



## ***Working Together For Health***

**Birmingham East and North and Solihull**

**Local Health Economy**

**Overarching Vision and Plans**

**2008-2013**

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## **Executive Summary**

This document sets out Birmingham East and North and Solihull Local Health Economy (BENS LHE) Vision and Plans for the period 2008 to 2013, this follows on from the initial draft submission from BENS LHE to NHS West Midlands on the 21<sup>st</sup> December 2007 which outlined the:-

- Local Health Economy Overarching Vision
- Local Health Economy Core Strategy
- Reflections on the initial “Darzi” nine clinical pathways and their fit with the overarching vision and core strategy for the LHE
- Comment on the most challenged specialities / services as outlined in the NHS West Midlands Investing for Health Strategy (IFH)
- Outline Commissioning Intentions for 08/09

This document builds on that initial submission and adds to it by setting out:-

- The aspirations of the BENS LHE
- The plans to support delivery across each of the nine clinical pathways
- The governance arrangements to assure delivery
- The deliverables
- The affect over time of the delivery of the strategy on activity, workforce, estates and finance

The changes envisaged over the next five years take account of the work and key messages coming out of the nine Clinical Pathway Groups (CPGs) as well as linking to the work of the ten Investing for Health projects (IFH).

The structure of this document reflects the nine CPGs; however it also shows how locally individual organisational objectives underpin the LHE vision.

This final submission should be read in conjunction with the control charts which will reflect outline activity projections, long term financial models and major change programmes.

## **1.0 Introduction**

The Local Health Economy of Birmingham East and North and Solihull which is made up primarily of four organisations the Birmingham East and North Primary Care Trust (BEN PCT), Solihull Care Trust (SCT), Heart of England Foundation Trust (HofEFT) and Birmingham and Solihull Mental Health NHS Trust. These organisations commission provide and in some cases undertake both the commissioning and provision of services to a resident population of 630,000. The organisations receive services from the West Midlands Ambulance Service, Badger Primary Care Out of Hours Service and a number of smaller providers who although do not sit within the LHE have a role to play in assisting the formal members of the LHE set out there vision, aspirations and plans.

The LHE is characterised by significant pockets of deprivation in the BEN PCT area and a more affluent community within the Solihull conurbation although there is deprivation on the borders of the BEN PCT and SCT area particularly in Chelmsley Wood, Kingshurst and Fordbridge and Smithswood. The registered population in BEN PCT is diverse, with significant differences in profile at ward level; Washwood Heath is 70% black and ethnic minority (mainly of Pakistani or Bangladeshi Muslim origin) with less than 15% over 60s and some 30% under 16 year olds; in contrast, Sutton Four Oaks has only 5% ethnic minority (mainly Indian) and 25% over 60s, with only some 15% under 16s. The diversity of demography is reproduced in significant disparities in socio-economic status with no super output area in Sutton in the most deprived percentage for England but 100% of the population in Washwood Heath living in an area falling within the highest 10% deprivation for the country as a whole. Not surprisingly, this disparity is again reflected in significant inequalities in health status and mortality with an over 6 year difference in average life expectancy between the two wards. Whilst these two illustrate the most extreme differences, each local area has distinct characteristics, within a majority deprived area. In SCT area health inequalities continue to be of concern. The Director of Public Health's report for 2007/08 highlighted the huge excess in poor health that is seen between people who live in some of Solihull's least affluent areas and is stark contrast to the extremely favourable health outcomes that people living in the borough's most affluent benefit from.

The LHE is a complex mix of organisations covering two Local Authorities and SCT having responsibility for both Health and Social Care. HofEFT has three sites covering Solihull, Eastern and North Birmingham. BSMHT has responsibility for providing services across Birmingham and Solihull and this means relationships with a range of Commissioners. Commissioning budgets total across the LHE £1.6 billion. Both Commissioners and Providers are financial sound.

The LHE has been developing since 2003 under the WTfH and this has allowed for a number of joint pieces of work to be undertaken across the LHE. The view about the level of success of this joint work from members of the partnership will be different, because although there has been stability in some organisations, others have had significant changes in senior leadership and this has necessitated a need to revisit the core purpose and goals of the WTfH programme on a regular basis.

The present LHE senior team has a well-established and close working relationship on day to day issues as well as WTfH. The Clinical leaders have a well established clinical leadership group which has driven forward issues such prior approval, use of clinical data to improve LHE performance.

The senior leadership team across the four organisations have recently reviewed the working arrangements for LHE working and have agreed a further powering up of WTfH to ensure issues and developments of importance across the LHE is addressed in systematic way.

The organisations have signed up to a clear set of principles which allows for the delivery of clinical service redesign. WTfH is now seen as core strategy by all organisations and this is reflected in the formal sign up to the core strategy by all four boards. This is also reinforced by organisations for example BEN PCT in its revision to its core purpose, goals and strategies has identified WTfH has one of its key strategies for delivery. Work is underway across the LHE to reinforce WTfH programme as a key way of delivering integrated service provision across the BENS LHE area.

## **2.0 Local Health Economy (LHE) Overarching Vision**

The LHE overarching vision has been developed between the following partners, Birmingham East and North Primary Care Trust (BENPCT) Heart of England Foundation Trust (HofEFT), Solihull Care Trust (SCT) and Birmingham and Solihull Mental Health Trust (BSMHT) and builds on work that the LHE has undertaken over the last four years. This vision brings together an amalgamation of work undertaken through the Working Together for Health programme (East of the patch) and the Lets Do programme (North of the patch). The LHE sets out an agreed vision and core strategy (see BENS LHE Core Strategy appendix one).

The LHE core strategy has six key strands:-

- Active identification and management of treatment and care to prevent illness and improve quality of life
- Promotion of self care and partnership in care between clinicians and patients
- Priority given to enabling people to stay at home
- Clinical leadership to drive change

- Use of information technology to support integrated patient care and change management
- Integrated approach to infrastructure development

These key strands help shape the development of commissioning and provision plans for the period 2008-2012.

The BENS LHE intentions are influenced by local need, the LHEs strategic approach, the messages from the nine clinical pathways groups (local and regional) which are a key part of the “Darzi review” alongside the 7 “big challenges” and 5 strategic priorities identified in the NHS West Midlands strategic framework “Investing for Health”. The vision and plan to 2012 continues to be influenced by each organisations local strategy and plans, particular future commissioning intentions. These are developed through clinical leaders within the organisations who are party to this plan either through individual and / or joint organisational approaches. Examples of how this works in practice are detailed below:-

**Example One**

Birmingham East and North PCT have recently reviewed its core purpose, organisational goals, core strategies and organisation design criteria. This has involved the ten Clinical Directors playing an active role in reviewing whether the core purpose, goals and strategies remain relevant and support the delivery of healthcare in the 21<sup>st</sup> Century. The result has been a revision of the core strategies of the PCT which underpin the delivery of the core purpose and goals. This has necessitated a further revision of clinical leaders responsibilities for leading and driving the work across the nine clinical pathways to ensure that services will in the future deliver what is envisaged by both clinicians, patients, public and other stakeholders

**Example Two**

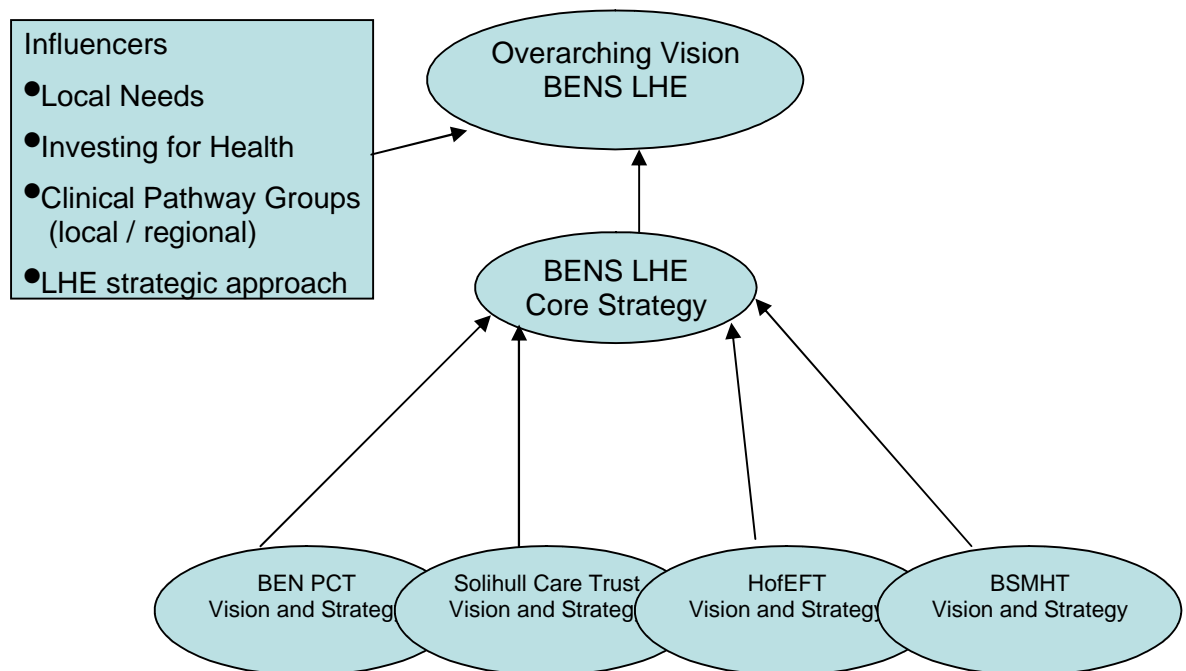
The LHE partners have recently reviewed the Working Together for Health (WTfH) programme. This programme has been in place since 2003 and has provided a vehicle for increased integration of work between organisations and clinicians to drive service change. The programme has delivered a number of significant clinical service changes whilst establishing a set of relationships between Managers and Clinicians which create an environment for conversations not only about service developments, but also the difficult issues such as decommissioning. There is now recognition by all parties that WTfH is now part of mainstream work and therefore needs an increasingly more formal infrastructure which further boosts clinician’s leadership across the economy and it has been agreed that a more formal Board and work programme which tackles major strategic issues now be put in place. This will mean that services such as Maternity Newborn Services will now be addressed through WTfH with Clinicians jointly driving the changes required

**Example Three**

SCT on behalf of the LHE partners is championing the personalisation agenda. Its unique position as a Care Trust covering both Health and Social Care allows the organisation to test out the delivery of personalised care packages for health and social care in a way which ensures the person is truly at the centre. SCT is also testing innovative approaches in relation approaches to personalisation including personalised budgets across the health and social care continuum. This work will be of particular importance to the whole LHE as attempts to scale up interventions related to people with long-term conditions

The process for developing the LHE vision has been one which takes account of the local organisations views of their own patch or area of service delivery which identifies local challenges and need, as well understanding what is being articulated through other work for example the “Darzi” clinical pathway groups and the Investing for Health strategy. How all the above relate to each other is shown below.

**Diagram one**



In developing BENS LHE Vision the LHE has reviewed the key outcomes of the nine Clinical Pathways Groups both locally and regionally against the work underway within the LHE. The LHE has confirmed that these pathways are helpful and reflect how the LHE wishes to see services

develop over the next five years. The fit of the pathways with the LHE vision has allowed for assimilation of the results of the nine Clinical Pathway Groups into the LHE work. The LHE will use those pathways to support local service change.

Sections three to ten of the overarching plan set out to describe the key themes from the CPGs on both a local and regional level, the LHE aspirations in each service and /or area, the proposed plans and the governance arrangements to assure deliver. Section eleven describes how the expected delivery of these plans will be reflected in changes to activity, workforce, estates and finance.

### **3.0 Maternity and Newborn**

#### **Key Messages (Local / Regional)**

- Encourage natural childbirth and keeping women out of hospital
- Ensure key worker i.e. Midwife is the anchor whilst improving accessibility and accountability (planned care with excellent care coordination)
- Invest in preconception care and antenatal education. Make education multi-media. Embrace every aspect of technology.
- Develop a local community approach (Village mentality) make care local and familiar and increase integrated approach to avoid fragmentation

To support these key messages all women in the LHE will be provided with a choice of safe, high quality maternity care, so to enable pregnancy and birth to be as safe and satisfying to both mother and baby and to support new parents to have a confident and happy start to family life. These choices need to be influenced and shaped by the people who use them

For children that require intensive medical interventions at birth, Commissioners and Providers will ensure that high quality, safe and effective medical intervention is available across the LHE.

Commissioners should target interventions to those at high medical and social risk and ensure appropriate support is provided before, during and after pregnancy by appropriate professionals.

The LHE partners should ensure that services commissioned and provided are women focused and family centred and offer a welcoming, safe and high quality environment for women to feel confident about their pre-birth, birth and after-birth care.

## **Aspirations**

The LHE aspires to a system which is well planned, focused on the individual and gives choice to those individuals in relation to the care they need and where they receive it.

## **Plans**

The delivery of this aspiration firstly means the LHE needs to get the basics right, the healthcare commission review on present maternity services leaves the LHE with work to do which includes the need to be increasingly systematic in its approach to supporting and giving choices to women both before they are pregnant, during their pregnancy and follow up afterwards. This includes the effective identification of risk factors for each woman and the collection of data to support these activities and the targeting of support to ensure women remain healthy and ultimately have a healthy baby. The challenge for the LHE to reduce peri-natal mortality must not be lost in the above aspiration.

The plan which will be drawn up by the LHE through the WTfH Board and will reflect the work being undertaken on a Pan-Birmingham basis will look to ensure that the current local issues relating to HCC action plan, local midwifery capacity and the management of data for effective identification of high risk cases are dealt with as a matter of urgency whilst developing a Maternity and Newborn Commissioning Strategy which is much more radical and will address issues of unit size and the need to increase and give real choice to women. The will of course mean that the scope, scale and size of units will need to be addressed. However, the need to deliver the ordinary extraordinarily well has to be the initial focus of the LHE particularly with the increase in the birth rate within the area.

It is envisaged that 2008 will be about the basics and the underpinning arrangements that need to be in place to ensure any women receive a level of service in line with best across England. In tandem with this there will be the development of a Maternity and Newborn commissioning service strategy. Experience has shown that to produce, consult and then start to deliver this strategy through an agreed business case takes eighteen months to two years and therefore any new arrangements in relation to units, size, scope and style will only start to be delivered in early 2010, with an implementation which takes the LHE from 2010 to 2012.

## **Governance**

The WTfH Programme Board will be responsible and accountable for overseeing development and implementation of the above plans which includes:-

- Getting the basics right
- Ensuring production of the plan to deliver the change
- Delivery of the agreed plan
- Monitoring outcomes

Each organisation will identify a clinical champion and one of these clinical champions will take the lead on behalf of WTfH and the LHE for ensuring effective arrangements are in place across organisations to deliver the plan.

### **Deliverables**

#### **Getting basics right**

1. Ensuring implementation of plan to improve position as outlined in Healthcare Commission report.
2. Ensuring that work implemented to support the reduction in Perinatal Mortality is firmly embedded into mainstream work
3. Risk stratification and data issues are fully resolved
4. Midwifery workforce planning is further developed to ensure that the opportunities for choice for women is available out with of major service change options.

#### **Development**

1. Develop, consult and implement a Commissioning service strategy for maternity and newborn Services which reviews and outlines future longer term intentions in relation scope, scale and style of services. This will take cognisance of the Birmingham wide review of Maternity services

### **4.0 Children**

#### **Key Messages (Local / Regional)**

- The role of partners in delivering health must be reflected in multi agency pathways
- Need to identify more effective ways of involving children in all areas of service planning, development, delivery and evaluation both at a whole service level and in individual packages of care, good communications being at the heart of developments
- There is a need to increase community and primary care based alternatives to acute care for children where appropriate
- Strategies need to be developed for a facilitative culture and leadership capable of providing child centred care
- Realisation that the age continuum starts at birth, unhealthy children are likely to become unhealthy adults, therefore early

intervention and more emphasis on children's care will benefit the whole health community

- Multi agency working in prevention and early detection
- Transition pathways for all conditions
- Prevention wherever possible
- Early assessment and intervention

To support these key messages the LHE with partner organisations will create support and services where all children and young people are happy, enjoy living, learning, developing and achieving together whilst feeling secure in a city that is child and family friendly.

The LHE will build on the work through the Children's Trust to date to develop an in-depth understanding of need that will help us secure the services children require. Radical changes to the way the LHE organises, commissions and delivers services, especially in how people from different organisations work together at the front-line through models of vertical integration at the service level where appropriate.

The LHE will support the drive to integrate service delivery and work with parents, carers and families across statutory, voluntary and community organisations with a focus on preventative services.

The pan-Birmingham Children's Services Steering Group (chaired by Sandy Bradbrook, HOBtPCT) has been set up to work on the strategic commissioning service of children's services. It includes the commissioners from the 5 PCTs across Sandwell, Solihull and Birmingham.

### **Aspirations**

To provide high quality safe children's care with partners in social care, education as well specialist services and is delivered in the most appropriate setting which offers convenience, choice and is personalised to the individual child.

### **Plans**

A significant amount of work is already in the place to support the delivery of this aspiration it includes:-

- Brighter Futures (the joint strategy developed and signed off by all partner organisations across health, social care, education)
- Local Commissioning strategies for children in relation to healthcare

- Three year Local Area Agreement
- Other strategies which apply as readily to children as they do to Adults this includes the other seven Darzi clinical pathways

## **Governance**

Each local PCT will have a significant amount of activity related to Children and the commissioning of children's services this work is coordinated through the Children's joint commissioning group Pan Birmingham. Each PCT has a clinical lead for Children's services that has a responsibility for ensuring that the local strategy is fully developed and is integrated with joint commissioning and partner plans. Over and above this the revision of the Children and Young peoples Partnership Board governance arrangements supports the need to now turn a range of plans into deliverable outcomes for Children. The LHE will use the present governance arrangements to assure itself of progress. Clearly the local focus will be addressed through specific actions within and across the LHE.

## **Deliverables**

1. To deliver the five outcomes outlined within Brighter Futures
2. To develop a fully costed joint commissioning plan which addresses the issues of service provision and changes to service provision applicable to all organisations
3. To complete the production of a LHE commissioning service strategy for Children. This plan will bring together a range of current activities and set out in a coordinated way how Children's healthcare services will be developed and delivered in a different way in the future
4. Implementation plan for the future provision of children's services which will focus on prevention, healthy lives and the development of incentives to support initiatives such as tackling obesity

## **5.0 Staying Healthy**

### **Key Messages (Local / National)**

- Priority should be given to ongoing support for people who are attempting to change their lifestyle
- Develop personal shoppers - to advocate for people and enable people to access service
- Exploit modern technologies - IT, communications, etc.
- Support/fund communities and voluntary sector to provide services at local level

- Change to locally relevant wellbeing outcomes not sickness targets
- Develop local pathways that are simple and navigable by all users and providers (by patients, public and staff)
- Develop systems that reward for moving to and maintaining healthy life styles
- Develop labelling/traffic light system for alcohol similar to that used for foods

To support these key messages the LHE will continue to develop its philosophy and focus on commissioning, redesign and developing new services that promote wellness rather than treat sickness. The services commissioned in the LHE reflect a requirement to build a partnership with communities whilst increasing the input of all sectors into supporting a major shift in healthcare focus. This is already being developed through a range of initiatives across the LHE and work with the Strategic Health Authority through its Investing for Health strategy. Work which will be of benefit to the LHE is the present procurement of a partner to work with BEN PCT to develop a new relationship with Patients, Public and other stakeholders.

### **Aspiration**

To have a system which fully engages individuals in understanding and taking action about their health prior to being ill as envisaged in the first Wanless report under the fully engaged scenario.

### **Plans**

A significant work plan on helping people to help themselves is underway through the LHE and within project one of the Investing for Health strategy. The secret to achieving a paradigm shift in the way the public react to healthcare is through the development of a new relationship with Patients, Public and Staff. I.E Patients should be given information and support to self-care, the public should be targeted with key health messages in an appropriate ways so we know that they will have a lasting effect for example in the way the food standards agency target messages about the food we eat. The LHE wishes to create an environment where staff are role models for the individuals they interact with. There are a number of plans already in place for example the procurement of partner in BEN PCT to develop a new relationship with patients, public and stakeholders. This partner will work with the PCT and will bring with them Social Marketing Techniques, new ideas about engagement using social networking and technology as well developing the concept of ownership of the PCT by the public. The piloting of incentives to support healthy behaviours and lifestyles will be piloted in 2008. By 2012 all individuals should have access to their own personal health plan and potential for personal budgets which linked

with better knowledge about healthcare choices will enable a shift from a set of unplanned and chaotic interventions to a more planned approach for the majority of the population rather than the minority. This will dramatically shift care responsibility to members of the public and much of that care will be undertaken by them in their own homes. For example it has already been demonstrated that people with a long-term condition who gain control and knowledge about their condition reduce their visits to a General practitioner by 30% and reduce their unplanned interventions by up to 50%.

### **Governance**

Much of the work is already underway through the individual commissioning arrangements within BEN PCT, SCT and the work of project one Investing for Health. For example the BEN PCT new relationships procurement, the work to pilot incentive schemes and the development of pilot staff wellness programme (other organisations in the LHE are interested in testing this programme) and the work lead by SCT on individualised budgets will indicate progress in this area for the LHE. A clinical lead has been identified within BEN PCT to lead the Staying Healthy stream. The work through Project one in the Investing for Health strategy will potentially support the LHE aspirations. Further work on the structure for the delivery of aspirations across the LHE needs to be undertaken.

### **Deliverables**

1. Confirm how staying healthy is being addressed across whole health economy.
2. Complete new relationships procurement and set out plan (3 years)
3. Implement pilot staff wellness programme
4. Implement pilot incentive programme linked to wellness with public
5. Gather information on all staying healthy programmes to build coordinated strategy for next five years
6. Undertake economic modelling of real effect of change in population behaviour

### **6.0 Long term conditions**

#### **Key Messages (Local / Regional)**

- Ensured joined resource planning which involves integration of the resources.
- Patient/customer focussed approach combining health and social care, recognising the role of unpaid carers and the voluntary sector.
- Create incentives for changed behaviours, especially for prevention.

- Utilise and develop the expertise of the workforce - empowering and releasing the talents. Redesign services means redesigning the workforce.
- Educate patients in using the health systems appropriately and educate clinical staff about initiating change for patients to allow staff to redirect patients without criticism
- Single Access point agreed across organisation with leads on the big killers, using existing staff that can take things forward, with clinical leaders in all areas. This will involve a level of service integration across acute, community and primary care staff
- The effective management of long term conditions requires different parts of the health and the social care systems to work together and provide integrated care for the individual. Support and care must be organised to match a pathway of illness lasting many years. Problems must be anticipated to reduce the rate and consequences of deterioration and the need for emergency care.

### **Aspirations**

All members of the LHE population have access to support to enable them to understand their condition and take proactive action to manage their condition, underpinned by appropriate levels of support.

### **Plans**

The White Paper, “Our Health, Our Care, Our Say” a new direction for community services, set out a vision for the future of primary care and community services. A key component of this vision is to provide care closer to home and/or in a community setting, shifting from a model of hospital based services towards more proactive community based approaches, allocating a larger share of the available resources to preventative, primary, community and social care services.

This fundamentally is about the redesign in the process of support and care for those with long term conditions so that the system fits around the person rather than the person fitting in with the system. This in turn meets the LHE objectives of moving care into the community, provide better outcomes for patients and gain the best value from available resources. Over and above this the need for individuals to understand more about their condition and take control of the management of that condition is key and the LHE has developed a number plans that facilitate this learning and taking control.

Examples of current commissioning and provision includes the Partners in Health Centre, Birmingham Own Health, Community based Dermatology services and Intermediate Care. The success of these developments has created an environment where innovation in commissioning flourishes allowing providers to test, learn and refine

services commissioned on a small scale before opening up the criteria to allow more patients with a long-term condition to access these services. Current services have to demonstrate their value and are evaluated using an appropriate outcomes framework ensuring that services deliver value for money, high quality, and are evidenced based.

The next step is to commission and provide services across the LHE at a scale which means all individuals have access to these services, whilst ensuring the integration with existing services and pathways, recognising that the commissioning and provision of long term conditions is far more than just shifting care from one location to another; this approach to helping people help themselves requires a significant change across the whole system of care.

The intention is to provide services to all people with a chronic disease whether ill or not and to attempt to ensure all these individuals are able to look after themselves for a longer period but when requiring help they access services in a planned way. For example by 2012 27,000 people within the BEN PCT area will have a telephone based care manager who will work with them to understand their condition and manage their health to avoid unnecessary illness. The costs of this proposal is the region of £15 million, however economic modelling undertaken to date suggests that some £32 million can be saved through reductions in unnecessary health interventions.

Further work will be commissioned through the LHE and the WTfH Board will be asked to develop and enhance the programme of work.

### **Governance**

Clinical Leadership will be provided through individual organisations although much of the work where appropriate will be coordinated through the WTfH Programme Board

### **Deliverables**

1. All organisations to agree and sign off a Long-term conditions strategy for LHE to 2012 during 2008.
2. Strategies for sharing present best practice and the development of plans to scale up this practice need to be developed
3. Implement next stage of Birmingham OwnHealth to target 27,000 members by 2012
4. Implement and test Wellness Programme and incentive schemes
5. Agree extended work programme via WTfH.
6. Develop workforce development plan for full implementation of services to support people with long-term conditions rather than aiming workforce development at treatment

## **7.0 Acute Episode (Urgent Care)**

### **Key Messages (Local / Regional)**

- General Surgery Admissions and General Admissions need 24/7 clinical and staffing cover as well as 24/7 local access for Primary Care services
- Integrated health care system - No more primary and secondary service. Access to social workers and social care 24/7 so services are consistent regardless of the day of the week.
- Public education on why we need to centralise emergency care to provide a better service. Educate the public in effective use of health services and clarify the role of the NHS.
- Don't create financial disincentives or use it as barrier for good practice
- Better data, coordinated integration of IT but securely held

The key messages regarding the Acute Episode are important to understand. The single biggest message for the LHE is the development of increased integration across the Acute Episode pathway which ensures that the present perverse incentives for admission to hospital are removed. This is not only about the system of Payment by Results it is also about patient streaming and development of a planned, unplanned care system which is predicated on patients being treated in the right place at the right time. These messages give significant impetus to the work already underway to create a vertically integrated urgent care system and to create a set of incentives which means patients use the most appropriate services for their need. Examples of the work to date include work to reshape the ambulance pathway whereby ambulance services do not automatically take everybody to an Accident and Emergency Department, integration of Out of Hours services with Hospital emergency services and the increased development of satellite emergency centres for non-urgent treatment for example the Urgent Care Centre at Warren Farm.

### **Aspirations**

To develop a planned interconnected system for unplanned interventions this means that whatever part of the system is accessed by Patients. They are navigated to the right part of the system for treatment. The system is also incentivised to do the right thing.

### **Plans**

There a significant number of pieces of work underway across the LHE to deliver the aspiration as set out above. These include:-

- A vertical integration project in urgent care which involves a redesign of the system and the payment regime that underpins that system. This is Department of Health / Strategic Health Authority sponsored project which runs for 12 months and subject to outcomes will be used to redesign the whole urgent care system over the next five years
- Project with Ambulance service and Out of Hours provider to triage prior to sending an ambulance or in the home with direct access to a general practitioner for advice and support
- Extension of the Urgent Care Centre model to cover the whole of the patch
- Work with providers to identify patients who have pre-existing conditions so that the urgent care provider can access mainstream services to avoid where possible an admission to hospital
- Work on educating patients and the Public on appropriate use of services
- Work across the LHE to manage the flow of Patients through the urgent care system into planned care

It is important to note that many of these developments are linked to other pathways for example there are a significant number of urgent admissions for End of Life Care and this is being addressed through additional commissioning of services to support people at the end of life. Furthermore the work to support people with long-term conditions will impact on how many acute episodes there are in the future that come as no surprise. The other point to make is that there is significant focus on this area as it is seen as area which can be controlled and thereby reducing costs for use elsewhere in the system. However this fundamentally relies on the LHE systematically agreeing the impact of these developments and having the confidence to take the acute capacity out of the system. The evidence to date suggests that although emergency activity seems to be flat over the last two years there is yet little evidence that this activity is reducing. Careful monitoring of the outcomes of the above strategy and developments will need to be undertaken to ensure we can achieve the potential activity and cost reductions envisaged.

### **Governance**

All LHE work is governed and coordinated through the Emergency Care Network which represents the LHE and wider partners. The WTfH will also take an active role in understanding the benefits and then the system changes which ensue from these programmes of work.

## **Deliverables**

1. Delivery of the pilot vertical integration urgent care project.
2. Subject to outcomes and evaluation develop plan for roll-out of the above 2009 onwards.
3. Test, learn and Measure effect of ambulance pilot with Out of Hours services.
4. Develop and implement system for patient identification across patients with Long-term conditions to support the effective management of exacerbations
5. Delivery a coordinated campaign to ensure that education of patients about which services to use is continually reinforced.
6. Implement revised InSight system to capture real time data for General practitioners to review on Accident and Emergency attendances and Emergency Admissions.
7. Implement Urgent Care Centre across the LHE

## **8.0 Planned Care**

### **Key Messages (Local / Regional)**

- Systems need to be designed with the patient journey in mind from start to end rather than organised in separate specialities, to provide seamless care
- Care needs to be user centred with shared responsibilities between health economy and patients
- Communication systems needs to be improved between patients and the healthcare system particularly IT and issues between departments
- Commissioning needs to improve the way services are integrated and delivered
- Information systems need to be improved so that referral is timely and barriers in Patient care are overcome

The messages resonate with discussions across the LHE through the Working Together for Health programme which has constantly championed a system based on commissioning for a patient rather than a separate set of interventions. The LHE struggled initially to explain this approach / concept and there have been particular barriers with regards resourcing. However due to the integrated approach the LHE now has a programme of work related to Planned Care which is more than delivery of key targets (i.e. 18 weeks). This work will also accelerate the move to integrated pathways for services based on the patient journey underpinned by providers working jointly to deliver commissioning requirements. For example the new primary care Dermatology service has been built around the patient and will mean

that the service is locally based and is predicated on a see and treat approach rather than multiple pathways and multi journeys to hospital.

The reality and experience within the LHE to date is that the amount of planned care required should reduce as populations become more knowledgeable and have increased choices for self-care. It is also worth pointing out that by General Practitioners peer reviewing referrals first outpatients reduced in 2006/07 by 14% and in 2007/08 by 7% with a subsequent reduction in follow ups. Much of the work is about simplifying pathways and ensuring opinions of Consultants are more accessible for General Practitioners so avoiding an unnecessary referral. Elective Care is in decline as less people are waiting and more individuals are being treated in different locations. For example there have always been significant numbers of referrals to see a specialist dermatologist in the past. The work to implement a locally accessible see and treat dermatology as not only reduced Acute activity to negligible levels but the provider is now reviewing all follow ups and returning people to either self-care or management in Primary Care. The orthopaedic triage service sees some 12,000 referrals per year of which only 30% go onto secondary care. This has been further developed with the introduction of the back pain service and the work has been extended further to a project to develop a single access point msk services which will reduce the need for outpatients further.

Much of the work already underway requires significant scaling up as the focus in planned care continues to be access and the 18 week target. As this becomes embedded then the focus will shift to further whole system approaches which will involve increasingly integrated pathways.

### **Aspirations**

A planned care system which has fully integrated pathways across secondary and primary care which are easily accessible to patients in local settings where appropriate and facilitate quick and rapid diagnostics and treatment but eradicate unnecessary appointments.

### **Plans**

Over the next five years there will be continued focus on reducing unnecessary outpatient attendances, increasing locally based services where appropriate and streamlining pathways so that there is clarity on a particular treatment regime for any patient. There will be continued focus on reducing unnecessary General Practitioner referrals, increasing through the use of prior approval schemes and ensuring systematic, holistic pre-operative assessments.

A substantial amount of work as already been undertaken in the area of rehabilitation and investments planned in BEN PCT over the next two years show the level of priority for this area as a significantly

important part of the planned care pathway and keeping patients in hospital for the minimum amount of time required.

Individual commissioning organisations are in the process of producing commissioning service strategies which will inform further developments.

### **Governance**

All planned care developments to date have been managed and signed off through the LHEs clinical leadership group which is a sub set of the LHE WTfH programme. It is envisaged that although there will be a clinical champion in each organisation for planned care the WTfH Programme will maintain overall responsibility for agreeing programmes LHE wide and monitoring progress.

### **Deliverables**

1. Complete and implement single point of access for MSK services
2. Extend the scope and range of prior approval approaches
3. Model the economic impact in detail of activity shifts and the declining market for elective care
4. Agree and implement further reductions in outpatients across a range of specialities
5. Deliver reductions alongside re-provision of services if required

## **9.0 Mental Health / Dementia**

### **Key Messages (Local / Regional)**

- Multi agency holistic health care assessment
- Equitable, consistent, modern, comprehensive services for people with mental health problems, learning disabilities, organic mental health or substance misuse problems with clear pathways including access to and exit from services
- High quality equitable physical health service for people with mental health problems, learning disabilities, organic mental health or substance misuse problems
- Equitable, appropriate mental health support for people with physical health problems or long-term conditions
- Commissioners should commission health promotion and clear mental wellbeing-specific commissioning of third sector services, and incorporate voluntary organisations
- Create an intermediate care service that combines the needs of physical health care and mental health care to reduce late discharges and bed blockers

- Access to services providing choice as to where and when seen by reducing stigma. Also create more capacity in primary care service - we need more gateway workers for working age and older adults
- Initiative pump priming
- Renewal of central government commitment to MH with meaningful targets and a national strategy that has targets that are meaningful and based on the priorities identified in earlier work
- Good customer relations is vital to progressing all these agendas
- MH must be incorporated into all care pathways in all the care pathways group

Significant challenges exist for the LHE in ensuring 21<sup>st</sup> Century Mental Health services as the predominant model of service at present is acute based. The LHE recognises this and is embarking on joint work to develop a plan which addresses the particular issues raised through the key messages. The LHE accepts the need to focus on an integrated model where primacy is given to prevention and management of a significant number of mental health conditions in Primary and Community services. This work will be led through the clinical leaders and this will be the model adopted to reshape the pathways and ensure that a range of new services will be provided in primary care over the next five years.

### **Aspirations**

The development of a system for proactive management of people with mental health problems with a focus on community based upstream interventions.

### **Plans**

- Services which offer interventions as early as possible
- Increased emphasis on mental health promotion and prevention
- Offer home/community treatment for an increasing number of people
- Provide safe and reliable alternatives to hospital admission.
- Make minimal use of the medical outpatient model in which service users repeatedly give the same history to a different doctor
- Easy, understandable access to secondary services (including in acute hospital settings) with properly integrated teams providing minimal assessments, maximum information and no bouncing around the system for service users and carers
- Offer therapeutic inpatient services that are part of the spectrum of care and not isolated from the community.
- Increased third sector provision
- Excellent transition arrangements or alternatively no transition as services are flexible enough to stay with a person through the lifetime of their need

- A range of flexible rehabilitation and recovery options to meet the needs of individuals including settled places to live
- Increased emphasis on the mind and the psychological effects of mental distress and ill health rather than diagnosis or symptoms
- Ageless holistic services as far as possible
- More integrated budgets and joint commissioning with social care

### **Governance**

Clinical /social pathways which are agreed and implemented by the Birmingham wide Joint Commissioning Group (Partnership) via the joint commissioning team. Accountable to the Birmingham Health and well being partnership and key stakeholder LITs and Partnership Boards.

### **Deliverables**

1. Increased access to Psychological Therapies
2. Reduction in hospital admissions
3. Reduced length of stay
4. Better co-ordinated care
5. Increased social inclusion and employment
6. Earlier diagnosis of dementia

### **10.0 End of Life Care**

#### **Key Messages (Local / Regional)**

The key messages from the LHE event on End of Life were as follows:-

- Essential basic nursing care
- Co-ordination/integration of services
- Think about the person and the care they need before the finance
- Give us the resources to enable patient focused care, providing services to the patient not patient to the service
- Agreed standard for the whole end of life pathway across the healthcare economy
- Executive driven expectation for cross boundary dialogue to outline common ground
- The vision for End of Life Care is predicated on the need to commission services that reflect patient and carer choice which guarantees access to a range of services along the End of Life pathway which includes specialist palliative care. It is supported by a new relationship between patients and their clinicians and increased care planning for individuals

The work undertaken across the LHE to date has culminated in a detailed business case which set out BEN PCTs commissioning intentions in relation to End of Life over the next three years and a plan which is being delivered in Solihull Care Trust and has been in place for the last two years. These intentions and work to develop services for the people at the end of life are a manifestation of the new pathways which in essence moves us away from a predominantly hospital based service to wholly integrated community based service.

### **Aspirations**

All people at the end of their lives have an individual care plan which is coordinated by a key worker which allows for choice and guarantees that when they need a service it is available without the carer having to spend time trying to coordinate the care of their loved ones.

### **Plans**

The LHE has plans in place to support all people at the end of life. In BEN PCT this means commissioning a range of services for the 4500 people who die in the BEN PCT area each year. The approach will be similar for the Solihull part of the LHE. Detailed work has been undertaken to ensure the pathway for end of life takes account of the potential needs of all individuals and their carers no matter what their condition. This will necessitate a radically different set of services in the community which reduce the need for hospital admission and hospital beds. There are commissioning strategies in place that have been the subject of public and stakeholder conversation. The process of implementation of these strategies will begin in 2008 and will be fully implemented in 2011; this will include reductions in hospital bed capacity as community bed capacity comes on line.

### **Governance**

Each PCT has its own strategy and implementation plan clearly these need to come together under the auspices of WTfH to ensure consistency of implementation in conjunction with the HofEFT particularly where bed reductions have been agreed.

### **Deliverables**

1. Implementation of strategies and plans for End of Life Care across LHE.
2. Ensure plans are implemented in tandem with a reduction in acute care interventions.
3. Deliver market for End of Life Care through proactive procurement approach

## **11.0 What do the above plans mean for Activity, Workforce, Estate and Finance?**

This plan is supported by a number of control charts for both BEN PCT and SCT. These control charts attempt to set out for the next five years the potential changes in activity, workforce, estates and finance. Although the plans do pick up the presently planned large scale changes for 08 /09 and beyond, there is a substantial level of estimation on the changes which can only be validated once detailed strategies and business cases have been developed and as part of that process a full economic evaluation will be undertaken to adequately describe the changes to the four areas but in particular activity and finance. The “big ticket” items which have a long term strategy and business case already in place do have detailed evaluation for example:-

### **Long-term conditions**

The implementation plan for the second stage development of Birmingham OwnHealth has been assessed through Deloitte's for its impact. The estimates are that for a £15 million investment by 2012 will give a potential return on investment of £32 million this is based on a membership level of 27000. The majority of the impact will come from reduced costs of secondary care interventions. However there will also be an impact on Primary Care if the 30% reduction rate in GP visits continues. The key question will can these savings be achieved? And will the activity changes be realised? The evidence to date is that the LHE will have to undertake a detailed exercise jointly to ensure the benefits are realised and any release of funds can be reinvested.

### **End of Life Care**

Both PCTs have a programme of investment in this area that involves increasing the number of home deaths. Even a modest increase should allow for better utilisation of beds in a hospital and reduction in the long term. Again we know from evidence that if community based services are available then the number of short-term exacerbations will reduce again reducing unplanned admissions. The plan to commission up to 36 community beds in BEN PCT and the agreed reduction of hospital beds will reduce hospital capacity for emergencies and therefore force the LHE to ensure the new model of care works effectively.

### **Planned Care**

Planned Care has seen a reduction in first outpatients and some follow ups. Prior Approval has reduced some unnecessary electives and outpatients follow ups have reduced. The message here is that simple changes bring long term gains. However the LHE needs to continue to focus on outpatients that are unnecessary and ensure that proactive management in Primary Care remains a consistent focus.

## **Urgent Care**

Although new services in place have diverted a substantial amount of activity away from A&E department the activity is still part of the Urgent Care. The activity going to the main provider is flat for the last two years. However the activity is not reducing. The continued focus will be to keep costs under control and activity at present levels so they do not increase. The vertical integration work will require a detailed financial and activity appraisal and therefore the activity and financial profiles will need to be refreshed at the point when this modelling takes place.

## **Estates Issues**

The main changes over the next five years in relation to the estate are as follows:-

- Primary Care procurements (BEN PCT and SCT)
- LIFT developments
- Temporary second urgent care centre (Saltley)
- Redevelopment of Sutton Cottage
- Move to Birmingham City Council two Care Centres (this involves transfer of beds from Sutton Cottage, Berwood Court and Grange Road)
- Potential redevelopment of Solihull hospital site (HofEFT)

All the estates are designed to increase capacity for planned care with additional services and facilities. Clearly further work on how over the next five years activity and finance will be affected in the acute sector this again needs to be part the strategy and business cases.

## **Workforce Issues**

You will note that the workforce control chart remains incomplete. There a number of issues which need to be addressed in relation workforce before an appropriate assessment can be made of future workforce needs. These include:-

- The effect on acute trust workforce of any activity shifts
- The requirement for new skills, competencies and knowledge in the provision of different services in Primary Care (i.e. provision of telephone care)
- The development of new market entrants
- The replacement of staff who retire etc

The hypothesis to date is that even if activity changes from the acute sector to primary care dependent on the activity transferring the expectation would be that the staff required in the acute sector needs to reduce. There is no real evidence that this is the case, for example

the Dermatology market testing exercise change the provider however it did not result in any staff reductions in HofEFT. This maybe because as a foundation trust there is enough other more high value activity available form a range of providers and therefore the effect on the Trust and its staffing is minimal.

What is more interesting is the requirement for staff both nurses, social care professionals or others to develop new skills, knowledge and competencies in new and redesigned services in Primary Care. For example Birmingham OwnHealth will require anything up to 135 telephone care managers and a number of health trainers at the front line. Their skill set will not be about hands on care, it will be about assessment, coordination and cognitive behavioural skills.

New market entrants will increase the staff complement but again these new providers will need to demonstrate that they have access to the appropriate skilled workforce. Where this workforce comes from is a key question. One of the expectations is that the LHE can generate opportunities for local people in these organisations in a variety of care roles.

The increase in Primary Care based services will necessitate an increase in the workforce and if there is no transfer from secondary care then there will be a need to increase training for nurses and social care professionals to ensure the LHE is able to provide the services commissioned within the LHE.

As with many long term projections concerning, activity, estates, workforce and finance there is a need within each strategy to describe these changes and ensure they are followed through. The control charts will continue to be work in progress and the LHE as part of its ongoing plans needs to continue to adjust its plan in light of LHE.

## **12.0 Response to challenged specialities Investing for Health**

Within the NHS West Midlands strategic framework “Investing for Health” there is reference to a number of challenged specialities / services. The LHE has considered these areas and has taken account of the challenges in each of these areas in developing the LHE vision and approach. For completeness below is a narrative description of the key issues facing this LHE economy in addressing those challenged specialties and services. It is important to recognise that the identification of these challenged specialities / services covers the whole of the West Midlands and therefore will have varying degrees of relevance. It is also important to recognise the specific local challenges in particular areas and these form part of Commissioners intentions for 2008/ 09.

The LHE recognises and agrees that the specialities and services identified as part of IFH do pose a considerable challenge to the LHE and as part of the continuing development of the LHE these areas will be looked at in greater depth over the next twelve months. However in recognition of the challenges, the actions the LHE is taking are detailed below:-

### **12.1 Accident and Emergency Services**

This area is a significant challenge for the LHE and recent events have reinforced the need to develop a service which removes artificial boundaries and ensures that the right incentives and levers are in place to manage both the demand for services balanced with an appropriate supply.

Much work is already in place to support the system working effectively. However the LHE has agreed that there is a need to test out the possibility of moving to a vertically integrated system which streamlines pathways and flows and develops a payment system which incentivises increased management of patients for unscheduled care in Primary Care.

### **12.2 Maternity Services**

A significant amount of work is underway across Birmingham and Solihull to assess the scope, scale and style of future maternity services which is in line with policy direction. This will necessitate by its very nature a review of workforce requirements in particular the level of midwives available in the community. Peri-natal mortality is key indicator of the need for change as the level of peri-natal mortality in BEN&S is one of the highest in the UK. Work is already underway with partners to set the strategic vision for maternity services in the future and some early commissioning interventions have been developed which has included increasing the number of midwives to work with women who are at high risk of problems during their pregnancy.

### **12.3 Paediatrics**

Work is underway with a range of partners to provide services for children and their families which respond to the requirements of work undertaken within Investing for Health. As highlighted in section 3.2, a pan-Birmingham Children's Services Steering Group (including Solihull and Sandwell) has been set up and work has been ongoing with a range of partners and stakeholders to produce a plan for children's service both health and social care which is based on the needs assessment of that population and an understanding of the interrelationships between health services, social care and education. This work was undertaken through the development of a logic model with partners and stakeholders which defined outcomes to be achieved. This work is now being implemented.

The next stage is to define the health element of this work which will need to be commissioned to support the logic model clearly this needs to be undertaken across the LHE to ensure future health service provision is sensitive to the needs of children. This work will include the whole range of children's commissioning including CAMHS, Specialist commissioning whilst also reviewing workforce needs particularly in relation to neo-natal care.

#### **12.4 Emergency Surgery**

The key to ensuring effective services which are available in an emergency needs to be considered in light of number of key policy drivers both in terms of adults and children's services. The LHE is yet to look in detail at this area and the first stage is to define where problems and issues related to meeting national policy and getting and agreeing an LHE strategy and implementation which is based on the reality of the populations needs. Another important factor in undertaking this work is the relationship with health economies and how economies of scale can be achieved to ensure that emergency surgery is carried out by high quality services that are appropriately staffed with the skills and level of expertise required.

#### **13.0 Future Commissioning Intentions**

As part of the initial submission commissioners outlined there commissioning intentions for 2008/09. These intentions cover in one way or another many of the Darzi pathways and start to address many of the issues highlighted as critical to changing services and the perceptions of the public about the NHS. These investments are restated in appendix two.

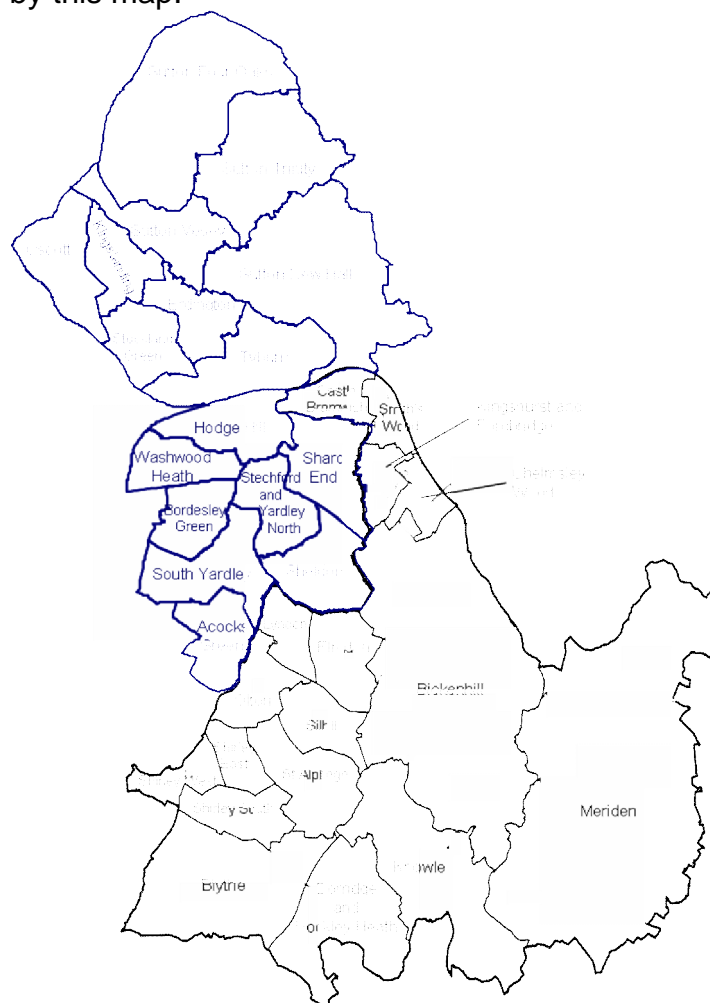
The three year Local Delivery plans being finalised set out proposed areas for investment up 2011 and it can be assumed that many of these investments will be continue through to 2012 and beyond.

**Appendix One**

**BIRMINGHAM EAST AND NORTH AND SOLIHULL  
CORE STRATEGY**

**“Working together to improve health and happiness  
in Birmingham and Solihull”**

This strategy relates to services for people who mainly live in the area described by this map.



This BENS local health economy includes Birmingham East and North PCT, Solihull Care Trust, Heart of England Foundation Trust and Birmingham and Solihull Mental Health Trust. We are committed to work together to tackle inequalities and improve health, through respectful communication between organisations, clinicians and managers and a long-term commitment to partnership working.

In this spirit we seek to sustain and develop our predecessor organisations' commitment in February 2006 to jointly creating a health economy that supports improved health status and ensures access to

excellent services based on need. Our vision is of a local health and care *system*: with aligned strategy, structure, processes, people, and metrics. In this context 'integration' is about joint strategy and planning, and joint metrics and accountability; we will ensure continuous improvement by working in partnership at a process

level, whilst using the distinctness of our organisations as a creative tension. We need for example to ensure that the introduction of practice led commissioning supports partnership thinking, and engages all stakeholders in its delivery, not least the service users and patients themselves.

### **The Environment – Global and National**

At a global level, the NHS is operating in an increasingly complex and challenging environment, characterised by international competition, growing expectations, newly emerging diseases and conditions, and increasing access to and exchange of information about health technologies. The NHS is a major player globally in procurement and has a history of reliance on overseas trained staff to supplement those trained in the UK. The increasing mobility of the international workforce brings both a ready exchange of ideas and policy with other health systems (most notably US and Scandinavia) at both a policy and individual level.

The NHS as an institution was established at a time (1948) when the average life expectancy was some 20 years younger than that of today, and where typically, an individual would have a limited number of major acute events at the end of their life. The current experience is of an extended period of increasing multiple morbidity resulting in high levels of ongoing contact with all levels of health, mental health and social care services. Simultaneously, increasing international travel has raised the spectre of new global health threats (SARS, avian flu, ebola and HIV), and an increased awareness of hospital acquired infections heralds a return to a concern with infectious disease control as core to risk management.

At a national level, the government is responding with a range of policy initiatives, which emphasise:

- ❑ Transactional Reforms: money following the patients through Payment by Results and direct payments, professionalising procurement, national core contracts, increasingly rigorous assessment of financial management.
- ❑ Demand side reforms: increasing emphasis on individual responsibility for looking after one's own health, early identification of disease through screening and active management in primary care, and improved chronic disease management, increasing focus on collaboration to tackle the determinants of ill-health and to sustain independence.
- ❑ Supply side reforms: increased choice in style and location of services, diversification of providers, rapid access to treatment when required with clear targets, both local and national,

establishing clear expectations of standards and outcomes, with local freedom to innovate and improve service delivery.

- System management reforms: a framework of system management, regulation and decision making, seeking to guarantee safety, quality, fairness, equity and value for money, a delegation to local accountability within a strict framework of national standards and targets, public benchmarking of organisations against core performance targets, and major investment in information availability, transfer, process re-design and use.

## **The Local Response**

Over the last 5 years we have both responded to these external influences and ourselves influenced national policy through the development across our economy of core principles which provide a framework for strategic investment and collaboration.

## **Our Strategic Approach**

- **Active identification and management of treatment and care to prevent illness and improve quality of life.** Both BENPCT and Solihull CT now perform strongly in the active identification and management of chronic disease in primary care against national averages. The performance of the best must become the norm for local service delivery, with all practices able to perform effectively in identifying patients and ensuring active medical management in primary care, in partnership with health colleagues and crucially, social care focussed on promoting independence and improvement in personal wellbeing.
- **Promotion of self-care and partnership in care between clinicians and patients.** The evidence is strong that engaging people in understanding and managing their own condition will not only deliver greater independence and better mind and body health outcomes, but will also lead to greater happiness. Our approach to service delivery is encapsulated in the three phrases: 'Patients as Partners'; 'Promoting Self-Care'; 'Care in the Right Place'.
- **Priority given to enabling people to stay at home.** This includes maximising the integration of care, support and treatment across organisational boundaries to enable people to remain at home as long as this is in their best interests and clinically appropriate, including at the end of life. The bulk of treatment and care will happen, as now, through delivery by peripatetic community-based staff to maximise flexibility and responsiveness of delivery and minimise unnecessary hospital visits or institutional care. High priority will be given to investment into developing an adequate range of flexible support services to deliver care close to home. It is essential that people receive the most appropriate treatment at the right time from someone with the right level of skill; much of this can and should happen outside of hospital settings. Moreover, for the vast majority of people who can not cope unaided at home it is, in the interests of mind and body health, more appropriate to provide rehabilitation and home based

services, including assistive technology, equipment and adaptations, extra care housing and tailored support, than to admit to a care home. An inpatient stay will remain essential where a patient is so acutely ill that they require 24hour medical supervision and rapid access to sophisticated technology; and we commit to seeking the most safe, effective and efficient acute hospital provision for those who are seriously ill.

- **Clinical leadership to drive change.** The Working Together for Health philosophy and its principles have proved to be a solid foundation for developing our whole system approach, particularly the partnership between clinicians and managers, both within and across our organisations. Clinical management across the health economy has been strengthened, clinical service strategies have been developed in partnership and new person-centred services are being delivered, which transcend organisational barriers. We have committed to modelling behaviour characterised by 'Respectful communication'; 'Your success is my success' (and vice versa) and 'A long-term commitment to partnership working'; both at an organisational and an individual level. In Solihull Care Trust for example there have increasingly been opportunities to extend the range of professional engagement to include social workers and for them to think about how the lessons from Direct Payments and Individual Budgets can be built into health care.
- **Use of information technology to support integrated patient care and change management.** As an economy, we seek to maximise the opportunities offered by emerging and available information and assistive technologies. We shall collaborate to make best use of national contracts and local investment to support information sharing and transfer in the interests of patient safety, clinical decision-making and system efficiency. Our economy benefits from a relatively IT literate population, and we shall invest in maximising public and patient access to information (both digitally and conventionally) which will enable self care, independence and informed use of local services.

#### **Integrated approach to infrastructure development.**

A core theme of the work in designing a new system, has been the need to undertake a system wide approach to workforce planning and estate development. This will anticipate the need to develop new roles, potentially working within new provider organisations or across existing organisational boundaries. We shall invest in core skills development with our local populations, developing the workforce (and informed consumer) of the future; and support specialisation and enhanced skills where this will enable the safest, most effective response to acute illness. We shall make best use of the existing estate, identifying opportunities for change of use and collaboration to enable service improvement and to invest in new buildings designed to support our delivery of new styles of services.

#### **At the forefront of Public Service Delivery and Development**

The next phase of public service reform requires a step change in effective planning and commissioning if we are to begin to truly tackle long-standing

inequalities in health and deliver continuing improvement in services within a public sector settlement that is growing at a much slower rate. The foundation and track record of the Working Together for Health (WTfH) programme gives us an excellent opportunity to succeed where others will struggle, but the partnership working will need to be extended at all levels. Locally, we have benefited from the international relationship with Kaiser Permanente as a NHS Beacon site, and early outputs from the collaboration between BENPCT and HEFT have been identified as one of 5 international sites exemplary of clinical system improvement by the University of Toronto. The integration of health and social care in Solihull provides a test and learning site for the whole economy and BSMHT's commitment to user empowerment and innovations in health and employment initiatives provide important models for roll out across chronic disease services. We have a responsibility to the wider NHS and local government to demonstrate how success is possible.

It is accepted within our organisations that success is more likely if we are collectively bold in our aspirations and brave in our approach. We must go from 'artisan to industrial' in scale. We need to accelerate the pace of change, shortening the transition period in which there is duplication of service models. This will need strong leadership and change management discipline.

The four organisations will continue to collaborate through the WTfH Programme Board to support and coordinate these change programmes. However, the scale of the changes is so great that one group cannot and should not manage the projects themselves. Moreover, we will need to extend partnership arrangements on many levels, both within the health economy and importantly with neighbouring economies

Nevertheless, to establish a platform for partnership working, the Programme Board will aim to oversee:

- Health economy data to identify where change is required and to measure improvement
- A dynamic register of service innovation, improvement and review
- Prioritisation of change so that intervention is targeted to where it will deliver most health gain at least cost
- Application of commissioning levers to promote increasingly consistent high quality, efficient, person-centred treatment and care
- Joint organisational and staff development to entrench partnership working
- A forum for overview of emerging estates strategies to identify opportunities for development, re-design and collaboration
- A leadership forum to debate approaches to emerging opportunities and threats, such as national policy, new technologies and treatments

The emerging priorities for 2008-11 include:

- Improving health from the start of life
- Support to increased self care and independence
- More systematic treatment and care along standardisable pathways

- Early access to assessment, diagnosis and response
- Increased capacity and competence in primary and community care with a focus on chronic disease management and minimising the impact of disability
- Increased support to individuals and their carers to enable them to stay safely at home
- Active help and support for people and families at the end of life
- Opening a new dialogue with the public about future aspirations for health and care.

**Sue Turner**, Chief Executive, Birmingham and Solihull Mental Health Trust

**Mark Goldman**, Chief Executive, Heart of England Foundation Trust

**Sophia Christie**, Chief Executive, Birmingham East and North PCT

**Sally Burton**, Chief Executive, Solihull Care Trust

**Appendix 2**

***Birmingham East and North PCT***

<b>BENPCT</b>	<b>Intention</b>	<b>Investment</b>
Birmingham OwnHealth	Expansion of existing scheme from 2,000 members to 11,000 in 08/09 and 27,000 members by 2012	Circa £4,000,000
End of Life Care	Commissioning of extended community services and beds	Circa £2,500,000
Intermediate Care	Commissioning of extended community services	Circa £1,500,000
Pain Management Service in Primary Care	Full implementation of service	Circa £500,000
Mental Health	Extension of Primary Care services	Circa £1,100,000
Sexual Health	Strategy Implementation	Circa £600,000
Older Peoples Mental Health	Strategy implementation	Circa £500,000
Older People	Additional Investment	Circa £750,000
2 <sup>nd</sup> Urgent Care Centre	New service	Circa £350,000
Children's Services	New investment	Circa £350,000
Practice Based Commissioners	New Investment	Circa £600,000

**Solihull Care Trust**

<b>Solihull Care Trust</b>	<b>Intention</b>	<b>Investment</b>
Practice Based Commissioners	New Investment	Circa £250,000
Community Services	Strengthening of Integrated health and social care teams	Circa £500,000
Health Inequalities	Investment to lower the gap between the North and South localities	Circa £750,000
Learning Disabilities	Additional investment	Circa £500,000
Continuing Care	Additional investment	Circa £2,000,000
Out of Hospital Services	Introduction of single point of access service	Circa £600,000
Palliative Care	Additional investment	Circa £200,000
Primary Care Premises	Additional investment	Circa £200,000
Mental Health	Additional investment	Circa £300,000