Project Ambition

Our ambition is to give people living with all types of mental health and learning disability challenges, better outcomes and better services across the Black Country. We will deliver this improvement by reducing the variation in services people receive, standardise our approach to commissioning and use the resources we have in the Black Country as a whole, better - including reducing the need for people to go out of area. By coming together as both commissioners and providers, we can build on mental health wellbeing

Key Actions	Milestones
<p>1 Become One Commissioner Co design, agree and deliver a pathway based suite of designed and specified services (CAMHS; Planned; Urgent; Functional Older Adults) common to all 4 areas of the STP footprint</p>	<p>April 2018</p>
<p>2 Build the Right Support for Learning Disabilities</p> <ul style="list-style-type: none"> • Review and redesign community pathways for supporting people • Review and redesign inpatient services in line with the national • Deliver targeted workforce, provider and family training to support new models of care • Develop the market to encourage robust provision, and increase the uptake of personal budgets • Develop key dashboard reporting tool across TCP • Align budgets from NHSE to redirect into CCG-commissioned services, in preparation for shadow budgets 2018/19 	<p>Q1 2017/18 Q4 2017/18 Q4 2017/18 Q4 2018/19 Q3 2016/17 Q4 2016/17</p>
<p>3 Improve Bed Utilisation and Stop Out of Area Treatments</p> <ul style="list-style-type: none"> • Baseline assessment of bed usage across the Black Country (both Acute overflow and specialist beds); Provider benchmarking review • Improved capacity management within CCG and Provider functions • Review of Urgent Care Pathway across Black Country and implementation of 5YFV recommendations • Explore the potential for bed reconfiguration as part of TCT • Merge Project with Gap Analysis on specialist bed provision to identify Black County based solutions. 	<p>Q4 2016/17 Q1 2017/18 Q2 2017/18 Q3 2018/19 Q4 2019/20</p>
<p>4 Deliver the Combined Authority Mental Health Challenges</p> <ul style="list-style-type: none"> • Implement and deliver Mental Health Waiting Times and Access Standards • Develop and implement a targeted demand reduction plan (incl. substance misuse/suicides & homicides; and addressing wider determinants e.g. MH supported Housing • Develop and implement an All Age Black Country Primary Care Mental Health Strategy • Develop and Implement an All Age Black Country Suicide Prevention Strategy • Develop and implement a Support into Employment Service (IPS) including support post-prison reintegration • Develop, pilot, implement and evaluate provision of 'Mental Health First Aid' training 	<p>Q4 2017/18 Q2 2017/18 Q4 2017/18 Q4 2017/18 Q1 2017/18 Q3 2017/18</p>
<p>5 Deliver extended efficiencies through TCT partnership</p> <ul style="list-style-type: none"> • Mobilise work streams • Feedback from work streams/Review of project proposals by Oversight group • Development of project business cases • Implementation of approved projects 	<p>Q2 2016/17 Q3 2016/17 Q3/4 2016/17 Q1 2017/18 →</p>

3. IMPROVING MENTAL HEALTH & LEARNING DISABILITIES SERVICES			Project Lead – Steven Marshall
Outcomes Impact			Resources Required
Category	Type/Scale	Timing	<p>Non-recurrent investment will be required to support delivery of the transformation. £10m has been allocated to enable the estates changes linked to service transformation.</p> <p>In addition, dedicated programme support will be required in order to ensure the programmes are delivered on time and in full.</p>
Better Health	Improved access to mental health and mental well-being initiatives, care pathways and services across the life span, reducing levels of complexity and chronicity including physical ill health and improving quality of life and life chances and opportunities.	2017/18	
Better Care	Improved access to health and social care driven initiatives across all statutory and non-statutory key stakeholder partners and agencies, aligned with WMCA MH Commission deliverables including focus on primary care and also mental well-being and the wider determinants of mental ill-health in individuals, families and communities.	2018/19	
Sustainability	£20m net savings. Transformed outcomes and experience and reducing demand of high levels and types of need on mental and physical health secondary and tertiary services, optimising recovery and developing and delivering initiatives to increase capability in Primary Care and Third and Voluntary Sector Services.	2020/21	
Key Risks & Mitigation			
<p>Alongside each works stream specific risk there are two overarching risks:</p> <ol style="list-style-type: none"> 1. The scale and timing of benefits across the Triple Aim will be reduced if all partners are not fully engaged and committed to a collaborative approach to delivering the maximum benefits for the Black Country population. This is being mitigated through on-going partnership working, which ensures patient outcomes remain firmly at the heart of decision making. 2. The creation of a new MCP vanguard within the footprint could result in a non aligned commissioning model and the provision from an alternative non BC provider (financial sustainability is not mitigated). Mitigated through GP engagement ensuring new MCP services and specs are aligned with the STP (or vice versa). 			
Governance			
<ul style="list-style-type: none"> • Project reports to the Operational Group and Sponsor Group. There is also a reporting line to the TCT partnership. Project includes 4 CCGs plus DWMHT, BCHT, BCPT. 			

4. IMPROVING MATERNAL & INFANT HEALTH				Project Lead – Richard Kirby
Project Ambition				Key Risks & Mitigation
To achieve a sustainable model of maternal and neonatal care, improving outcomes for mothers and babies across the Black Country				Clinical input – Identified system leads engaged Unsuccessful bid application- Maternal mental health innovation bid Interdependency with West Mids regional neo natal review – Review recommendations Future workforce capacity – Represented on LWAG Co-design of revised pathways lacks patient engagement- ensure effective engagement strategy is in place.
Key Actions			Milestones	
1	Implement the recommendations of the Cumberledge report		Q3 2017/18	
2	Develop an STP-wide network for sharing intelligence and best practice on maternal, neonatal and infant health		Q1 2017/18	
3	Develop a Black Country Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes		Q3 2017/18	
4	Identify opportunities for system wide action on the wider determinants of health		Q3 2017/18	
5	Model maternity capacity projections across the Black Country and develop options for delivery		Q2 2017/18	
6	Ensure best practice arrangements for birth agenda, improving maternity safety outcomes across the Black Country.		Q4 2017/18	
Outcomes Impact				Resources Required
Category	Type/Scale		Timing	Project Management Clinician time and meeting attendance Data analysis Financial analysis
Better Health	Improved maternal health and infant mortality outcomes		2018/19	
Better Care	Sustainable options for future delivery of standardised care; Reflective of national direction - Better Births: access, choice and empowerment		2018/19	
Sustainability	Effective pre-conception care; Healthy pregnancy pathway; Neo-natal pathway ; Normalisation agenda for delivery		2018/19	
Governance				
<ul style="list-style-type: none"> Project reports to the Operational Group and Sponsor Group. There is an interdependency with the West Midlands Neonatal Review. 				

5. WORKFORCE			Project Lead – tbc
Project Ambition			Key Risks & Mitigation
To ensure that we provide the workforce, now and in the future, that can ensure patients receive safe, sustainable, high quality care in the right place and at the right time.			<p>The changing landscape of the workforce availability – aging workforce, generation XYZ. LWAB to understand all workforce data Service demands – 7 day services, care closer to home, TCT etc. From workforce plans Reduced funding – apprenticeship levy, living wage increase, changes to LBR, tariff – LWAB to explore other funding sources Possible changes in terms and conditions with new care models . LWAB to understand implications</p> <p>The system must find ways of working together on matters of consistency ie recruitment and retention, negotiated band/agency costs, workforce planning – LWAB to support</p> <p>Engagement across the system – Utilise the LWAB to support this.</p>
Key Actions		Milestones	
1	STP project leads to work with the LWAB on identified workforce implications to deliver transformation	Current and ongoing	
2	Scoping of new and existing workforce hotspot areas across the system and LWAB system task and finish groups to deliver the solutions	Nov 16 onwards	
3	Develop a robust methodology for workforce planning across the system	2017/18	
4	Development and delivery of a work plan on the priorities identified by the LWAB from the STP and Human Resources perspective. Bank and Agency spend/skill mix of workforce/integrated, sustainable and effective workforce/recruitment and retention of the workforce	Nov 16 onwards	
5	Understand the Carer and Volunteers workforce to identify good practice and make recommendations on areas for development.	2017/18	
Outcomes Impact			Resources Required
Category	Type/Scale	Timing	This is not fully clear yet. Part of the ongoing work with the STP Project Leads and LWAB will be to identify the resources required.
Better Health	Reduced reliance on non-substantive staff will improve consistency of service	2017/18	
Better Care	Skill mix will deliver competent care, in right place by right person.	Q4 2016/17 on	
Sustainability	£14m at-scale savings beyond standard Cost Improvement Programmes. There will be a reduction in bank/agency costs, a different skill mix and a reduction in recruitment and retention costs. The transformation being developed will deliver a sustainable and flexible workforce for the future delivery of health and care provision.	2017/18	
Governance			
<ul style="list-style-type: none"> This project reports to the Operational Group and Sponsor Group. It is materially dependent on the work of other transformation groups for the definition of models of care and associated workforce requirements. Its work will be enabled through the Local Workforce Action Board. 			

7. INFRASTRUCTURE			Project Lead – Tony Gallagher
Project Ambition			Key Risks & Mitigation
To ensure the STP has a sustainable infrastructure (One Public Estate and Digital) that supports transformation of care models.			<p>Estates: Access specialist advice and renegotiation of existing contractual arrangements. Usage options linked to Transformation plans.</p> <p>Digital: Alignment of collaboration – strong leadership, transparency, geographical implications, cross boundary patient flow . Funding – at scale procurements, shared learning, willingness to implement change to forward 5YFV. Development of Digital Culture – shared learning, strong leadership, transparency, good communication. Variance in digital maturity (technologically and culturally) – planning, accurate baselines. Feasibility of technology vendors offering solutions to benefit all health and care services within existing portfolio, without requiring bespoke development – Effective development of requirement specifications and standards. Effective procurement processes. Existing locality contract values of existing solution may be superseded through preferred shared solutions – planning, transparency, strong collaboration, working with NHSE, Head of Digital Technology. Gaining buy in [providers and patients] to share information across the Black Country – Communication, established group approach, governance, shared learning from peer organisations. Organisational change impact is workforce efficiency – effective change management/communication.</p>
Key Actions		Milestones	
1	Explore potential to buy-out elements of PFI or Lift	Q3 2017/18	
2	Review utilisation of current public estate and develop options for more efficient usage	Review to be completed by Q4 2016-17 with options to be developed by Q3 2017/18	
3	Form Black Country Digital Transformation Board to lead, drive & own delivery of Local Digital Roadmaps	<ul style="list-style-type: none"> Well established BC LDR Group - complete Ratify MOU and ToR – Q3 16/17 	
4	Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20)	<ul style="list-style-type: none"> Develop agreed digital architecture – Q4 2016/17 Develop phased digital plan including interoperability, empowerment, intelligence, infrastructure) – Q1 17/18 Deliver digital plan Q1 17/18 – Q4 19/20 Paper free - Q4 19/20 	
5	Accelerate & support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise ‘risk of regret’ & maximise triple aim benefits	<ul style="list-style-type: none"> Well established BC LDR Group – complete Develop risk register – Q3 16/17 Finalise governance - Q3 16/17 Shared Learning - Q3 16/17 Benefit realisation - Q3 16/17 to Q4 19/20 Vanguards - TBC ETTF funded integration within LDR’s Q4 16/17 	
6	Rapidly identify & deliver ‘quick wins’ such as ePrescribing, ToC (electronic correspondence), network rationalisation, and procurement efficiencies	<ul style="list-style-type: none"> Agree strategy to deliver integrated roadmap – Q4 16/17 ePrescribing – Q4 17/18 Network rationalisation e.g. HSCN (plan) – Q4 16/17 Procurement Efficiencies Q4 16/17 – Q1 19/20 	
Outcomes Impact			Resources Required
Category	Type/Scale	Timing	Specialist advice. Capital funding - £5m to support implementation of ePrescribing.
Better Care	Delivery of solutions to support new care models	2020/21	
Sustainability	Savings from ePrescribing (£24m). Additional reduction in STP estates costs (£3m).	2020/21	
Governance			
<ul style="list-style-type: none"> This project reports to the Operational Group and Sponsor Group. It is dependent on the work of other transformation groups for the definition of requirements. 			

8. FUTURE COMMISSIONING			Project Lead – Andy Williams
Project Ambition			Key Risks & Mitigation
To simplify and standardise commissioning mechanisms across the Black Country in order to support Better Health and Better Care, and to remove duplicated costs.			
Key Actions		Milestones	
1	Identify priority areas for streamlining and standardisation – both quick wins and major opportunities – via Clinical Reference Group	April 2017	
2	Strengthen collaborative commissioning between CCGs and Local Authorities on a place-based basis	Ongoing	
3	Undertake clinically led service reviews (informed by Senate Assurance framework)	December 2018	
4	Identify and evaluate alternative mechanisms (including new contracts types and organisational forms) through which streamlining and standardisation can best be enabled, and efficiencies delivered	April 2018	
5	New commissioning arrangements to be implemented and relationship with regulators to be confirmed	April 2019 (Dudley Apr 18)	
6	Assess system-wide impact of MMH and develop plans in response (as required)	April 2017	
7	Seek to achieve stretch target savings of £82m to enable further investment in service developments	Ongoing	
Outcomes Impact			Resources Required
Category	Type/Scale	Timing	
Better Health	Reduction in unwarranted variation in service outcomes	2019/20	
Better Care	Less complex and more effective models of care	2019/20	
Sustainability	More efficient service delivery and removal of duplicated commissioning costs. Services at risk due to workforce challenges are retained in the Black Country	2019/20	
Governance			
This project reports to the Operational Group and Sponsor Group. There are critical interdependencies with CCG decision-making and NHSE specialised commissioning.			

Project Ambition				Key Risks & Mitigation
To take effective and coordinated action with LA partners (including the WMCA) through a focus on the wider determinants of health to support people live healthier longer lives.				To be identified as plans for each key action are developed.
Key Actions			Milestones	
1	Develop and implement a range of evidence-based recommendations that support the whole prevention agenda and what that means across the health and social care system.		Completion of local preventions/ early intervention framework.	
2	Implement the recommendations of the Mental Health Commission once published.		Plan developed.	
3	Deliver ambitious programmes across the Black Country to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count and mental health literacy. This will include the implementation of workplace health and wellbeing programmes across all health and social care sectors including local business.		Adoption of NHS Healthy Workforce Programme and associated CQUIN/ Workplace Wellbeing Charter (PHE).	
4	Develop STP-wide network of best practice. Identify prevention resources /self-help tools.		Collection of case studies	
5	Work across health and social care system including the WMCA to build social capital and improve resilience: reduce social isolation; promote independence through personalisation; develop place-based models of care to improve management of LTC; improve employability and skills development to make an impact on productivity; and encourage a wellbeing focus across all health, social care and spatial planning policies.		Mapping of community resources	
Outcomes Impact				Resources Required
Category	Type/Scale		Timing	Local Public Health departments working together with WMCA and STP workstreams.
Better Health	Bridges the divide between population change and individual behaviour change to scale up ill health prevention to improve healthy life expectancy and mental wellbeing.		2020/21	
Better Care	Supports investment in a preventative approach across the system that should impact on health inequalities and reduce avoidable hospital admissions		2020/21	
Sustainability	Large scale implementation of a preventative approach should provide clarity on the return on investment from a health, social and financial perspective leading to sustained investment.		2020/21	

Governance

This work links the work of the Sponsor Group with the 5 Local Authorities and the West Midlands Combined Authority.