

Birmingham East and North

STRATEGIC PLAN

2009- 12

DRAFT

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Foreword

NHS Birmingham East & North delights in serving a diverse and challenging population across half of Europe's largest local authority. We are committed to working with local people to tackle health inequalities and improve health outcomes. We recognise that to do this we must draw on a range of skills, knowledge and leverage, much of which exists outside the NHS, with local people, in Local Government and with commercial and other partners.

We are also committed to improving people's experience of health services. Although we have only been live as an integrated organisation since October 2006, we are proud of our record in pioneering new styles of health care services, and the international recognition of our collaboration with Heart of England NHS Foundation Trust to redesign services for increased access, safety and responsiveness. NHS BEN residents enjoy access to a range of cutting edge services, achieved through wise investment and service re-design, earning NHS BEN national best practice (level 3) in three areas in the first year of World Class commissioning. We remain committed both to innovation and to getting the basics right.

We are increasingly reaching out to communities who have historically avoided services, or come into them too late, with the aim of promoting good health as effectively as we have historically treated illness. We are developing new partnerships in the public sector on the employment agenda, and commercially to commission and deliver new services and to better understand our local communities and their preferences.

We are serious about the importance of investing public funds wisely. At times this means taking difficult decisions where the opportunity costs for the population of a particular intervention have outweighed the potential benefits to the individual. However, we remain committed to ensuring access to a range of excellent services for our residents, at the point they need them.

Our core commitment to tackling health inequalities and health improvement through prevention, service excellence and a new relationship with patients and public is now aligned with national policy through the NHS Next Stage Review. In an increasingly challenging financial context, it has become even more important to focus our investment in preventing illness and limiting its impact, and in maximising the use of new technology to offer services which are effective, efficient and responsive.

AAACM All Ages All causes mortality
ACSC Ambulatory care sensitive conditions
ACM Assertive case manager
ALE Auditors Local Evaluation
A&E Accident and Emergency
BCC Birmingham City Council
BEN Birmingham East and North
BENeFIT Staff wellness programme
BHWP Birmingham Health & Well Being Partnership
BME Black minority ethnic
BMI Body mass index
BRISK Bold, Redesign, Investment, Sustainability, Knowledge
BSAB Birmingham Safeguarding Adults Board
BSMHFT Birmingham and Solihull Mental Health Foundation Trust
CAA Comprehensive Area Assessment
CABG Coronary artery bypass graft
CAMHS Child and adolescent mental health services
CBSA Commissioning Business Support Agency
C Diff Clostridium Difficile
CEO Chief Executive Officer
CfH Connecting for Health
CHS Community Health Services
COPD Chronic Obstructive Pulmonary Disease
CPA Care programme approach
CQUIN Commissioning for Quality and Innovation
CSR Comprehensive Spending Review
CT Computer tomography
CVD Cardio vascular disease
CYP Children and Young People's Partnership
DAAT Drug alcohol action team
DES Directed enhanced service within GP contract
DFI Dr Foster Intelligence
DTOC Delayed transfers of care
EOL End of life
FNP Family Nurse Partnership
GP General Practitioner
GPwSI General Practitioner with a special interest
GSF Gold Standard Framework for end of life care
GUM Genito-urinary medicine
HCC Healthcare Commission
HCAI Healthcare associated infection
HoBtPCT Heart of Birmingham Teaching Primary Care Trust
HoEFT Heart of England Foundation Trust
HPV Human Papilloma Virus Vaccine
HRG Health Resource Group
HSJ Health Service Journal
HV Health visitor
IfH Investing for Health
IMD Index of Multiple Deprivation
IT Information technology
JSNA Joint Strategic Needs Assessment
KM Knowledge management
KPI Key performance indicator
LAA Local Area Agreement
LARC Long Acting Reversible Contraception
LD Learning disabilities
LES Locally enhanced service within GP contract
LGBT Lesbian, gay, bi-sexual, transgender
LIFT Local improvement finance trust
LINKs Local Involvement Networks

LSC Learning Skills Council
LTC Long term conditions
MDT Multidisciplinary team
MESH Methodology for Ensuring Seamless Healthcare
MI Myocardial infarction
MORI Opinion Poling Organisation
MRI Magnetic Resonance Imaging
MRSA Methicillin-resistant Staphylococcus Aureus
MSK Musculoskeletal services
NEET Not in education employment or training
NHS National Health Service
NHS BEN NHS Birmingham East & North
NHS BENCHS- Birmingham East & North Community services provider
NHSSB NHS South Birmingham
NHSD NHS Direct
NSCG National Specialised Commissioning Group
NST National Support Team
OECD Organisation for Economic Cooperation and Development
NI National indicator
NICU Neonatal intensive care unit
NHS WM NHS West Midlands Strategic Health Authority
NRAG National Radiotherapy Advisory Group
NSCG National Specialised Commissioning Group
NST National Support Team for Inequalities
OD Organisational design/development
OECD Organisation for Economic Co-operation and Development
OJEU Official Journal of the European Union
ONS Office of National Statistics
OPD Outpatient department
OSCAR Organisational, satisfaction, clinical, activity, resources - performance metrics
PBC Practice Based Commissioning
PCI Percutaneous coronary intervention
PCT Primary Care Trust
PEC Professional Executive Committee
PET Patient Experience Tracker
PHSE Physical health & social education
PICU Paediatric intensive care unit
PIPE Planning innovation process excellence
PPI Patient and public involvement
PRIDE Personal Responsibility in Delivering Excellence (Management Development Programme)
PRIME Programme for Relationships, Intelligence, Metrics and Equality (key initiative)
PROMS Patient Reported Outcome Measures
PSA Public Service Agreement
PUK Partnerships UK
PYLL Potential years of life lost
QoF Quality and Outcomes Framework within GP contract
QIPPP Quality Innovation Productivity Prevention Partnership
R&D Research and development
SAR Standardised admission rate
SCT Solihull Care Trust
SHA Strategic Health Authority
SWBT Sandwell and West Birmingham NHS Trust
Three S's Shard End, Stechford & Yardley North and Sheldon Locality Commissioning Group
TIA Transient Ischaemic Attack
UHBFT University Hospital Birmingham Foundation Trust
UK United Kingdom
UNICEF United Nations Children's Fund
USA United States of America
UoR Use of Resources assessment
WCC World Class Commissioning

CHAPTER 2: Our Vision for NHS Birmingham East and North

2.1 Core Purpose and Audacious Goals

At NHS Birmingham East and North we believe that the NHS not only has a role to play in offering an increasingly responsive range of safe, effective services, but that we can and should tackle long-standing inequalities in population health through targeted interventions to deliver enhanced life expectancy and improved health status at all stages of life. In this context we developed in 2002 a clear core purpose to stand the test of time and four audacious goals which provide challenge for the next twenty years. Our core purpose is:

Working in partnership to tackle inequalities and improve health and well-being.

We firmly believe that if the NHS is to be fit for purpose in the 21st Century and able to respond to economic challenges, we must become as good at improving health and preventing disease as historically we have been at treating illness. The economic challenges that lay ahead require a paradigm shift in the pattern of care.

Our four audacious goals are:

- To be so responsive to the population we serve that no one waits for the health care they need
- That the health and well-being of the population will have improved so much that people will enjoy ten more years of healthy life
- That people regard us as the first choice organisation to work with and for
- Our communities will be the most involved, informed and empowered in the country

This ambitious framework was developed through a series of whole system stakeholder groups in Eastern Birmingham in 2002 and has since been tested and refined at key points in our history, most recently at a series of PCT-wide locality-based events in June-July 2008 and reaffirmed through our Organisational Development Programme of activities during 2009. It operates as our key prioritisation framework for investment, not only of money but more generally of PCT focus and activity. In the context of learning drawn from Collins and Porras¹, the core purpose was intended to give a 75 year plus direction, with the goals set as suitably audacious to be challenging until 2020. The PCT then has a set of strategic intentions, designed to be relevant for circa five year periods, which underpin our approach across a range of initiatives; we are now working with our second iteration of these, re-developed as part of the integration process of Eastern and North Birmingham PCTs to form NHS Birmingham East and North in October 2006.

NHS BEN went live on 1 October 2006 bringing together two predecessor organisations and largely retaining our high performing Executive Team. As a result of a thoughtful approach to integration, the new organisation was able to

¹ *Collins and Porras (2000) *Built to last* (Random House)

build on the history of formal organisational design and development in the predecessors, particularly sustaining and building upon the clear core purpose and ambition of Eastern Birmingham PCT for health improvement and a partnership approach to tackle health inequalities and improve services. This continuity has retained organisational memory through a period of potentially disruptive change and enabled us to retain focus on our core business, delivering sustained improvements in performance and process.

This strategic plan seeks to describe our current context and priority activities over the next five years to ensure further progress on our audacious goals and key strategies.

2.2 Health Outcomes

The PCT is committed to demonstrating not only that disadvantaged communities can have access to world class health care, but that effective commissioning can drive real improvements in health outcomes. The statistics of ill-health, deprivation and disadvantage which characterise the PCT have driven our ambition for 'ten more years of healthy life' and commitment to 'the most informed and empowered community'. Our four goals act as a core prioritisation framework for investment and improvement. The PCT has now highlighted 10 health outcomes, we shall seek to deliver over the next 5-10 years, which support our ambitious goals and go beyond current targets and the national indicators adopted within the Local Area Agreement. These are unashamedly ambitious aspirations which are however, even more crucial to achieve in the context of the economic downturn. The historic legacy of poor health status, variation in clinical practice and outcomes have always been ethically unpalatable but will also increasingly be simply unaffordable. It is now crucial that we design and commission new styles of services which engage those most at risk, are cost-effective and which make best use of 21st century technology to support people to stay well, and offer timely and positive interventions at times of illness.

We have the third highest infant mortality rate in the country, which is 83% higher than the national average. We aspire to bring our IMR within current national average by 2015

WCC OUTCOME

Health inequalities (LAA)	There will be no health inequalities in BEN PCT. By 2018 someone from Washwood Heath can expect to live as long and well as someone from Sutton Four Oaks does now.
Life expectancy Premature mortality in <ul style="list-style-type: none"> • Adults • Infants 	By tackling premature mortality in babies and adults, we shall release an extra 1000 years of life each year, and create an additional classroom of kids in school by 2014.
Under 18 conception rates (LAA)	By 2012, no ward in BEN will have more than eight babies born each year to teenage mums.
Breastfeeding	By 2018 85% of mothers will initiate breastfeeding at birth, providing natural protection against illness and future obesity.
Smoking quitters (LAA)	By 2018, we shall have the lowest smoking prevalence of any core city, with only 15% of people putting themselves at risk.
Stroke admissions	By 2012, 75% of people admitted to hospital who have had a TIA will receive a brain scan within 24 hours, and everyone will spend at least 90% of their stroke admission on a dedicated unit.
Transfer of care from acute to alternative care is delayed (LAA)	Rapid assessment and appropriate transition will ensure that in 2012 only 2% of people awaiting discharge from an acute hospital are delayed on a ward.
High risk of Coronary Heart Disease (LAA)	Each year from 2009 we shall find an additional 1000 people most at risk of MI and ensure they receive effective treatment and support to stay healthy.
End of life care	In BEN PCT people will exercise choice at all stages of their illness. By 2012 70% of people will realise their preference to die at home with support.
Patient satisfaction (removed)	During 2009 we have removed the Patient Experience outcome as this will be measured through our PRIME programme

CHAPTER 3: Local Context

NHS BEN is responsible for the wise investment of circa £700m per annum of public money to ensure health improvement, access to health services and (where appropriate) the provision of health services to a diverse (registered) population of 440,000 people concentrated in 17 wards of Europe's largest Local Authority. With the second highest perinatal mortality rate in the country and men dying an average six years earlier than the national rate, the Trust has prioritised improving population health status. We also host the infrastructure functions of Estates, Information Technology and Finance and Contractor Services for all three PCTs in Birmingham. We have built expertise in commissioning, hosting the West Midlands Specialised Services Commissioning Team (an additional budget of some £917m- total specialised commissioning) on behalf of the 17 PCTs in the region, and leading the commissioning of mental health, learning disabilities, sexual health and complex care for the three PCTs in the city. The Trust is the commissioner of primary care services, most of which are provided by small independent contractors, and a range of NHS and third sector providers of Community Health Services. We also hold the contract, on behalf of all 153 English PCTs, for the National Commissioning Appraisals Support Service to work with NICE to ensure that commissioners are participating in the introduction of new technology.

Increasingly we are prioritising the commissioning of primary care as key to improving health and good resource utilisation. The organisation works with 82 General Medical Practices of which 33% are single-handed GPs (down from 60% in 2002). These practices have been encouraged to collaborate at a local level in six locality groups to deliver Practice Based Commissioning (PBC) each covering 55,000 to 100,000 people. The PCT is in the process of developing relationships with other key groups (dentists, pharmacists and opticians), building on our learning with family doctors. A number of local independent medical and other practitioners are employed on a sessional basis by the PCT as clinical directors and leads.

We collaborate with NHS South Birmingham PCT (NHSSB), Heart of Birmingham PCT (HoBtPCT) and colleagues from Birmingham City Council through the Birmingham Health and Well-being Partnership (BHWP) and Children's and Young People's Partnership with a focus on health improvement and services for vulnerable people. We are co-ordinating commissioner for Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), and are NHS hosts of the emerging joint commissioning arrangements with Birmingham City Council for services for people with learning disabilities and for mental health problems. As coordinating commissioner for Heart of England Foundation Trust (HoEFT) we work closely with Solihull Care Trust (SCT) and have engaged them in our Working Together for Health programme of re-design and service improvement.

3.1 Population Demographics, Health Needs and Clinical Quality

During 2009, the three Birmingham PCTs with the City Council together invested in an assessment of health need across the city and expanded the Public Health Information Team with additional City Council posts to support the Joint Strategic Needs Assessment (JSNA). Our updated JSNA for Birmingham gives an overview of

the challenges facing the city. This can be accessed through www.benpct.nhs.uk or directly from www.bhwp.nhs.uk/jsna and is supported by a range of public health data available through the Public Health Information Team site (www.bphn.nhs.uk). A JSNA Board oversees this work on behalf of the Birmingham Health and Wellbeing Partnership.

The JSNA is supported by a series of local needs assessment and service reviews which address the health priorities of NHS BEN. The JSNA has an initial focus on epidemiology, but is supported by an increasingly sophisticated understanding of the diversity of local communities, and their preferences for access to and style of services. In NHS Birmingham East and North, we have made additional investment in the creative generation of intelligence to tackle inequalities through our Programme for Relationships, Intelligence, Metrics and Equality (PRIME). Developed in partnership with Doctor Foster Intelligence, we have undertaken a rigorous baseline assessment which has challenged our historic understanding of the distribution of ill health, particularly in relation to infant mortality and alcohol use. Together, we have developed a new population segmentation tool, 'Health Typologies', which gives us enhanced insight into the preferences, health behaviours and health outcomes of local people. This empirical data is supported by the Patient and Public Involvement (PPI) database and micro site which enables us to track local opinion and response and increasingly engage in a digital dialogue alongside our more traditional community development and consultation processes.

At this stage, information on clinical outcomes remains limited and ad hoc in comparison. We have developed sophisticated tracking in new services, including Birmingham OwnHealth and the MESH (Methodology for Ensuring Seamless Healthcare) programme with Health Care at Home. However NHS providers continue to produce relatively limited evidence of impact for investment. CQUINs are in place as part of both Foundation Trust contracts and with our own Community Health Services (CHS). The latter are also developing Patient Reported Outcome Measures (PROM) for each service area. Patient Experience Tracker (PET) is in place across our CHS, and is being piloted in 18 General Practices. Reinforcing our access to intelligence on outcomes and patient experiences is a key element of our knowledge management strategy.

3.1.1 BEN Population Profile

Our JSNA summarises key demographic and epidemiological information for NHS BEN. The following section will focus on the deeper analysis which has underpinned our strategic initiatives and investment.

Geographically, the Trust covers 17 wards across the eastern half of Birmingham City Council. Although Birmingham as a whole is a relatively young city, outside of Bordesley Green and Washwood Heath, BEN is relatively under-represented in 18-34 year olds, and over-represented in 75 -85+ with associated high utilisation of health services.

White European is the single largest group at just over 75% of the population, but the PCT is culturally diverse, with over 22 % of the population self reporting a non-white British background.

However, the predominance of a disadvantaged white population is a key driver for ill health, associated with sedentary lifestyle, poor diet, smoking and alcohol consumption. Overall the 2007 Index of Multiple Deprivation (IMD) ranked Birmingham as the 14th most deprived local authority in Britain, and half of the city's ten priority wards fall into our area. Unemployment is highly concentrated in the most deprived wards, including Kingstanding, Washwood Heath and Shard End, which have consistently featured in the top twelve constituencies for unemployment over the last 30 years.

This pattern of deprivation has a disproportionate impact upon children in our area, with over one in three living in poverty. It is significant that children beginning their lives in social deprivation are more likely to experience poor health later in life. These circumstances may go some way to explaining why depression is an issue for 10% of all 11-15 year olds, compared to 5% nationally and 17% have been identified with a conduct disorder, compared to 12% nationally. Childhood obesity, and malnutrition, is largely related to deprivation and can only be tackled in ways that will engage the communities where the need is greatest.

Over 20% of the population, concentrated in the Sutton constituency, are well-established career professionals or successful white collar older families, giving the PCT strong social capital to draw upon. However, even in localities dominated by these groups there are significant pockets of deprivation. Variations in health outcomes are stark. Within the PCT, there is a more than six year difference in average life expectancy in the six miles from Washwood Heath to Sutton town centre; one of the greatest divides in the region.

This pattern of disadvantage expresses itself in a well-established burden of chronic disease and is a key determinant of limited life expectancy, particularly in men over 55. Analysis underpinning our first Local Area Agreement in 2004 identified that Cardio-vascular disease was the single most significant driver of premature death in Eastern Birmingham, and this insight has underpinned our health improvement and service intervention activity since that time.

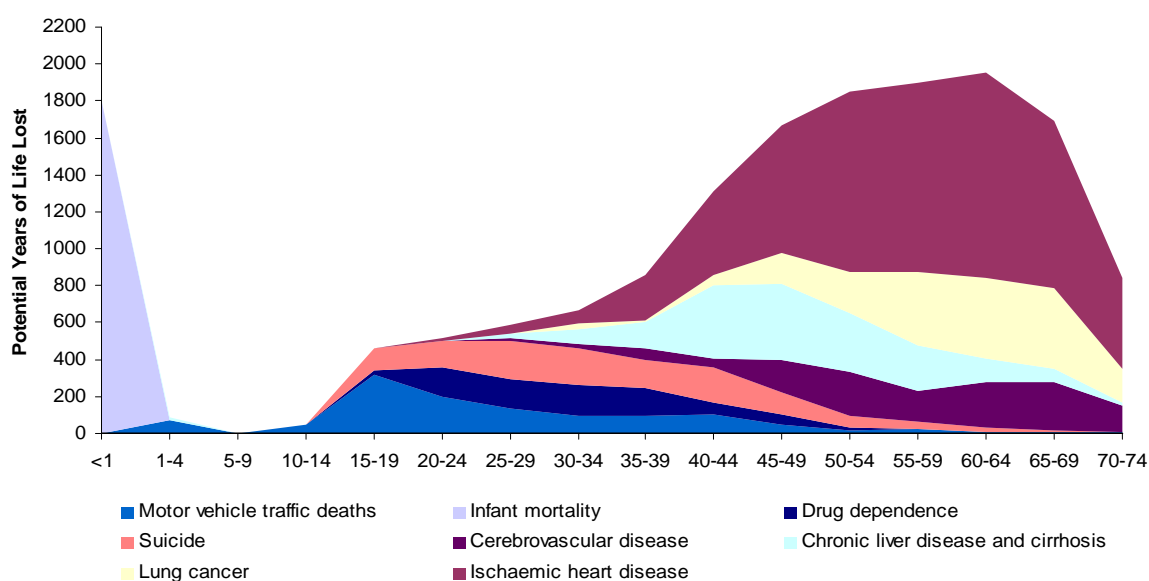


Fig 2 Premature Years of Life Lost

As part of PRIME, a baseline survey comparing the PCT to other core cities and our ONS comparator group, identified 5 key priority areas for us to tackle if we are to impact upon life expectancy and tackle long-standing health inequality. Supporting documentation is available within our JSNA as our PRIME baseline survey.

- **Infant Mortality:** we have been working to improve outcomes for babies since our first LAA of 2004, however our baseline analysis revealed for the first time the significant prevalence of mortality in our disadvantaged white community (rates 3 times the national average), beyond the usual focus on those of Bangladeshi, Pakistani and Kashmiri origin, where rates are known to be 4 times the national average. This has caused us to rethink our health interventions to ensure they are targeted to these different communities and therefore designed in different ways. A recent visit of the National Support Team has further drawn attention to the proportion of deaths arising from infections as a potential significant contributor to our outlier status.
- **Smoking:** having set ourselves some of the most demanding 4 week quit rates in the Region over the last 5 years², we have now identified a group of committed smokers, who we shall have to find new ways of reaching, if we are to impact on the burden of heart disease and COPD which characterises local communities. There is also emerging evidence of smoking within younger Muslim communities who are reflecting the behaviours of their white friends.
- **Alcohol Use:** at a global level, Birmingham compares well to other core cities on alcohol misuse, but this masks significant and damaging drinking at all ages and classes within women in the East and North of the city.. Men remain dominant in numbers, but the rates in women will require targeted interventions in marketing and considerable service re-design to respond effectively to established misuse.
- **Obesity:** as with alcohol, a global analysis misses the concentration of obesity into women aged 40-69, and older women can be up to 90% above the England average. In children only 45% are assessed as having a 'healthy' body mass index, with the greatest problems of both under and over-weight being concentrated into our blue typology groups.
- **Mental Wellbeing:** a paucity of information has limited our ability to effectively benchmark the impact of mental illness on our population, however we know that mental illness is associated with both other chronic disease and premature mortality, and that the survey information of children and young people reveals levels of self reported distress double the national averages, which evidence suggests will translate into significant mental illness in later life. We are now applying emerging thinking collated by the New Economics Foundation on sources of mental resilience to promote mental well-being as protective both in relation to mental illness and other chronic diseases.

² Currently achieving 118.3 per 1000 compared to a Wet Midlands average of 93.3 per 1000

These five areas form the focus for our PRIME programme, including tracking performance in primary care, social marketing and self-reported behaviours through our household panel. They have also driven our programme of investment and strategic initiatives including service re-design and innovation. The work to promote mental resilience is emerging as both crucial and challenging.

Teenage pregnancy is a complex issue, affected by young people's aspirations, education and self-esteem as well as their risk-taking behaviour and access to contraception. The Trusts strategy for teenage pregnancy has produced some success with conception rates falling most significantly in those wards that have received targeted interventions (e.g. Shard End and Kingstanding)

Across the Trust, eight of NHS Birmingham East & North wards appear in Birmingham's top 20 highest rate wards for teenage conceptions. At a ward level, variations in the under 18 conception rate largely reflect the local pattern of deprivation, poor educational attainment and disengagement with school with the majority of conceptions occurring within the most deprived wards.

Birmingham has shown an overall downward trend in conceptions, with a percentage change of 9.5% since the 1998 baseline. In 2007 the rate was 52.8 per 1000 young women 15 to 17 which is a slight reduction on the 2006 rate of 53.2 per 1000. Within NHS BEN, we have on average a lower teenage conception rate, of 44.87 per 1000 in 2007/08. Significant investment is being made by the Trust, to support three posts dedicated to the prevention strategy for teenage pregnancies.

3.1.2 Health Typologies

Working with Dr Foster Intelligence (DFI), we have cross-referenced Mosaic 'consumer' segmentation with health service utilisation and epidemiology to identify 10 distinct groups within the population of NHS Birmingham East and North. This process has caused us to radically re-think our approach to focus on 'people not places' as the map demonstrates a complex distribution of 'types' across the geography of the PCT and confounds some of the historic assumptions about both the 'wealth' of Sutton Coldfield and the 'need' of Washwood Heath), amongst others. We are making this tool available to others but in 2009, we are the only PCT in the country to have fully profiled our population in this way and to be applying our learning to risk identification, population targeting, service design, social marketing and communication with the public,

Case Study:

We have published 3 different versions of our Health News paper, designed to appeal in content to the three different broad groups across the PCT. The papers are distributed by postcode to target the relevant copy to each type of household. This approach will be evaluated during the winter of 2009 to determine how both future style and content of the newspaper should change.

Health Typologies won the 'Engaging Communities' at the first West Midlands Black and Ethnic Minority Achievement Awards in 2009.

The typologies are organised within three themes. Green are generally healthier than the average for the area, with the Red groups being disproportionately characterised by ill health, high risk behaviours and heavy service utilisation. Blue is a genuinely diverse group, but characterised by community cohesion within the diverse ethnic and cultured groups which it includes.

Blue 1: Unemployed Tweens

Young people and families, including white and Pakistani. Some live in old Victorian terraces, others in 60s high rise blocks. Many rely on benefits. Youth crime is significant, with street gangs and drug and alcohol abusers. Although rates of alcohol-related liver disease are currently low, this may disguise future problems. Various other health problems persist, from poor mental health to heart disease. Diabetes is common, though sufferers manage it relatively well. Child obesity is an issue, as is high usage of A&E. There are a disproportionate number of complications in pregnancy.

Blue 2: Healthy Mixed

A mix of races and religions, with Pakistan the most common background. Racial tension has been known in the past. There are many young families but unemployment is high, and those who do have jobs work in the low paid unskilled sector. Overall their current health is relatively good, with few suffering from diabetes, cardiovascular disease, alcohol-related liver disease or cancer, including lung cancer. They are less likely than average to use A&E, but they do miss appointments quite frequently. The rate of infant death is high, despite low levels of admissions for complications in pregnancy and birth. Not many children suffer from obesity.

Blue 3: Cohesive Communities

Tight family units in Edwardian, Victorian or 30s terraces. Many are Muslims living close to the mosque. There is a strong ethic of education and work, plus a tendency to stay in or near the area as prosperity increases. The rate of infant deaths is high in this group, with above average complications during pregnancy and birth. A relatively high number of children are obese, though they do tend to have the MMR jab. Diabetes is also relatively common, but cancer and alcohol-related liver disease are not, and fewer than average go to A&E.

Red 1: Benefits and Educated

Highly educated students and care professionals on low incomes whilst training, as well as the socially excluded living on benefits. Many are single parent families. Despite significant deprivation in this mainly young group, their health is about average for the BEN area, though problems may arise later in life. Mental health appears to be an issue for some. Infant deaths are below average but abortions are common. A number in this group are transient and the students may use health services in other parts of the city.

Red 2: Unwell and Ageing

An ageing population, including retirees and factory workers in their 50's, 60's and 70's, some of Irish background. They're set in their ways and like drinking and smoking. Without going out much or straying too far from familiar areas, they socialise mainly in their "care homes" or local pubs and working men's clubs. This is probably the least healthy of all the groups. Admissions are higher than average for cancer (especially lung cancer), obesity, alcohol-related liver disease, heart disease, cardiovascular disease, COPD, stroke and mental health problems. As a result, the death rate is unusually high (especially for cardiovascular disease). Members of this group are more likely to visit A&E, need emergency admissions and have excess bed days. Readmissions are also frequent and many repeatedly go to hospital for conditions that could be dealt with beforehand elsewhere, by a GP for example. There are a number of teenage mums here, while the MMR job is less popular than average. However, infant deaths are uncommon and relatively few children are obese.

Red 3: Troubled Dependence

Mainly white, living on benefits or working in low paid unskilled jobs. Unhealthy lifestyles involve cigarettes, takeaways and alcohol. Many in this group suffer from ill health, such as obesity, COPD, diabetes and complications during pregnancy and birth. Death rates are especially high for both cancer and cardiovascular disease, while A&E attendance and excess bed days are also above average. Teenage mums and abortions are both common in this group. There aren't many infant deaths.

Green 1: Longer Lives

A mix of older, successful professionals, plus others who are less well off. Those with money like to enjoy the fruits of their labour through big houses, golf and exotic holidays. Some are starting to suffer from ill health as time moves on. Many have diabetes and don't always manage it well. Stroke can affect some people, but lung cancer and mental health problems less so. In fact, many in this group live longer than average, with cardiovascular disease an especially low cause of death. Few of their children have emergency admissions.

Green 2: Motivated Management

Middle aged, in high or middle management. They're better off than many and enjoy what they can afford. This means socialising quite a lot and enjoying a glass of wine or two. They still have ambitions in life and are conscious of what others have and don't have. This group is healthier than average, though some may face problems in the future. Rates of lung cancer, obesity, alcohol-related liver disease, diabetes, stroke, COPD and mental health problems are all below average. Few die from cancer or cardiovascular disease. They are also less likely to need emergency or repeated visits to hospital or to readmit or have excess bed days. Many of their children have the MMR job, but some are also obese. Infant deaths, abortions and children's emergency admissions don't often happen.

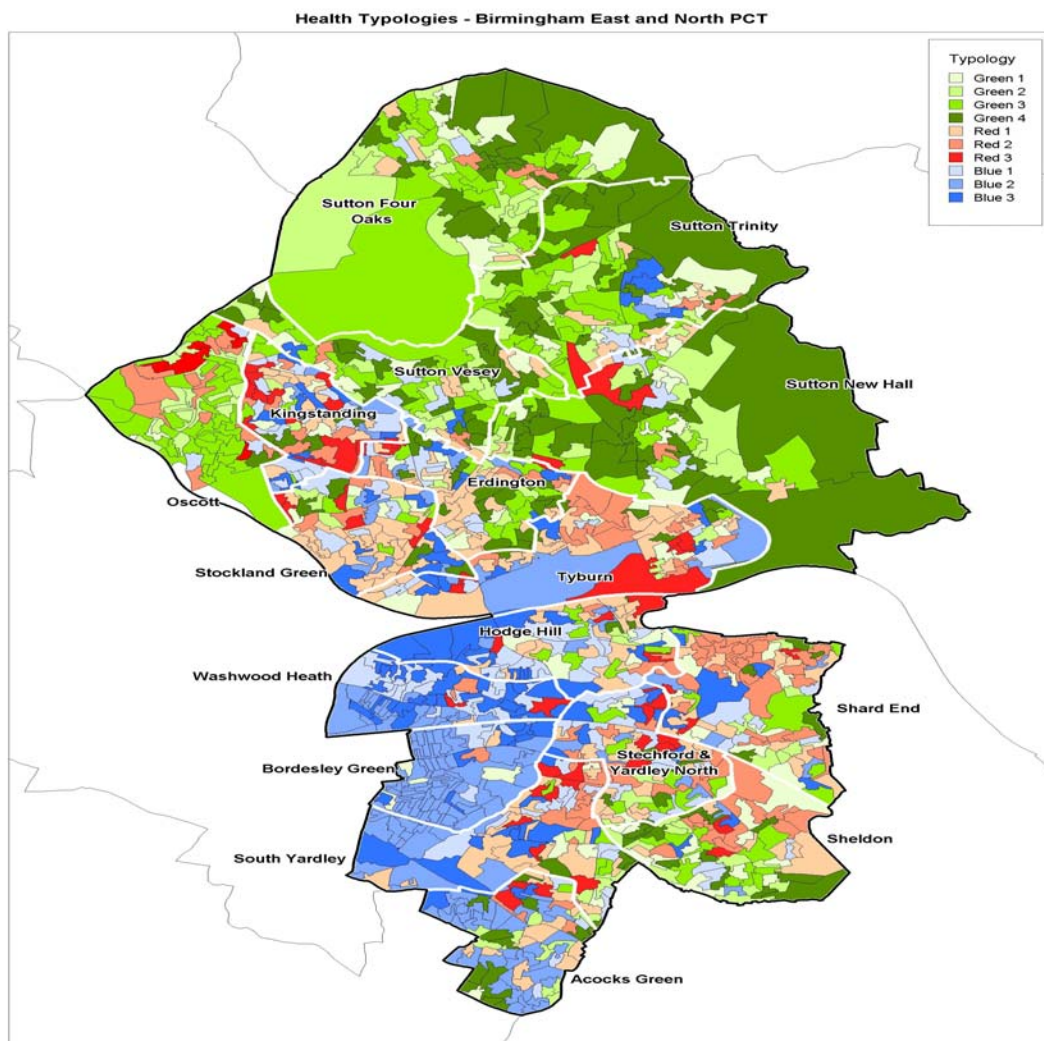
Green 3: Contented Comfort

Better off than average and content with their lot. Living in semi-detached "between the wars" housing, they may enjoy an occasional meal out at a local Harvester or curry house. They like nothing in excess, are set in their ways and have healthier

lifestyles than average. Mental health problems, obesity, alcohol-related liver disease, diabetes, heart disease and COPD do not affect them widely and death rates are below average, in particular for cardiovascular disease. However, a number suffer from cancer. Most attend their appointments and fewer than average are admitted to hospital for emergencies (both children and adults). Many of the children are obese, unlike their parents, but infant deaths, abortions and teenage mums are all quite rare.

Green 4: City Edge Wellbeing

Rural or semi-rural communities, though very close to the city. Often in green wellies and wax jackets, they are concerned about the environment and recycle, but won't give up their 4x4s. Overall, they are no more prosperous than average for BEN but are better off in terms of health. Cancer and cardiovascular disease do not cause many deaths. Likewise, rates are low for obesity, mental health problems and alcohol-related liver disease. Few in this group are "high impact users". Neither do they need emergency visits to hospital, or readmit or fail to show up for appointments. In addition, while parents are less likely to insist on MMR jabs, not many of their children are obese or need emergency admissions. Infant deaths seldom occur and there are few teenage mums.



This detail has been mapped at street level and is available in that format to support neighbourhood analysis, targeting and design.

3.2 Our Stakeholders: Insights from Patients, Public, Clinicians and Local Partners

3.2.1 Patients and Public

Our ability to make a real difference to local health status is crucially dependent on our ability to develop new relationships with local patients and public. Given the legacy of low skills and poor educational attainment driving low expectations (concentrated in our red typology groups), we made an early commitment to “the most informed and empowered community” as a key goal if we are to tackle inequality. Over the last 7 years, the PCT and its predecessors have developed a range of mechanisms for engaging with the public, specific neighbourhoods, communities of interest, voluntary and community sector organisations and patient groups. In 2007/8, the Audit Commission awarded us a score of 4 for our work in this area (ALE). In 2008, in anticipation of an increasing need to have a relationship with the public which could underpin and survive through a period of significant change in health services, we invested in PRIME. This programme includes a range of activities which support the active development and application of intelligence to drive a new relationship with both patients and public including:

- Health Typologies profiling of the BEN population providing insight into risk and preferences
- Video diaries of 2 people within each typology indicative of daily lives and pressures which underpin personal decision-making and activity and highlight areas we need to re-think and re-design if we are to serve different communities and individuals effectively
- “Seldom heard” workshops involving 300 people drawn from groups which are typically under-represented in public service and commercial outreach and research
- Recruitment of 1000 households, reflective of the typologies within the PCT as a standing citizens panel for consultation and comment in addition to existing citizens panel of 1000 individuals
- Development of a fully searchable database to host the emerging library of learning from patient and public participation activities
- Patient and Public interactive micro site within the NHS BEN web presence to support conversations and live feedback
- Re-development of main website to promote participation in and understanding of NHS BEN role and activity
- Development of a significant social marketing programme focused on each of the 5 health priorities, and targeted to specific high risk groups within it.

This is in addition to and support of the historic range of activity, which continues, now underpinned by a formal methodology through typologies of targeting and reporting.

Summary of existing mechanisms for Public and Patient Engagement	
Ipsos Mori poll	Constituency Health Forums
Household Panel of 2000 local people	Customer Journey Mapping
Stakeholder events	Work with religious groups
Public consultations (8 conducted 09/10)	Health promotion events
Citizens panel of 1,000 people	Patient focus groups
Surveys	Equality and Diversity Community Group
Public Patient micro site blog	Discovery interviews
Neighbourhood forums	Community workshops
Patient participation in redesign workshops	Patient surveys
Analysis of Complaints	Patient Advice and Liaison Service (PALs)
Health Improvement Forums	Work with local community & voluntary sector
Cascade – sent to local agencies and partner organisations as well as contractors	b-well – mental health promotion activity
Health news – sent to all residents key health information/problems, now sent by typologies i.e. three different versions for each typology	Carers team for support and feedback
BME Community Development Worker x 5 working with local BME communities to tackle mental health inequalities.	PCT publications: Annual report, Public Health Report, AGM Awards magazine.
Patient and public involvement team x 6 working with local communities directly and services to develop engagement with patients.	Barbershop magazine – for BME young people to inform and tackle mental health inequalities.
Press releases to local community newspapers/radio stations	‘Your Guide’ newsletter providing information on local primary care services delivered to all residents
Increasingly interactive Trust website	School cluster Forums
Older Peoples reference Groups	Birmingham Own Health Membership model

We have learnt a lot from the different ways in which we engage with our public and patients, using feedback in order to redesign our services, often engaging service users directly in that process, as well as in strategy development. For example feedback during the end of life care consultation made us re-think our approach to identifying the ‘lead professional’ and level of capacity in the mainstream services, and more recently PRIME video diaries are challenging us to think about the counselling support available to family members making difficult decisions at the end of a loved one’s life. The PPI database can now track not only feedback and key messages but also the action taken in response.

Nationally our performance is benchmarked through the annual patient survey. The methodology of an extensive written questionnaire is not well suited to a population characterised by a low level of literacy. MORI analysis undertaken by NHS West Midlands suggests that although NHS BEN does not do well against the regional

average, it does better than expected given its population profile and particularly the significant population of people from Black and Ethnic Communities.

Case Study:

Focus Groups with men aged 50 – 65 identified a reluctance to use the GP. In response, we commissioned a bus as a screening base travelling around supermarkets and football grounds and a dedicated contract with Lloyds Pharmacist resulting in over 10,000 men being screened who were previously not in contact with services, and over 1,000 with frank disease being highlighted for follow up.

3.2.2 Leadership and Partnership

The Trust has committed to developing a new narrative of the NHS to develop public expectation of a service which engages in disease prevention and health improvement, rather than just treatment of the ill. To this end we participated in the BBC documentary “Price of Life”, which received significant public national coverage and stimulated web chatter. We appear regularly on local radio programmes stimulating debate on key health issues. Our work to support all 153 PCTs to be able to respond to NICE calls to participate in technology appraisal has stimulated significant discussion of commissioning and publication in the national press. Internationally we are known for our work on quality improvement, care management and organisation design, hosting visitors from European countries and appearing on platforms in US, Canada, Europe, New Zealand and Japanese News.

More locally the Trust has invested significant time and energy in developing strong relationships with key partners, believing this to be essential if we are to effectively tackle long-standing inequalities in health and variability in services:

- NHS BEN has played a key role in the development of a partnership culture in the city and in the active re-design of partnership structures and processes of Be Birmingham (the Local Strategic Partnership). We have been active members of the executive, held accountable alongside the city for the LAA by Government Office West Midlands, and most recently in piloting the introduction of the Comprehensive Area Assessment (CAA). We play an active role in the Children’s and Young People’s Partnership. More generally, the PCT enjoys membership of the City Council Chief Executives key partners group, the Leaders’ Economic Prospectus group, the Digital Birmingham Board amongst others, and is seen as a key player in the civic life of the city, contributing to the adoption of ‘Be Healthy’ as one of five key outcomes in the Community Plan.
- The Trust has been instrumental in working with council colleagues to develop the Birmingham Health and Well-being Partnership (BHWP) Executive, which brings together the three PCT’s with the Corporate Directors of both Adults and Communities, Housing and Constituencies from the City Council. NHS BEN has been an active member since its inception, with our Chief Executive chairing from 2004-7. The BHWP drove the development of the male life

expectancy and infant mortality programmes in the city's first Local Area Agreement (2004-7), for which we received excellent feedback from the National Support Team for Tackling Health Inequalities. This in turn informed our approach to the development of the second LAA and our partnership programme for 2008 -2011.

- As members of the CYP Partnership, we have been active participants in the City's innovative 'Brighter Futures' approach, which has sought to apply a public health approach across the breadth of children's organisations and investment in the city. This included a comprehensive survey of children and young people in the city, which highlighted high levels of anxiety and distress, (even in the younger age groups) benchmarked against other areas. This is driving a new multi-agency strategy focused on early intervention with vulnerable families to achieve the partnership's five desired outcomes of: make a positive contribution, be healthy, enjoy and achieve, stay safe and succeed economically.
- We enjoy a particularly close relationship with Adults and Communities (adult social care). We pioneered section 75 agreements in the city, for commissioning of learning disabilities and the provision of integrated intermediate care (for which we received the HSJ cost effective partnership award in 2007). We are now leading the integration of both learning disability and mental health commissioning budgets across NHS and social care to create a single budget of some £355m under the management of a single jointly appointed director working between BEN as lead PCT for the NHS and the Adults and Communities Directorate. We have also led the NHS in experimenting with the adoption of personalised budgets, and have now been recognised as a national pilot site for our approach to chronic disease and also in mental health.
- The PCT has been active in a number of employer forums at the request of the Learning Skills Council (LSC), including chairing the Public Service Compact of large public sector employers and being the public sector representative, with the Council, on the (largely commercial) Employer Skills Board. The Trust collaborated with Job Centre Plus and LSC in 2006 to pilot an integrated approach to people on incapacity benefit, which has become a core stream within the economic development element of the LAA, achieving 10% back into employment and 20% in training or volunteering. This has now been adopted as a national 'Fit for Work' initiative.
- The PCT has led the development of a number of networks with other commissioners to share learning, develop best practice and recognise key challenges. As one of ten PCTs represented at the National Specialised Commissioning Group, we convened a regular fringe meeting of the ten PCT CEO's to further opportunities for pan-regional collaboration. We also convened the Core Cities group of CEO's drawn from the PCTs of the eight largest cities in England outside London, which face a similar set of challenges in health improvement. We co-hosted with Bristol the first bi-annual 'Tackling Inequalities in Health' conference in June 2008 and were an active participant in the Liverpool Conference of 2009. We hold the contract

on behalf of the cities for the Health Improvement Collaborative programme seeking to achieve system learning on how best to tackle health inequalities across the cities in obesity, alcohol misuse, teenage pregnancy and premature mortality.

- In the Region, we initiated a series of meetings of the 17 PCT CEO's to identify areas for potential collaboration and alignment, which has resulted in formally adopting a new approach to collaborative commissioning beyond specialised services, and ensured that it was attractive to others by supporting others in taking lead roles going forward. As host to the West Midlands Specialised Commissioning Team, collaborative commissioning is embedded in our approach, and we are very active players in stimulating collective approaches across the Region and more locally; most recently in convening the Region-wide whole system event as a basis for a regional strategy for Paediatric Surgery.
- We are active players in Birmingham's Total Place pilot (one of 12 nationally), which seeks to deliver better outcomes at lower cost in public services by aligning activity across organisational boundaries. The five programmes reflect our activity in joint commissioning of mental health and learning disabilities, early intervention with vulnerable families, harm reduction in alcohol misuse and historic work in the city on guns and gangs. All themes come together in a significant new mainstream regeneration programme in Shard End / Yardley as the 'Total Community' initiative chaired by NHS Birmingham East and North. This will model a new integrated 'public service offer' operating through a single hub, host the development of a new 'village centre' for the area, and set the scene for housing growth.
- The PCT has pioneered partnering with commercial companies. We have set out a unique approach in which we explicitly share our strategic objectives with partner organisations and relate their commercial incentives to those objectives. This approach creates scaleable relationships in which creativity and trust can flourish. In particular, we have enjoyed a close working relationship, (cemented through an OJEU procurement in 2008) with Vista Consulting as an organisational development partner which has ensured we remain 'consistently fit for purpose' through a number of policy and structural changes. We have developed a cutting edge tri-partner relationship with NHS Direct (NHSD) and Pfizer Health Solutions (PHS) to design and commission Birmingham OwnHealth®, delivering significant improvements in symptom control and behaviour change for over 4,500 patients. We have initiated a new relationship with Dr Foster Intelligence and Humana for our PRIME and BENEFIT well-being work to develop a new relationship with our public. We have collaborated with the Young Foundation to develop our first social enterprise project trialling Healthy Incentives for behaviour change, and have recently developed a programme of 5 initiatives through MESH to bring care closer to home at reduced cost with Healthcare at Home. With PHS and NHSD, we received the partnership award at the independent sector health care awards in September 2007.

- We were also the first Trust in England to employ a Social Entrepreneur in Residence in partnership with the Young Foundation to develop and support up to four health related social enterprises which will provide preventative health services to specific communities whilst also creating local employment opportunities.

3.2.3 Clinical Engagement and Leadership

The PCT has a long-standing system of clinical engagement in which the Professional Executive Committee (PEC) is the Clinical Executive of the PCT acting as a full sub-committee of the Board with a focus on clinical and service strategy. The clinical members each hold a clinical director role and are responsible for leading key areas of work, including involvement, clinical governance and infrastructure in addition to those who chair Practice Based Commissioning Groups. Clinicians are active members of our Gateway boards which challenge proposals for investment and improvement. This structure continues to evolve in the context of our strategy, and is currently in transition again to better reflect our emerging approach to partnering with key practices.

The PCT was an early adopter of practice based commissioning (PbC), as this policy reflected our commitment to clinical leadership and the key role of GPs in demand management. However, continued experimentation and national learning suggests that GPs achieve best outcomes both clinically and in respect of service utilisation when their focus is on their core competence of excellent risk assessment and chronic disease management in primary care. Increasingly, the PCT will focus on our role as commissioners of primary care to drive improvements in this core competence as key to population health improvement, service productivity and tackling inequalities. In the meantime, Each of our six localities has a signed off PbC locality commissioning delivery plan and local strategy, which is aligned with the PCT's four goals, but responds to key issues as they are played out at the local level.

We have appointed a number of non PEC clinicians as clinical leads in particular areas, and they have driven service improvement in end of life care, COPD, sexual health, heart failure, and BOH amongst others. The PCT has invested in developing a strong cohort of non medical consultants, who have led significant service improvements including in orthopaedic triage, urgent care and diabetes. Social care practitioners have been actively engaged in our re-design activity and the development of intermediate care.

Building on our learning as a Kaiser Permanente Beacon site, we have invested in the relationship between local General Practitioners and hospital consultants, driving collaboration for service improvement. The ex-Medical Director of Heart of England Foundation trust has now taken a sessional Clinical Director role in the PCT, alongside our existing Clinical Director - Chronic Disease Management, and a dedicated role in Mental Health is in development.

This investment in our relationship with our main acute provider, (HoEFT), through 'Working Together for Health' (WTfH) has been a core strategy for driving improvements in accessibility, responsiveness, safety and effectiveness in services,

grounded in clinical engagement and close collaboration between primary and secondary care clinical colleagues. This programme has been the subject of academic commentary as a Kaiser Beacon site since 2003 (by Universities of Birmingham and Warwick) and has been identified through the Ontario Quality by Design programme as an exemplar of system improvement alongside Jonkoping in Sweden, Veteran's Administration in the USA, Henry Ford Health System and Inter Mountain Healthcare USA.

Within the framework of WTfH, we have developed a joint clinical leadership programme with HoEFT, Solihull Care Trust and Birmingham and Solihull Mental Health FT (BSMHFT), which has built capacity for leadership in the system and extended engagement to a broader group of clinicians. It includes coaching and mentoring and is supported by an informal monthly meeting of the medical directors. Within the PCT, we survey clinicians to understand learning and development requirements, and respond with bespoke primary / secondary care education events.

WtFH provides a formal framework for clinical participation in a whole system approach to redesign and improvement, increasingly using formal 'LEAN' processes. Building on a strong history across a range of specialities, we are now working with HoEFT on the introduction of the Map of Medicine as a consistent basis for the introduction of new pathways as recommended by the NHS: Next Stage Review. This tool supports effective clinical decision making by providing best practice information through a single website.

3.2.4 Our Workforce

The NHS is a major local employer and we have actively collaborated with partners in the economic development partnership to create new opportunities for local people from wards with high levels of worklessness to enter NHS employment and to then develop the skills and experience which will enable them to progress in their careers. Apprenticeships, targeted recruitment, and basic skills will continue to form a plank of our workforce development strategy and will be increasingly important with the broader economy in recession. A key area will also be our partnership work to minimise numbers of people claiming incapacity benefit (fit for work), which we must address as an employer as well as a service provider.

We have a strong track record in talent identification and management. We have invested in existing staff, many of whom have been promoted over the last five years internally, but also taking the NHS BEN approach into other West Midlands organisations at senior and middle management level. Our significant commissioning scope and reputation for innovation and performance has also proved attractive to colleagues from commercial organisations, in addition to those already seeking development within the NHS. We have identified talent management as a key element of our workforce development strategy within our 2009/10 OD Plan.

NHS BEN has taken the lead for workforce planning across the local health economy in 2009. The PCT was highly commended in the workforce planning category in the 2008/9 Health Service Journal awards. We have successfully combined recruitment, training, succession planning, meeting the workforce needs of a changing organisation and embedding the Knowledge and Skills Framework at the core of the

process, to assist in identifying the core competencies required for current and future roles. Our approach to workforce planning in this case was to seek out what skills we have in our local community, invest in the development of new employees through training opportunities, and create a career ladder to reach the overall workforce need, that will not only meet both our short term goal, but provides a framework for effective future succession planning.

We will draw upon our Healthy Incentives work and other social enterprise development, to invest in local people to deliver improved health outcomes.

Case Study:
Apprenticeships in Future Jobs Fund
Or HV Case mix

In delivering our ambitious change management programmes over the last six years, we have demonstrated an ability to ensure that our workforce are 'fit for purpose' whether in extending the scope of practice through formal professional training (e.g. development of cohort of extended scope physiotherapists), management development through new opportunities, secondments and more recently the PRIDE programme, introduction of new roles at entry level (lay health workers) or more senior (non-medical consultants) and personal development as agreed through our well established appraisal processes. There will be opportunities as we develop new models of 'out of hospital' care for clinical staff traditionally employed in hospital settings to follow the patients into new style of services.

Some 50% of our workforce live locally, and are thus part of our local public as well as employees. We hope that our initiatives to act as a good employer also therefore have a positive impact for local communities. In particular, our staff wellness programme (BENeFIT), which promotes physical activity and greater personal health awareness, amongst our workforce, and provides a foundation for future work directly with local people.

3.3 Existing Targets and Local/National Priorities

Building on our work since 2002, NHS BEN has achieved significant improvements in outcomes and service experience for our population, improving trends on mortality and making significant progress in achieving Quality and Outcome framework targets in primary care. In 2006/07 we were one of only three PCTs in the country to receive a rating of 'excellent' for services. We were awarded an overall Auditor's Local Assessment (ALE) of three in 2007/8, with four for value for money, one of only three PCTs in the country to achieve this highest score. The new methodologies introduced in 2008/9, have not differentiated so clearly between PCT's in the first year, and we have achieved more average scores including a rating of 'good' in Use of Resources and a rating of 'Fair' for the Care Quality Commission quality of service assessments. Whilst we fully met all core standards, and could demonstrate significant additional assurance in the quality of primary care achieved in year, failure to meet key access targets, poor processes and reporting in local acute trusts and lack of local target achievement by West Midlands Ambulance Services contributed to our compromised quality of service rating. This will be actively addressed in year and going forward.

Our strong focus on performance means we recognise we shall need to focus our attention in a limited number of areas if we are to make significant progress on achieving our four strategic goals.

Performance against the core PSA targets for mortality and inequalities will continue to be challenging given our demography; with reducing smoking prevalence a key challenge after 5 years of successful intervention. There continues to be significant variability in the capacity, capability and commitment of local primary care, with commensurate variability in service experience for patients. The shift in focus to our commissioning of primary care, rather than primary care's discussion of secondary care will support this. We are developing a clear differentiation of those contractors who will be partners in strategic delivery, and those with whom we have a more transactional relationship. Our ability both to effectively manage individual practice contracts and to engage in strategic and improvement dialogue will be enhanced with the development of GP MyPractice, a practice focused knowledge management system within PRIME.

As co-ordinating commissioner of two Foundation Trusts and a significant CHS contract, we have developed a formal contract management process which includes a monthly performance meeting actively engaging associate commissioners, and a dedicated Quality Review Group for each contract (see 6.6). In the last 12 months, we have actively applied levers within the contract to drive improvement where discussion has failed.

The safety agenda is a core component of commissioning, and we access regional and national benchmarking data wherever possible, including increasingly through the Commissioning Business Support Agency, in addition to national sources such as Doctor Foster publications. In the last year we introduced CQUINs for each of our major contracts, which include reduction in bed days in Mental Health services, targeted patient satisfaction, increase in detection of foetal growth rates and readmissions at a cost of £1million.

Despite significant investment in care closer to home, achieving reductions in local acute capacity, continues to be a challenge. We shall agree a programme of bed reduction at HEFT to reflect the success of 21st century models of care, and ensure return on our investment.

Over the last 6 years, all three PCTs in the city have invested in developing a rich understanding of our local areas and health economies, and in 2005 we each believed that further work was required to develop our own local health economy. However, the 2006 integrations across the rest of the country, mean that we are now an outlier as the only core city, which does not have a single PCT. It is our belief that this lack of coterminosity is increasingly compromising our ability to work efficiently and effectively with the City Council and is driving investment in management overhead which is only necessary because there are three PCTs, increasingly this will be a luxury we cannot afford as we seek to maximise health return on investment. NHS BEN believes it cannot, in setting out our strategic plan for the next five years, ignore the necessity of further consideration of whether a single commissioning organisation for health in the city, would not now enable acceleration

of achieving 'life to years and years to life', and ensuring best return on public investment. The three Birmingham PCTs are currently undertaking an option appraisal on this issue. An agreed recommendation will be presented to NHSWM by 4 January 2010.

DRAFT

CHAPTER 4: Provider Landscape and Market Analysis

4.1 Provider Analysis

Local investment in health provision continues to be dominated by expenditure on NHS providers, but this does vary significantly by market. This section notes the current high level analysis of investment by provider and goes on to highlight key issues by market. This analysis is based on more comprehensive work which has been undertaken, most thoroughly in respect of Community Health Service provision, according to the model set out in **Figure 4**. Our PRIME programme gives us new capability to profile our customers.

Figure 4 Market Analysis Approach



4.1.2 Primary Care

The PCT invests almost **£79m** or 18% of investment through 330 primary care contractors. Approximately 80 % of health contacts with the population take place in Primary Care, with the majority of this activity undertaken by small local businesses in sole contract with the PCT. NHS BEN currently commissions primary care through:

- 77 General Practice contracts
- 56 Dental practices contracts
- 59 Mandatory optical contracts
- 33 additional optical contracts
- 100 Pharmacy contracts

The PCT has developed an overarching strategy for Primary Care, with a specific strategy developed for General Practice and will be developing strategies for Dentists, Pharmacists and Optometrists. The legacy position in 2002 was a disproportionate number (60%) of single-handed or small general practices serving

the most disadvantaged communities in the PCT. The proportion of single –handed practices in 2009 is 33%. Many of the primary care contractors operate out of converted houses not designed for the delivery of 21st century health care. There are limits to capacity and significant variations in performance continue to exist. NHS BEN is addressing a historic position of being under-doctored through the introduction of 3 new practices within the equitable access scheme, and using LIFT developments as leverage for practice amalgamation and consolidation within an expectation of a optimum 1:1500 doctor to patient ratio.

The Primary Care market is also key in managing demand for acute services. The PCT believes that an increasing number of patients could be managed by their own GPs in primary care as part of core contractual arrangements. In NHSBEN in 2006, the commissioning of the Insight referral management tool reduced referrals to secondary care by 14% and in 2007/08 by a further 7%. In 2008, in collaboration with HoEFT, we extended the tool to give live tracking of emergency admissions and A&E attendances. Practices now actively monitor attendances at A&E and emergency admissions on a daily basis demonstrating action with individual patients when appropriate.

NHS BEN has developed four new primary care centres in the last three years, bringing together ten GP partnerships into four, and has tendered four practices on retirement to expand three, including a new multi-partner team established by the Trust in Washwood Heath to diversify the style and range of services available to a very diverse population with a significant burden of ill health. However, NHS BEN continues to be characterised in our more deprived areas by small practices offering a limited range of services and access. Respondents to our patient surveys have increasingly identified access to GP services as a concern, and dissatisfaction is concentrated in black and ethnic minority respondents, who are more likely to be registered with small or single-handed practices. We shall achieve national targets for extended opening hours by December 2008, but in small practices the national requirements are unlikely to be visible to patients (an extra 30 minutes per 1000 patients despite £1m investment for 2009/10. We have committed to achieving 90% of practices offering extended hours by 2012 and will expect these to be highly visible (no closures during normal working hours and additional time on Saturday mornings).

The PCT population has traditionally enjoyed relatively good access to NHS dentistry, but there have been some public concerns expressed since the introduction of the new NHS contract in 2006. It is less of an issue for our PCT than elsewhere in the West Midlands for adults (58.5% access in last 24 months against 53% average) and we are more concerned about the emerging evidence of limited access by children and young people (66.8% in the last 24 months compared to average of 69%). The PCT has commissioned additional units of dental activity in year where there is capacity from established providers and will introduce a new dental practice into Hodge Hill as part of the LIFT development in the area. This programme will be kept under active review to ensure capacity reflects demand from our more assertive communities (particularly for orthodontics) and maintains equal access for the more disadvantaged populations. Through our collaborative commissioning arrangements we shall ensure appropriate investment to secure a

sustainable dental hospital for the future, which is key to maintaining a resilient dental workforce in the Region.

We expect to see increasing competition amongst primary care contractors as we seek to improve access and responsiveness. The national GP contract remains a relatively blunt instrument, with limited opportunities for de-commissioning within General Medical Services contracts, and the PCT will continue to explore how to develop more leverage for quality and value for money within and beyond these limitations using its segmentation and partnering approach. We have already procured Lloyds Pharmacy to deliver screening as part of our male life expectancy programme, and this has been a positive experiment in exploring how to make best use of the range of primary care provision, beyond historic models of intervention.

4.1.3 Heart of England FT

Of the £218m, which the PCT invests in acute care, £167m (76%) goes to Heart of England FT. NHS BEN is the coordinating commissioner for HoEFT, primarily on behalf of Solihull Care Trust, South Staffordshire PCT and to a lesser extent Heart of Birmingham and South Birmingham PCTs. The Trust is the dominant provider of choice within a densely-populated, deprived urban conurbation. NHS BEN views HoEFT as a preferred supplier of acute care for local people for a number of reasons including:

- Its traditional high level of performance as a Foundation Trust in delivering services to the PCT population.
- Its status as an active partner in the re-design of care pathways and service improvement.
- Its ready accessibility to the majority of NHS BEN's population, including those dependent on local buses.
- Its importance as a large employer which invests in training within a community characterised by low skills and high levels of worklessness.

In this context, the PCT has pursued a twin strategy of building long-term relationships for clinical engagement in collaborative re-design through our Working Together for Health programme, alongside tactical market interventions to provide leverage for improvement. Where HoEFT has been reluctant to respond to commissioners, we have undertaken limited market tests, as with tendering a contract for dermatology provision for a new style of service; or re-designed our own, community capacity as in the introduction of risk stratified assertive case management. To further strengthen our relationships, the PCT has recruited the former medical director from HoEFT as Clinical Director for Commissioning within the Working Together for Health Framework.

4.1.4 Birmingham and Solihull Mental Health FT

Of £41m invested in Mental Health services, all but £1m goes to Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), accounting for 78% of mental health care provided to Birmingham across a range of acute and community settings. There is at present limited competition from other statutory, third sector and private

sector providers but integrated commissioning with the Adults and Communities directorate from April 2009 will stimulate new entrants and new networks of care, particularly for those either with minor acute illness or those with established and long term conditions. BSMHFT is likely to continue as the dominant provider of acute treatment for significant and enduring mental illness.

BSMHFT has grown out of a number of mergers over the last ten years to be one of the largest providers of mental health services in England with a current contract value with the Birmingham PCTs of £130 million. The size of BSMHFT and the scope of services provided create opportunities in the ability to provide an integrated connected pathway from primary to specialist care. Alongside this however is the risk that such a large provider could become entrenched in legacy service models, and fail to respond to commissioner proposals because of a monopoly position. NHS BEN as lead commissioner for mental health on behalf of the three Birmingham PCTs has taken a proactive stance when working with BSMHFT and has agreed a set of principles that provide a framework for the relationship and the way commissioners and providers will act. This framework underpins the contract and facilitates dialogue and redesign in an environment where healthy tensions exist. As with Heart of England Foundation Trust the PCT takes a twin track approach. This included designating BSMHFT as a preferred supplier of acute and specialist mental health services and the tender for independent provision for forensic mental health services through WMSCG. In 2009 the PCT has set out a Strategic Service Framework with BSMHT which articulated the need to redesign services and reduce costs of secondary care mental health provision by 10% between now and 2014.

The current process of re-design and re-specification will stimulate the market through the development of a provider forum which will support new entrants into the market, with a focus on provision of primary care mental health services. The MESH programme with Healthcare at Home, includes a dedicated strand designed to develop new models of primary intervention in mental illness.

4.1.5 NHS BEN Community Provision

The PCT invests some £82m in community health services, of which £78m is within the NHS, including £48m with NHS BEN Community Health Services.

We have taken a commissioning led approach to Transforming Community Services, including market analysis to understand the current pattern of community health services provision, its scope, performance and the particular role and any limitations of our own Community Health Service provision. This is in the context of the key role which local CHS provision has played to date, including:

- Demand management – supporting us in reducing costs in secondary care by up to £10m in any given year.
- Research and innovation – we have been able to take ideas from elsewhere and build on local innovation to test and prototype services, making many live changes as we have learnt how they deliver in practice.
- Direct relationship with our public – we have a privileged relationship with local people as we not only ensure their access to a range of health services, we are also a local direct provider of much of their care. This gives us insight

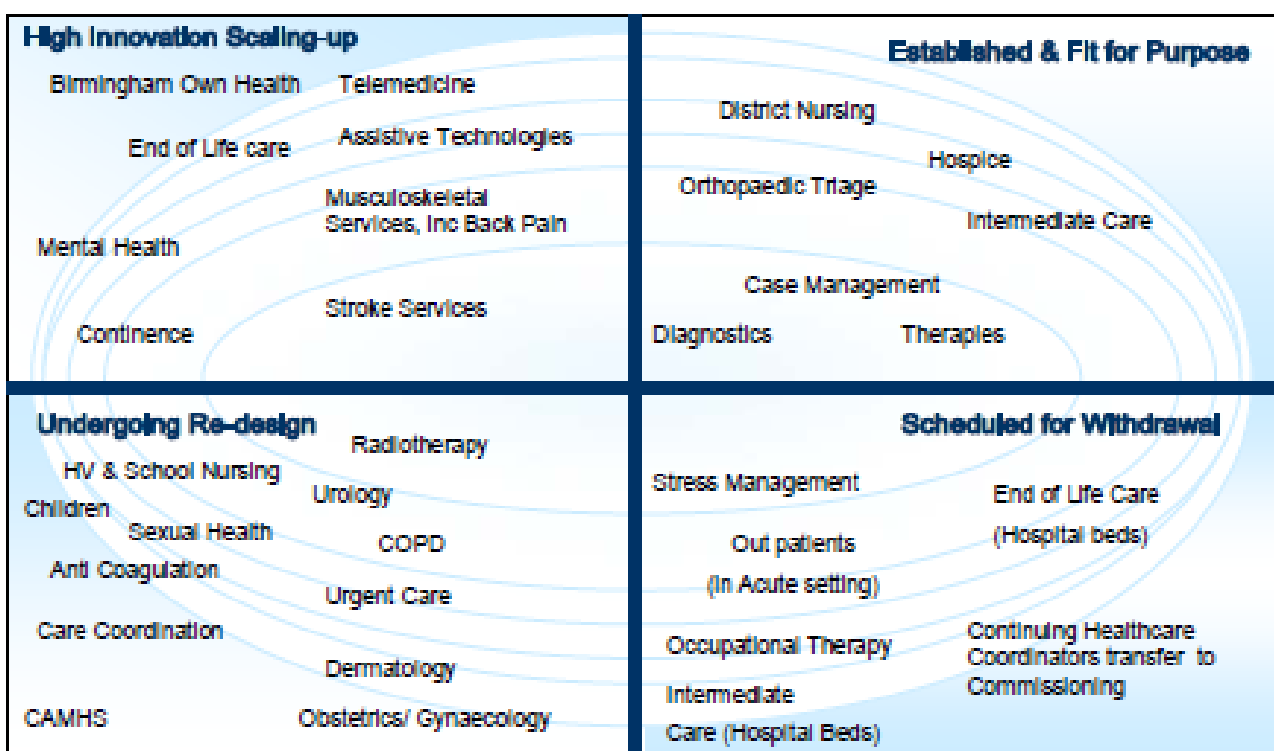
into their preferences, lifestyles and their experience of other local service providers. This relationship is key when we are also making difficult investment choices and at times limiting access to treatments of limited value and high cost.

- Market leverage – our major local acute providers have a market interest in generating and sustaining demand for a range of services, which may be more safely, appropriately and sustainably delivered closer to home. Where they have not been interested in re-design to deliver this, we have been able to develop alternatives to stimulate change through our own direct market interventions.

In primary care too, a direct intervention in 2003, through a PCT practice of salaried GPs introduced a disadvantaged population to a new style of primary care and raised expectations of neighbouring services which had enjoyed the privileges of a cartel. Retaining some direct provision also provides resilience in the context of potential market failure (e.g. of nursing homes); those local authorities which contracted out all public provision a decade ago are now largely trying to re-gain some foothold in the market. Nevertheless the legacy position of £78m of our £83m spend going into local NHS provision, suggests that this is an under-developed market; given it is also growing (55% in 3 years with a further £16.5m recurrent investment planned by 2012/13), there is clearly room for greater diversity and competition.

In Phase 1 of our business readiness programme we worked with Partnerships UK (PUK) to establish a clear baseline understanding of contestability and performance in our provider arm (see **Figure 5** below). The detailed market analysis in Phase 2 has demonstrated overall strong performance and driven an increasingly sophisticated understanding of the relative contribution of our own provider, other local NHS provision (particularly from NHSSB) and alternative players within a defined set of activities.

Figure 5 Phase/Analysis of NHS BEN CHS Range of Services



The most immediate areas of change are to seek partners for the transition of residential End of Life care and universal services for Children and Young People. There are emerging opportunities for growth in both the Musculoskeletal and Adult Rehabilitation services; either of these could be considered for a social enterprise or vertical integration. The market in chronic disease management is likely to become increasingly diverse over the next few years.

Overall we can demonstrate significant contestability in our legacy CHS provision, but the market is open to development. Despite the historic strengths of maintaining a foothold of personalisation in the local market, national policy is now such that we anticipate finding a number of new homes for these services by April 2011.

4.1.6 Birmingham Children's Hospital FT

We invest some £9.9m in this hospital, the fourth largest source of acute expenditure, this is in addition to £9.7m on paediatrics at HoEFT and excluding specialised services. BCHFT is a significant national player, delivering a range of specialised services to the Region and nationally. However, it is increasingly also a provider of choice locally for routine paediatric care, and this is placing significant pressure on physical and workforce capacity, particularly in relation to surgery. Given, emerging changes in paediatric workforce profile, in which fewer surgeons and anaesthetists are trained or feel confident in undertaking work on children, particularly those under 11 years, there are significant challenges emerging across the Region. As local services are increasingly unable to manage their historic routine activity, parents increasingly choose the specialist provider, and BCHFT is unable to respond to demand. BCHFT faces a crucial decision in the next year or so, whether to become a bespoke provider of highly specialist care, or whether to franchise its brand more widely and actively seek to become provider of choice for acute children's care, operating through a series of local outlets. If the former, it is likely that we shall seek to develop dedicated day case activity at HOEFT, and shift investment from the children's for routine care; if the latter they may yet grow their share of acute activity.

Given rising numbers of children and young people, and increasing rates of complexity and disability as very damaged babies are rescued at birth, the investment in specialised and very expensive treatments at BCHFT is set to grow.

4.2 Market Analysis

4.2.1 Prevention and Screening

This is an under-developed area, which has not historically attracted mainstream commissioning focus, but this position is changing rapidly as the value of preventive and early intervention activity is becoming clear, both in relation to outcomes and productivity. The largest investment historically has been in NHS and local contractor provision of national screening and vaccination programmes, however increasingly the PCT has invested in local programmes and from a diversity of providers, e.g. screening of men out of contact with primary care for CVD through Lloyds

Pharmacies and Gateway health workers. We are also experimenting with the impact of offering incentives to support lifestyle change through partnership with the Young Foundation; the activity supporting smoking cessation in pregnancy is already showing promising results. We are hosting a Social Entrepreneur in Residence to identify business opportunities in the development of community based prevention services, with the aim of a dual impact on health improvement; new and effective service interventions and employment for local people, which will itself improve life chances. This will be a growing and increasingly diverse market over the next ten years. In specialised services, our work with the National Genetics Centre at University Hospital Birmingham has identified a growing area of screening and targeting for therapeutics.

4.2.2 Urgent and Acute Care

Across the country, the introduction of 48 hour access targets for primary care has perversely had the effect of reducing the role of GPs in responding to acute and self limiting illnesses, with many people opting to seek help at Accident and Emergency departments, with a maximum 4 hour wait instead. NHS BEN has bucked the national trend on attendances with a combination of signposting to appropriate routes and the strategic positioning of a nurse-led walk in Urgent Care Centre in Kingstanding, a historic source of many of the attendances at Good Hope A&E. The positive impact of this model will be extended to Heartlands with the opening of a second centre in Saltley in Winter 2009/10. Greater emphasis is required in understanding the role of A&E in responding to mental distress and as used by people with learning disabilities, substance misuse problems, and often a combination of all three conditions, and in ensuring resilience and the availability of appropriate skills in the response.

The monopoly Ambulance Service has a key role to play in emergency care, but has struggled to keep pace with changes in the broader system, largely reproducing conservative service models which do not meet the requirements of capacity management and fail to make use of alternative sites to A&E. Increasingly investment in WMAS will be limited to emergency activity in an effort to concentrate their focus on delivery of key performance targets. The transport of vulnerable people is potentially a more diverse market, which we have already been developing through specialised services investment in 'retrieval and transport' of very sick babies, where active competition should drive up both quality and productivity. There is also work to be done to dis-invest in the legacy of the transport of 'not ill at all people' around the conurbation.

The PCT's historic acute care portfolio includes a range of local specialist and general trusts however 74% of acute care is provided through Heart of England Foundation Trust (HoEFT) University Hospital Birmingham FT is a key provider of tertiary care and much of our relationship there is through commissioning of specialised services. Sandwell and West Birmingham Trust has a limited role, but we are developing that relationship to offer a source of competition and leverage at the margins with HoEFT. HoEFT has a well-established portfolio of paediatric care, including level 3 neonatal provision, which could provide the basis for growth in routine surgery at the expense of BCHFT, releasing capacity for more specialised activity, which is currently under pressure.

Birmingham and Solihull Mental Health Foundation Trust will continue to be the major local provider of acute and specialist care for significant mental illness, with significant work to be done at the interface with primary care to develop a more resilient and strategic approach to acute but self limiting illness, and in continuing care of those with established but stable disease. South Birmingham Community Services Provider will concentrate its activity for learning disability into active treatment and acute response, with the continuing care element moving increasingly into the third sector.

The NHS is likely to continue to be the dominant provider of acute and urgent care into the future, given the key role which local hospitals play in community life. However, the business model of the Foundation trust does not readily support innovation and where there is reluctance to pilot and test new models of intervention which improve outcomes at reduced cost, the PCT will continue to develop alternative partnerships, and encourage new players into this market. Building on our learning from the development of Birmingham OwnHealth®, we have implemented an initial programme of activity with Health Care at Home, which will provide domiciliary chemotherapy and enhanced supported discharge following acute orthopaedic admission, a family liaison service for people in the End of Life phase of care and a proactive service to manage people with a chronic disease in the community 24/7. Over the next five years our strategy to improve chronic disease management and offer care closer to home assumes disinvestment in unplanned medical admissions in HoEFT and BSMHFT and this needs to be accompanied by a parallel programme of reduction in bed capacity within the hospital to realise the productivity gains which they could offer. Our emerging understanding of the capacity pressures in paediatric surgery at BCHFT, alongside the need to redesign the maternity service at HOEFT offer significant opportunities for the development of capacity serving an extended population through that Trust.

The largest growth area for hospitals is in expensive technologies in both diagnostics and pharmacy, and this requires significant review to achieve maximum efficiency and return on investment. As effective chronic disease management increasingly takes place in other settings, and routine surgery moves to day case activity, hospitals will have to re-think business models which have been driven by profits on routine care. The hospital bed is now obsolete technology where previously it was a major intervention, and this needs to reflect in the future scope and scale of hospital provision.

4.2.3 Rehabilitation

This market currently includes a legacy range of services with a focus on active rehabilitation after injury or acute episode (including stroke), alternatives to admission and support to health improvement and wellbeing. In the community, it includes podiatry, speech and language therapy, falls prevention, physiotherapy, community equipment, cardiac rehabilitation and wheelchairs. NHSBEN has developed an award-winning integrated model of rehabilitation with adult social care, now delivered in both purpose-built and domiciliary settings. Work is underway with Elderly Services at HoEFT to re-design historic day hospital activity to play a more active rehabilitation, assessment and stabilisation role. This has included the

transfer of wards on both the Heartlands and Good Hope sites to BEN CHS to support active convalescence and preparation for discharge. This new model is tackling historic high levels of delayed transfers of care, and resulting in 50% of patients able to go home without further support, where previously they were on a trajectory for long term institutional care, bringing considerable savings to BCC.

NHSBEN spends circa £16m on rehabilitation (excluding hospital care) on historically fragmented activity, the majority in NHS BEN Community Health Services. These services now need to be organised into coherent bundles or distinct services, and commissioned accordingly. Particular work is needed to consider the future NHS role in services where logistics is a key competence, including community equipment and wheelchair provision. Our model of intermediate care should stimulate thinking of how best to develop specialty areas of rehabilitation, including stroke and cardiac to make the most of community-based learning, and release acute capacity.

4.2.4 Chronic Disease Management

Over 25% of the population within NHSBEN have one or more long-term conditions. Given the productivity and outcome impacts of excellent chronic disease management, the PCT has prioritised market development and innovation in this area. The current configuration represents a range of legacy services inherited from predecessor organisations, supplemented by strategic developments with new partners and an incremental response from NHS BEN Community Health Services

NHS BEN commissions circa £5m of CDM services including OwnHealth®, Health Trainers, Expert Patient Programme and management of CHD, COPD, Stroke and Community Diabetes. This does not include the cost of Long Term Conditions in Acute services where we benchmark poorly, showing high level of activity for Ambulatory Care Sensitive Conditions (ACSCs). We have undertaken active market stimulation and development, particularly in relation to use of digital technologies, commissioning Birmingham OwnHealth® in partnership with Pfizer Health Solutions, identifying a commercial provider of assistive technology solutions and developing a social enterprise to deliver the Healthy Incentives Programme as well as supporting existing 3rd sector organisations to provide services in the NHSBEN area. A new partnership with Healthcare at Home will create further opportunities for domiciliary support and intervention.

This is an increasingly volatile market, where innovations in care delivery are beginning to have a significant impact upon historic patterns of demand and acute business models. Key trends include:

- Development of new models of care, which prioritise education, self care, remote support and group interventions.
- Active market management and stimulation with non NHS providers emerging as strong players.
- Investment in social enterprise models to build social capital in our more deprived communities.
- Partnerships with commercial sector to develop and deliver new models, e.g. MESH programme with Healthcare at Home.

This approach has driven significant re-design across the boundaries of existing providers, particularly within PCT provision and the interface with each of HoEFT and Adults and Communities in the City Council. We have also sought to stimulate market interest in providing different types of services that move away from the traditional face to face contact to a system of care (for example telephone based care/use of assistive technology) which increases the responsibility of the individual to understand more about their condition and feel confident to increase self management. Significant shifts in activity and resources are planned through Birmingham OwnHealth® and an increasing number of services in this area will be provided by public, private and third sector organisations in partnership with the PCT as commissioner. Joint commissioning in mental health and learning disability will diversify the market supporting those with chronic disability including an increasing role for the third sector. Increasingly the focus for commissioning of primary care will be on the sector's contribution in this area. This market is a growth area and we shall seek active diversification to maximise innovation for quality and productivity.

The development of individual patient budgets in both chronic disease and mental illness will also change the market structure and the provider landscape as the potential range of services that a patient can commission with an individual budget will start to move outside of traditional provision, or may shift significant health spend into care and support activity. This creates a challenge to ensure that new providers can not only deliver their service but continue to have a relationship with the traditional provision for necessary medical care. Joint commissioning with Birmingham City Council of learning disability is already having a significant impact on our understanding and ability to manage the local market, which is increasingly third sector dominated.

Thinking on chronic disease management in children is relatively under developed nationally and locally, however trends in complexity of disability and emerging drivers of disease, particularly obesity, will require a more resilient response from core services in primary care with community support. More effective joint commissioning with City Council colleagues should drive better outcomes at lower cost, particularly for children with significant physical and or learning disabilities, and / or mental health problems.

4.2.5 Continuing Care

NHS BEN commissions NHS Continuing Healthcare services on behalf of all 3 Birmingham Primary Care Trusts. The services are commissioned for people with ongoing significant health care needs and include nursing home placements, tailored care packages, respite and specialist inpatient services across a range of specialities including physical disability and long-term conditions, Acquired Brain Injury, mental illness and end of life care; for both adults and children.

Since the introduction of the National Framework for Continuing Health Care in October 2007, Birmingham has experienced an increase of new referrals of 81% (a net growth in demand of 56%). This is now a significant cost in the city of some £45.5m in 2009/10. Some 71% of this investment sits with independent nursing home providers, with 76% of this activity commissioned through spot purchase

arrangements. This arrangement creates complexity and management overheads and will be re-profiled as the result of a major tender exercise, currently in PQQ evaluation phase. This will draw on the learning of the specialised services team in reconfiguring the contracts with Independent providers of medium secure mental health services, which reduced price and enhanced quality. From 1 April 2010, we expect to have in place a combination of block contracts and a framework agreement, offering a menu of nursing home services, which can be matched to assessed dependency levels of the individual.

Individual care packages account for some 14% of spend, and are currently commissioned from NHS South Birmingham and Complete Holdings (an independent sector provider), who each account for about 10% of the total market. There has been a lack of systematic intelligence gathering or reporting in the past and it is currently difficult to form judgements about quality or value of care. NHSSB Community Health Services has been relatively slow to respond to changes in demand and new models of care, with Complete Holdings being more responsive to date. Further to completion of the continuing care tender, a similar process will be put in place to develop and shape the market in care packages. This area is also a priority for development in conjunction with Birmingham City Council as an area of joint commissioning.

4.2.6 Sexual Health

The current provision is NHS dominated and includes local enhanced services in primary care, a range of specialist voluntary sector agencies, significant provision through HoEFT Genito-urinary medicine and HOBtPCT community GUM clinic. NHS BEN has recently developed and consulted upon a Pan Birmingham Sexual Health strategy (Sex and the City). This sets out expectations of an increasingly community-based service, with a clear role for primary care. We explicitly tackle the historic (and counter-intuitive) separation of 'sperms' and 'germs' between family planning versus sexually transmitted disease oriented providers.

NHS BEN spends circa £6m on Sexual Health services, with limited historic information about outcome and impact of those services. There is rising incidence of sexually transmitted disease at a range of ages, and new treatments and immunisation programmes are emerging to support interventions. The development of an integrated, primary care based hub in Erdington is an early opportunity to model expectations of future provision, and will be a challenge to legacy providers. The hub will provide a base for holistic sexual health services, particularly attractive to a younger population in an area that has significant teenage conception. The teenage pregnancy strategy is now a more integrated part of the Trust Sexual Health Strategy and has informed activity by the Youth Service, Connexions, GPs and Birmingham Reproductive and Sexual Health (BRASH) to improve young people's sexual health. Proposed changes to PCT provision of service provide an opportunity to review the current configuration in the city, and potentially integrate the secondary care provision, whilst clearly differentiating an emerging model of integrated primary sexual health in community settings. This is a market likely to both grow and diversify over the next five years.

Teenage pregnancy is a complex issue, affected by young people's aspirations, education and self-esteem as well as their risk-taking behaviour and access to contraception. The Trusts strategy for teenage pregnancy has produced some success. Conception rates have fallen most significantly in wards that have received targeted interventions (e.g. Shard End and Kingstanding)

Across the Trust, eight of NHS Birmingham East & North wards appear in Birmingham's top 20 highest rate wards for teenage conceptions. At a ward level, variations in the under 18 conception rate largely reflect the pattern of deprivation, poor educational attainment and disengagement at school across the Trust with the majority of conceptions occurring in the most deprived wards with the exception of Washwood Heath and Bordesley Green. This could possibly be explained by the ethnic make up of the population in the area, with a high proportion of people from South Asian backgrounds.

- Birmingham has shown an overall downward trend, in conceptions with a percentage change of 9.5% since the 1998 baseline. In 2007 the rate was 52.8 per 1000 young women 15 to 17 which is a slight reduction on the 2006 rate of 53.2 per 1000.
- NHS Birmingham East & North has a lower teenage conception rate, which is 44.87 per 1000 in 2007/08.
- Significant investment is being made by the Trust, to enable three full time posts to be commissioned to work specifically on the prevention strategy for teenage pregnancies. A key focus of their work is
 1. The development of a school and community based holistic health service that offers advice, information, support and a full range of contraception services to young people in targeted schools.
 2. To support school to achieve good quality sustainable Sex and relationship education for young people
 3. To implement the youth development programmes in areas with high rates of teenage conceptions

Commissioning Connexions service to provide personal advisors to work specifically with young parents regarding positive engagement in education, training and employment in order to reduce second unplanned pregnancies and reduce social isolation of young parents.

The Trusts teenage pregnancy strategy, has become a more integrated part of the Trust Sexual Health Strategy and we are working closely with the Youth Service, Connexions, GPs and Birmingham Reproductive and Sexual Health (BRASH) to improve young peoples sexual health

4.2.7 End of Life

Historically, despite expressed preferences to die at home, the majority of people (over 80%) have ended up dying in hospital usually following an unplanned admission for acute exacerbation. There has therefore been huge expenditure on End of Life Care in acute settings, with largely poor patient experience. In addition, we invest over £8m in a diverse community market in supported care at the end of life, including primary care participation in the Gold Standard Framework, local hospices in the third sector for both adults and children and community and inpatient support for adults provided through NHS BEN CHS and for adults with learning disability through SBPCT. Some £4m of this investment is in District Nursing support to people in their own homes, and this is likely to be a growing area of demand and cost. However the majority of expenditure remains in unplanned admission to local hospitals.

The combination of high cost, and variable quality has driven a new specification for services as the basis for a major procurement, which will seek to identify a 'network manager' as the co-ordinator of the future pathway, likely to be a non- NHS provider. Significant additional investment in community infrastructure, including the Partnership with Healthcare @Home, provides an increasingly resilient alternative to hospital admission. This combined with better identification of those in the End of Life phase through the Gold Standard Framework, will make an active contribution to our ambitious health outcome of 70% realising their preference to die at home. This will be a growing market, but with anticipated significant shifts in investment from unplanned care in hospital to supportive care at home from a range of increasingly diverse providers.

CHAPTER 5: FINANCIAL SITUATION

5.1 Historic and Current Performance

Since the formation of NHS BEN in October 2006, the emphasis on resources has been on returning to robust financial health and in an environment of limited resources, ensuring we achieve maximum return on investment. In our first year we faced significant challenges as a result of changes to the national financial framework, and the strategy of NHS West Midlands, which resulted in the PCT being given a £25.8m savings target in order to contribute to delivery of a balanced budget for the region for the year.

Whilst we identified some £8m through application of national policy (e.g. changes to tariff), we delivered the other £17m through a real reduction of £5m in commissioned activity and £12m from our mainstream cost base. Throughout this period, we continued to make investments where these were needed to deliver our strategic goals. This commitment to ensure we pursued investments which would deliver medium term gain beyond the year end period meant that we did record a small deficit for the year 2006/7. This did affect our performance ratings with the Trust receiving an overall ALE score of two, however it gave us invaluable experience in commissioning in a challenging environment. This persistence in investing for change, despite tough times meant that we were able to sustain development and innovation during this period, delivering significant cost control through demand management and further improvements in service quality and responsiveness (increasing our HCC rating to 'excellent' for services the following year). Ultimately, this policy has delivered robust financial health, and a position where we continue to invest the majority of the resources available to us in improving the health of our population.

During the last two years we have built on the strong base created in 2006/7 and have returned to financial balance recording a surplus of £3.2m in 2007/8 and £1.9m last year. This improved financial performance has been built on strong financial governance with the Trust consistently scoring highly in external assessments. We received an overall ALE score of three in 2007/8, achieving a rating of four for value for money (one of only three PCTs in the country to achieve this rating) and three for each of financial standing, internal control, financial reporting and financial management. In 2008/9 under the Use of Resources assessment the PCT scored a 3 each for managing finances and governing the business.

In 2009/10, we are investing £697m to achieve a small surplus of £2.47m. This provides the PCT with a small buffer against its statutory breakeven duty and at only 0.3% of our allocation ensures that we continue to invest the substantial majority of our resources on healthcare, the purpose for which it was voted by Parliament.

5.2 Current Situation

In order to ensure we realised a return on our investment in our Strategic Initiatives, the PCT bought £8.5 million below outturn in HEFT for 2009/10. This has ensured we are very focused on continuing demand management, and although there is a forecast over-performance of circa 6% of the contract, we can demonstrate that

where we have invested in additional capacity in Community Health Services these have reduced activity in the Acute sector. It is now clear going forward, that if we are to release savings across the health economy we need to ensure that there is a corresponding reduction in Acute capacity. The move to HRG4 has made it difficult to benchmark accurately against previous years, but it appears that we are effectively holding emergency admissions at between 1-2% above last year's level and A&E attendances have reduced by 1% against a national growth of 4.4%.

In line with our financial strategy we are managing the forecast over performance at HoEFT and other pressures across our portfolio and are expecting to manage within our financial resources for the year. This is being achieved without the need to slow down investment in our strategic initiatives but has required us to implement a number of costs control measures as we did to great effect in 2006/7.

In 2009 /10 we continue to experience some pressure on our Acute contracts particularly in emergency admissions and outpatient activity. We have seen a small rise in Emergency admissions of around 1.7% on 2008/09 but, as we had contracted for a 9% reduction on 2008/9 outturn, this is resulting in a forecast over-performance of around 10%. We shall continue to track activity closely through Commissioning Business Support Agency and our tripartite contract performance group with Solihull Care Trust and initiate formal modelling and (as necessary) re-design work through our 'Working Together for Health' programme to ensure that we have a level of capacity that is affordable across the health economy.

5.3 Economic Outlook

Over the last ten years, the NHS has received record levels of growth with the total investment rising from £36b in 1997/98 to £110b by the end of this comprehensive spending review (CSR) in 2010/11.

Given the disruption in the global economy, and the burden of accumulated Government debt, even if the UK economy does begin to show limited growth again in 2010 it is now inevitable that we will see a significant reduction in public spending over the medium term. At almost 30% of public expenditure, it will not be affordable for any government to sustain continuing growth in NHS expenditure; increases are likely to be limited to zero over the next CSR. If the level of resources required continues to rise at the current rate to meet increases in demand and above inflation increases in NHS costs then the shortfall in funding in the NHS will be up to £15 billion over the next 5 years. In this context we have to focus on the totality of our allocation ensuring that we obtain value for money across our portfolio and using service redesign to release resources for investment in other areas. We continue to develop annual efficiency plans to maximise available resources, with up to £8m full year effect identified within 2009/10, and a potential additional £1.7m per annum arising from targeted interventions in Ambulatory Care Sensitive Conditions (ACSC).

5.4 Revenue/Capital Outlook

The Department of Health has notified Commissioners of an increase of 5.5% to allocations for the last year of the existing CSR although we are planning on

committing up to 2% of this non-recurrently to provide us with some head room going into a more limited allocation in future. The position beyond that is uncertain and in line with most commentators we are planning on a “flat cash” scenario over the next CSR.

Inflation is expected to be at 0.5% across all areas in 2010/11 reducing to minus 2% in future years with the exception of primary care contractors where our assumptions range from a net cash uplift 0.3% to a reduction of 1%, and our drugs bill which is expected to increase by 4% per annum. This is driven by improved identification and active management of disease in primary care as well as market rises. This inflation figure is net of a 3.5% efficiency requirement in 2010/11 rising to 4.5% over the next CSR that we will apply to our entire portfolio. In addition to this we are assuming that an additional 1.5% is invested in quality improvement through CQUINs

Our financial plans will ensure that the Trust can invest smoothly over the next five years. NHS BEN will deliver a surplus in each year of the next five years with these surpluses being available for reinvestment in future years. We need to ensure that by 2011/12 any new initiatives are realising all financial benefits to be self financing. In the absence of the opportunity to spread spend across financial years, the Trust has established non recurrent provisions of £3m in 2010/11 and 2011/12 to support initiatives that are cost neutral on a recurrent basis, thus enabling us to invest strategically.

Given the significant burden of ill-health and premature mortality in NHS BEN, our focus will continue to be on maximising the benefits to local people of our investment. We shall maintain an active overview of the broader economic environment; where this continues to worsen we shall undertake an early review of planned surpluses for the next couple of years to build in greater resilience.

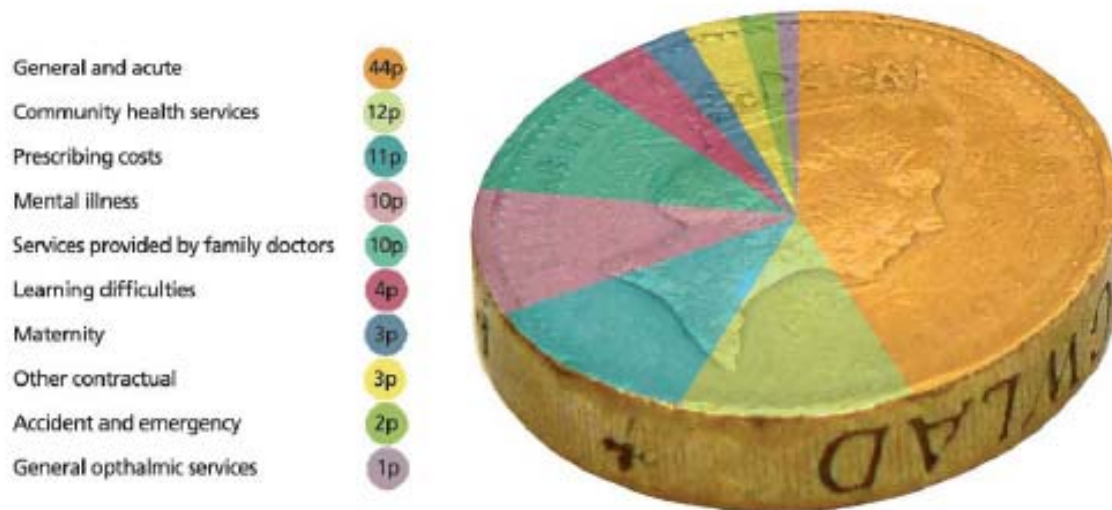
5.5 Commissioning Activity

The PCT invests some £700m of taxpayers’ money annually. Much of this spend is determined by history and in the highly political context of the NHS can be difficult to divert or shift. We have sought to invest an increasing proportion in upstream preventive and capacity-building activity and to ensure best value by commissioning interventions which enable the patient to see the right person in the right place at the right time. We are reinforcing a new narrative with the public and local patients which emphasises the importance of prevention of disease, early intervention and the key role which patients and families play as primary care givers. This is underpinned with increasing investment into prevention, marketing and education as the foundation for effective and affordable health services in the future.

The PCT has set out its commissioning intentions in a plan, which seeks to invest to achieve maximum progress on our core purpose and ambitious goals. Given the historic bulk of investment goes into a few NHS providers, with a focus on acute care, it primarily reflects our local health economy strategy, and focuses on service re-design for quality and productivity across our strategic initiatives. Chapter 5 summarises this activity.

The pie chart below (fig. 6) shows the PCT's current investment by provision type. This investment is made with a range of providers including foundation trusts, NHS BEN CHS and other PCTs, independent contractors in primary care, NHS trusts and a range of independent and voluntary sector organisations. **Appendix 1** provides a more detailed list of providers.

Figure 6 Investment by Type of Provision



DRY

CHAPTER 6: CORE PROCESS MANAGEMENT

6.1 Core Process Management

The PCT has a key principle of paying attention both to our cultural preference for innovation and to the necessity of getting the basics right. Over the last 2 years we have made particularly progress on the latter, with this section setting out some of the core processes which support excellence in commissioning and delivery.

6.2 Needs Assessment Process

The city wide JSNA sets out our assessment of health needs with the City Council and partner PCTs and our priorities for action across the city. It draws largely upon epidemiological and service analysis and the population profiling of health status. In addition, we have supported greater understanding of our population needs and local priorities through the PRIME programme, which makes a particular contribution to need assessment through:

- Baseline benchmarking and analysis against ONS group and other core cities
- Health typology analysis
- Collection and collation of PPI feedback and insights
- Outputs of focus group and associated social marketing activity
- Integration and presentation of key information within GP MyPractice.

6.3 Core Metrics

Evidence of impact has historically been limited in health services, with great effort and expenditure nationally going into making a clinical case for change, but very little research going into demonstrating impact after adoption. We have developed an increasingly rigorous set of key performance indicators, the OSCAR framework³, which seeks to build a set of metrics which will increasingly offer assurance of value for money investment. This framework has been adopted into our contracts with NHSBENCHS and in new initiatives and with new providers of care, including Birmingham OwnHealth activity and MESH. NHS providers remain relatively complacent about providing evidence of positive impact of their interventions and this is an area for continuing development, through increasingly rigorous CQUINs, and the adoption of PROMs and PET.

6.4 Improvement and Innovation

We have invested in leadership and capacity to ensure an assertive approach to knowledge and process management through our Director of Process Improvement, and have a growing cohort of staff from Directors to front-line practitioners who are applying LEAN methodology in their daily practice.

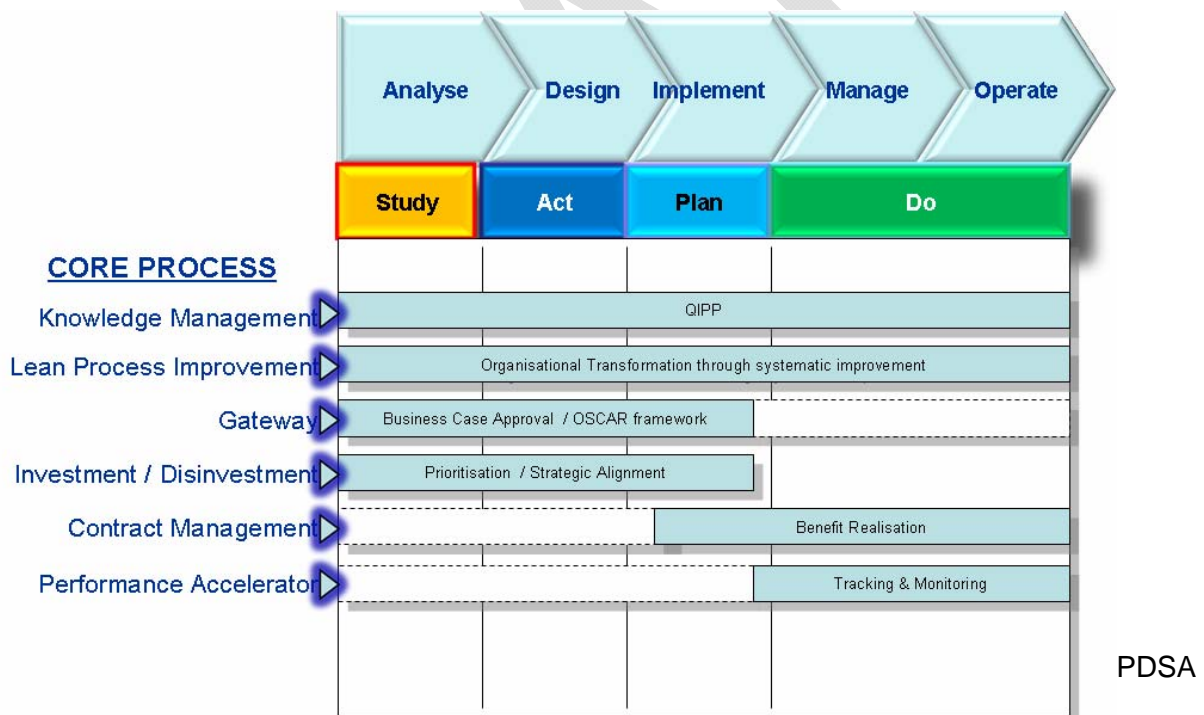
The past 12 months has seen the Trust roll-out a comprehensive process improvement methodology based on the LEAN model. Fundamental to our approach

³ Organisational, Satisfaction, Clinical Activity, Resource

is the scientific improvement construct known as PDSA (Plan Do Study Act) which supports the Trust's future development as a learning organisation. The PDSA improvement cycle ensures that the Trust innovates within a systematic and structured framework and that insights and knowledge are quickly applied to its core business processes. Over 400 members of staff have been trained in the methodology to ensure that improvement culture is permanent and deeply embedded in the way the PCT operates. Further to this a specialist Trends and Learning Lessons (TALL) Group has been set-up to apply PDSA techniques to review the variation in process performance data, and to work with staff on the ground to "ask questions" and investigate trends.

Figure 7 below illustrates the practical implications of operating a learning organisation based on the PDSA principle. All projects are managed through the stages via the Gateway process (see 6.5) in order to maintain a tight focus on their performance. The key benefit of this approach is that all stakeholders are able to have a clear understanding of the status and progress of the key programmes and initiatives that are taking forward the Trust's strategy from early analysis through implementation and operation. The table below brings together PDSA, the project deployment stages and the Trust's core innovation tools into a single framework.

Figure 7 – PDSA Deployed Across Core Processes



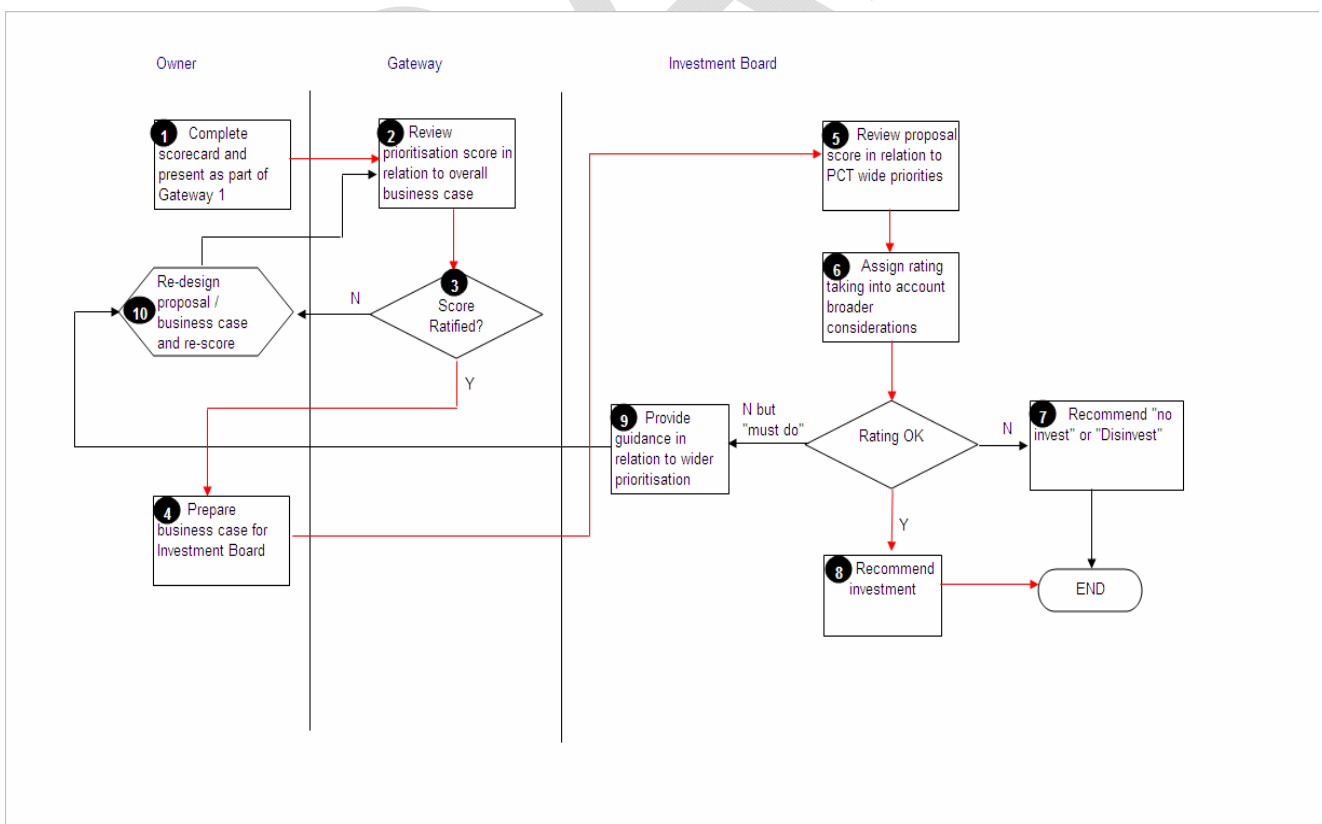
6.5 Programme Management

NHS BEN has invested in Performance Accelerator to support active management of initiatives to achieve key targets and activities within each of the 7 strategic initiatives. Each Initiative has a lead Director who monitors and challenges progress as reported and tracked by the named activity manager. The programme is open to interrogation by any Board member and forms the basis of monthly tracking reports to Board.

6.6 Investment and Disinvestment

Our four goals provide an over-arching framework for prioritisation and investment. As we have always operated in an environment where there has been more to do, than money available, we have prioritised an approach which will bring gains both in quality and productivity. We have developed a 4-phase Gateway process to govern investment and innovation, which ensures that proposals for re-design or development have an evidence base, or can develop one, and that interventions are designed to scale, to support wholesale roll out and substitution where they demonstrate success. In 2009/10 we have added a further dimension to the prioritisation process prior to Gateway challenge, which tests whether proposals fit with a fixed set of criteria and have clearly identified how the investment will be delivered i.e. as self-financing or through dis-investment in historic spend.

Figure 8 Gateway Process



In addition to all proposals, including those from PBC, being subjected to the gateway process, we have established a standing investment/disinvestment group, chaired by Director of Resources. This group receives proposals for changes in investment, and seeks to ensure we focus on effective use of our core allocation.

However, all innovation involves risk and failure and not all good ideas can translate into efficient and effective alternatives for 443,500 people. As we take the Gateway process very seriously, within each strategic initiative, there are activities which fail at pilot or roll out phases, which may therefore be live one year, but de-commissioned or finished the following where they do not add sufficient value. We also react quickly to new opportunities and challenges and significant interventions may be developed in year, in response to a change in local systems or financial challenge.

Case Study: winter 2008 piloting of step down beds at 2 weeks notice in response to capacity pressures arising from a simultaneous combination of snow, flu and norovirus has led to commissioning of a full scale service based on transfer of management responsibility for two hospital wards and staff into CHS within the last ten months with significant impact on DTOCs.

6.7 Contract Management

NHS BEN is assertive in discharging our statutory responsibilities for securing quality and value for money for all services we commission, paying attention to safety, patient experience and accessibility. Our Contract Management approach reflects the paramount role of commissioners in managing and improving performance and the primacy of the contract between commissioners and providers –

“The contract that a PCT holds with a provider is the key line of accountability for service performance”.⁴

Our approach sets out the process by which the Board of NHS Birmingham East and North can be assured that all the services it commissions are:

- Safe and of appropriate quality
- Meeting operational standards and targets including activity management and resource utilisation
- Fulfilling all contractual requirements
- Responding to patient and public experience
- Continuously Improving

It is underpinned by a set of core metrics including:

- A balanced scorecard of key performance and improvement indicators for performance, quality and safety (OSCAR)
- Measures of quality and safety such as incidents, complaints, claims, significant and never events.
- Morbidity and mortality measures
- Staff and user experience
- Benchmarking and periodic review

⁴ Developing the NHS Performance Regime – DH June 2008 p.22

- Reporting on any relevant Independent reviews (by CQC, Monitor, Dr Foster Intelligence, etc)

The process is underpinned by a triad of groups described below, in place for each key contract with HoEFT, BSMHFT and NHS BEN CHS. We have made clear arrangements for:

- How and where issues will be reported and escalated
- Ensuring the impact of any national / local changes influencing overall performance can be assessed and resolved
- Assure other non-lead commissioners that we are appropriately addressing performance, quality and safety issues
- Ensure it meets external expectations of scrutiny and assurance

The three groups are described below and in fig 9 below

6.6.1 Clinical Quality Review Group (CQRG)

The Terms of Reference ensure:

- Appropriate KPIs , metrics, reporting and escalation
- The meetings are focused on high risk areas for safety
- Where monitoring identifies an area of concern and triggers a more substantial piece of work the CQRG is the governing body and all reports should be reviewed by CQRG before going elsewhere
- Each meeting concludes with a sign off flash report highlighting key metrics, action in progress and a documented judgement of status identifying ‘Serious Concern’, ‘Some Concern’, ‘Specific Concerns (listed)’ or ‘No concerns’.
- The flash report and schedule of monitored measurements, including CQUINS, are sent to other commissioners, the relevant Tripartite contract management group and the NHS BEN Quality and Safety Committee with onward reporting to NHS BEN Integrated Governance and Performance Committee (sub-committee of the PCT Board).

The Clinical Quality Review Groups escalate issues and report to the relevant Tripartite group for each contract. Core monitoring information available to the group includes:

- Quality and safety core and developmental measures
- CQUIN measures
- Information on patient experience, complaints, medication errors, SUIs, NHS ratings,
- Relevant reports from regulators or other independent bodies
- Benchmarking information as available,
- Essence of care findings,
- Feedback from programmed and unannounced visits,
- Outcomes reports from dedicated sub groups
- Minutes of the PMG will be circulated to the CQRG for information every month.

The review of the above will then inform the assessment of risk and judgement of overall current status reporting captured in highlight reports to Integrated Governance as sub-committee of the Board.

6.6.2 Performance Monitoring Group (PMG)

The PMG for each contract exists to ensure that all KPIs on the balanced scorecard are reviewed and to log any unresolved issues of concern for escalation to Tripartite. Meetings are held monthly, include a range of operational officers from across the local health economy and the Chair of PMG provides a written summary of key issues for the Tripartite Group. There is cross membership between each PMG and each Clinical Quality Review Group for each provider / contract. Membership includes associate and other commissioners.

Core metrics include:

- Finance and activity information
- Contract KPIs and key targets.
- Minutes of the CQRG

6.6.3 Tripartite Groups

The Group comprises Director level members from NHS BEN and the relevant provider. Membership includes the Chair of the dedicated Clinical Quality Review Group and the Chair of the dedicated PMG in order to ensure an integrated view of issues for resolution and risk severity. The Chair of Tripartite is held by NHS BEN.

6.6.4 Trust Clinical Quality and Safety (CQSG)

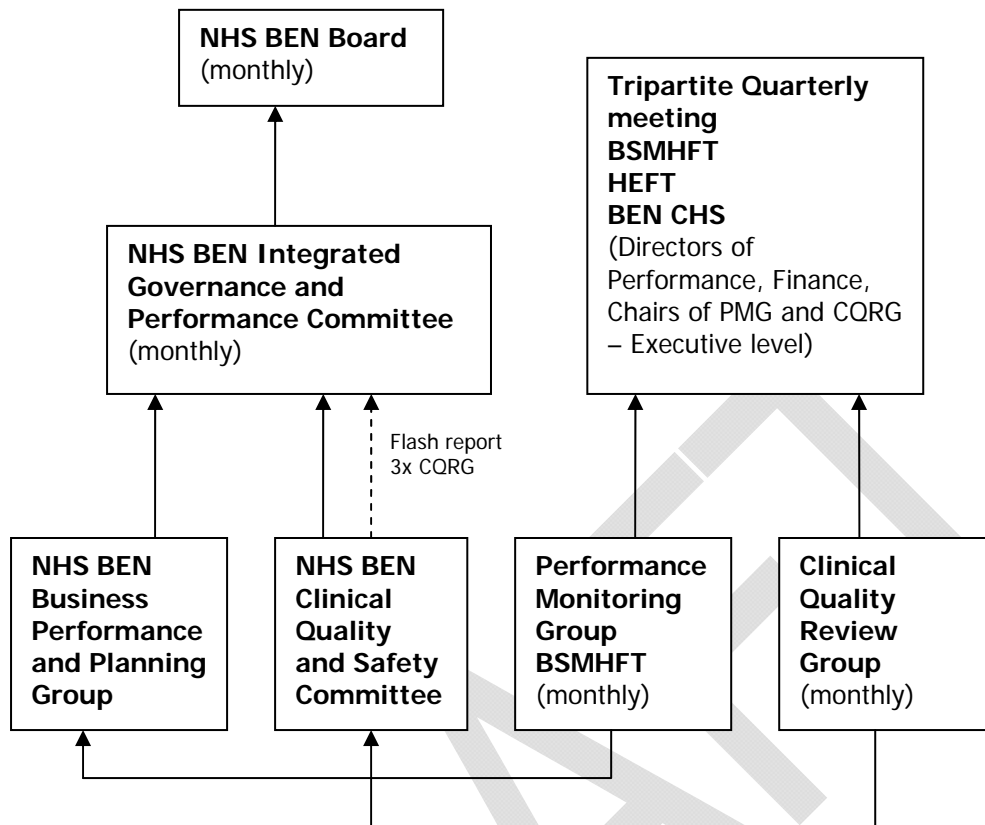
Given the range of activity within the core £700m spend per annum, other commissioned services provide assurance on a regular programmed basis to the NHS BEN Quality and Safety Committee. The following providers are currently included in this group:

- NHS BEN Community Health Services
- Primary care contractor services – including general medical and dental practitioners, optometrists and pharmacists
- Care Homes with Nursing
- Community Health Services from other NHS providers e.g. sexual health (HoB) and children's services (SBPCT)
- Complex care
- Out of hours services (BADGER)

Any other independent or third sector contractors.

The major change programmes of Birmingham OwnHealth and Healthcare at Home, each have a dedicated programme board which tracks specific quality, safety and performance issues, applying the same framework of metrics described above. Where a significant issue is identified, this is reported through to the Integrated Governance sub-committee of the Board.

Figure 9 – Performance and Quality Management Structure



CHAPTER 7 STRATEGIC INITIATIVES

NHS BEN has seven core programmes of activity:

- **Programme for Relationships, Intelligence and Equality (PRIME)**
- **Promoting Health and Self care**
- **Maternity and Children's Services**
- **Excellence in Chronic Disease Management**
- **Care Closer to Home**
- **Vulnerable Adults**
- **Collaborative Commissioning**

7.1 PRIME

PRIME seeks to develop new relationships with public, patients and partners (particularly GP contractors and our own workforce as key communicators of NHS values and experience to the wider public). Following OJEU procurement, we entered a three year partnership with Doctor Foster Intelligence in July 2008. PRIME seeks to tackle health inequalities through the creative use of healthcare intelligence generated by a range of innovative approaches. Most importantly for us at NHSBEN, the programme will build on our established commitment to patient and public involvement (PPI) and together with Dr Foster's strong record in public health innovation, will provide an exciting platform for us to consistently and comprehensively reach out and engage with our diverse communities. PRIME will support our ambition to tackle health inequalities through World Class Commissioning with a focus on delivering our goals of 'ten more years of healthy life' and 'most informed and empowered community'.

The programme includes a number of work streams, which are developing and shifting over time as we gain insight into the scale and scope of the work, and as new opportunities arise:

- Developing a rich picture of local diversity of NHSBEN, with a focus on understanding the needs, aspirations and preferences of the most disadvantaged and those most at risk of premature death.
- Developing much more personalised routes of communication with key sectors of our public, patients and clinical workforce and maintaining this over time.
- Investing in a targeted programme of social marketing to address priority health issues and tackle inequalities and service use and health outcome.
- Agree a core set of key performance indicators which will track progress on tackling health inequalities over time.
- Maximise opportunities to use digital technologies to communicate regularly and effectively on issues of relevance to local people.
- Transfer specialist knowledge and skills building capacity between both organisations.

- We plan to invest £1m in 2008/9 rising to £3m pa from 2011, with the potential for additional expenditure on associated marketing campaigns.

Social marketing

Social Marketing is a significant element of PRIME. We have increasingly understood the importance of undertaking market research before launching new services. Our focus group work with men over 55 in target groups for premature Life Expectancy made us realise that we had to provide alternatives to going to the GP as first contact for this group.

As an entirely innovative intervention, members in Birmingham Own Health® participate in regular satisfaction and feedback activity to ensure that this programme develops effectively and acceptably. In this context we have also learnt that it is important not to be bound by people's views on services which break new ground. People in focus groups told us that they would not want to receive services over the phone, but over 80 percent of those approached for BOH have chosen to participate and satisfaction levels run at 96 percent.

To support further systematic engagement in accordance with our strategic goal of involved, informed, empowered communities, we have now designed a 3 year programme of social marketing focused on the key health inequality areas of PRIME. The first full programme based on typologies has sought to reach established male smokers 30-55 in red typology 'Troubled dependence' who are our most committed and sustained smokers, disproportionately at risk of CVD and COPD, and driving both premature mortality and high service utilisation across the PCT. We collaborated with celebrity photographer Rankin in a hard hitting viral video, supported by very specific on street marketing and posters. Future campaigns will include 'reduce to quit' activity, and for infant mortality, low key interventions on pregnancy test packaging to stimulate early contact with services.

7.2 Promoting Health and Self Care

Given the heavy burden of disease in our community, and premature mortality, we are committed to developing an approach which will support people in making healthier choices, and being increasingly able to act as their own primary care giver. As a community our population will be fully engaged in making decisions about their health and wellbeing, the onset of disease will be delayed but when it does occur they will be the best informed about their disease and how effectively to manage the consequences by modifying lifestyle choices and managing personal risk on a day to day basis. This requires us to actively engage local people in being interested and concerned in their own health and in understanding how best to keep well and to minimise the impact of any disease as it develops.

The National Support Team for Tackling Inequalities identifies four system level areas for intervention in population health improvement, and we have tried to intervene in all four areas across our programme of initiatives.

- Physiological risk (e.g. high blood pressure, HBAC1 control, stress hormones), typically the domain of the NHS with primary care having a strong

contribution to make, and most effective as a form of secondary prevention (tackled here through 'excellence in CDM' theme)

- Behavioural risks (e.g. smoking, poor diet, lack of activity and substance misuse), increasingly seen as the legitimate domain of the NHS as we focus on primary prevention of disease and engagement at an earlier stage before disease takes hold; PRIME makes a significant contribution in this area through social marketing.
- Psycho-social risk (isolation, low self esteem, lack of perceived control, lack of sense of purpose in life); this is more contentious territory for the NHS, but key to interventions which support sensible decision-making in relation to behavioural risk and to developing mental resilience, colleagues in social care and education are key partners in this work
- Risk conditions (e.g. poverty, poor housing, dangerous environments, discrimination, low skills); this is primarily the domain of other public agencies and a key area of partnership activity through Be Birmingham Executive and its constituent partnerships including the Health and Work programme with Birmingham Economic Development partnership and Total Place Total Community pilot.

In this context, and informed by our learning to date, our approach to improving life expectancy and well-being throughout life will be to:

- Profile the population to identify high risk groups for marketing and earlier service intervention
- Identify at risk individuals not in contact with services and reach out to them
- Target and increase uptake of services by those who traditionally do not access services until too late, (e.g. through increasing up take of cancer and cardio-vascular screening, and by delivering services outside of traditional settings and times)
- Promote self care and signpost at risk individuals into support for lifestyle change through Birmingham OwnHealth® (assertive telephone outreach and coaching), Healthy Incentives and other lifestyle services
- Work in partnership with economic development partners to support people to remain in work and to return to work from incapacity benefit and with employers to develop healthier workplaces, including modelling best practice through our own staff BENEfit programme with Humana
- Increase our understanding of the preferences of different segments of our population through Health Typologies and other aspects of PRIME and design services and communications which will prove attractive to each target group
- Develop our knowledge of what works where and with whom and systematically applying that learning in future practice
- Develop new styles of service and interventions, from pilot through prototype to industrial scale delivery
- Educate and empower people to take control of their health and well being
- Build activity to support mental well-being into all programmes.

Our work to improve population health will benefit over time from our collaboration with the other 7 Core City PCTs through the Health Improvement Collaborative which seeks to maximise and fast track learning and innovation as it emerges,

targeted to improving outcomes in relation to mental well-being, teenage conception, alcohol misuse, smoking cessation and life expectancy. The particular priorities for NHSBEN, where our PRIME baseline assessment identified us as an outlier benchmarked against other core cities and our ONS group are: infant mortality, obesity and alcohol (particularly in women), smoking and mental wellbeing. Interventions particularly focused during maternity and in infants and children are:

- The development of a school and community based holistic health service that offers advice, information, support and a full range of contraception services to young people in targeted schools.
- To support school to achieve good quality sustainable Sex and relationship education for young people
- To implement the youth development programmes in areas with high rates of teenage conceptions
- Commissioning Connexions service to provide personal advisors to work specifically with young parents regarding positive engagement in education, training and employment in order to reduce second unplanned pregnancies and reduce social isolation of young parents.

We face a significant challenge in building mental resilience at population level and with individuals. To support this we are exploring the model developed through New Economics Foundation of '**5 ways to wellbeing**':

- **Connect.. Connect with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.**
- **Be Active...Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and one that suits your level of mobility and fitness.**
- **Take notice...Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.**
- **Keep learning....Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more content as well as being fun.**
- **Give...Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well**

as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

7.3 Maternity and Children Services

In the context of our rising birth rate, and continuing high levels of infant mortality and disability, we shall increase the capacity of community midwifery services and work with HOEFT to re-design the maternity service to meet the standards in 'Maternity Matters' and Safer Childbirth across the 3 hospital sites. Market stimulation will create culturally appropriate, integrated social and medical support services in the community and increased diagnostic capacity in local settings. This pathway will be the local iteration of our BHWP approach to tackling **infant mortality**, with an emphasis on maximising the benefits arising from:

- An assertive approach to social risk management, including 'overcrowding' assessment, 'vulnerable families, in addition to clinical risk assessment
- Clinical risk assessment to actively manage obesity in pregnancy
- Minimising **smoking** in pregnancy
- Maximising proportion of mothers who initiate and sustain **breastfeeding**, working to UNICEF 'baby friendly' guidelines
- Promoting early booking into ante-natal care
- Reviewing pathway to support early counselling and intervention for those at risk of inherited disorders
- Understanding impact of infections in first year of life and support to parents re response and information

Through our Typology profiling and shared intelligence with CHS and BCC, we shall seek to identify the most vulnerable families at an early stage and develop integrated 'wrap around' services, which create greater resilience and enable the children to thrive. A particular challenge is continuing to reduce the number of families in which young people themselves become mothers at an early age, with significant risk of subsequent poor health outcomes for both mother and child through their lives. We shall reduce **teenage conceptions** from current 51.7 per 1000 to the average rate for England of 42.1 per 1000. Previous work in BEN in collaboration with other agencies has demonstrated significant impact in target wards, this will be maintained seeking a 10% reduction in prevalence in each year, and be rolled out across the PCT with a focus on accessible education and contraception and the expansion of our 'Here 4 U' young person friendly sexual health services to achieve 5% overall reduction in BEN. We shall target activity to girls on second pregnancies, those 'Not in Education, Employment or Training' and looked after children.

We are committed to the development of new pathway approach with an emphasis on prevention and early intervention to support the growing number of children with disabilities, including management of children with long term conditions in the community, with dedicated specialist support for complex needs. Children with disabilities and chronic disease are currently managed through many different services operating out of each of NHSSB, HOEFT and BCHFT, with generalist care coming from BENCHS, and the Children's directorate of BCC. This is a complex

arrangement, which is high risk in relation to families falling between different elements of service, or of safeguarding issues being missed. We shall increasingly differentiate specific pathways for children as we have for adults, and commission networks of support in relation to specific need, considering:

- Prevention and screening
- Urgent, acute care and rehabilitation
- Chronic disease and disability
- Mental illness
- Sexual Health
- End of Life

Within each area, we shall consider the specific needs and response to children at risk of abuse or neglect, or who are in the care of the Local Authority.

Given the profile of mental distress amongst local children, we need to reinforce the range of support available to children and adolescents with mental health problems; including prevention and early intervention through local services (primarily tiers 1-2 of child and adolescent mental health services (CAMHS)), and expand capacity and capability for CAMHS at tiers 3- 4 or the more specialised services. This work includes the active review and development of alternative pathways and providers of independent sector 'out of area' placements, which has been undertaken collectively by PCTs across the West Midlands.

For the above we shall seek to work increasingly closely with CYP directorate of BCC, and prioritise integration of service across NHS organisations.

Through WMSCT as Collaborative Commissioner, we shall develop a regional strategy for paediatric surgery, which will establish local and resilient services for routine activity, and release and grow capacity in specialist centres for more complex work. We shall seek to build on the relationships developed with BCHFT over the last year to re-align local co-ordinating commissioning arrangements, with our host role for WMSCT, to reinforce strategic planning for capacity and demand across the system. We seek to support BCHFT in continuing to develop as a major provider of and quality services.

7.4 Excellence in Chronic Disease Management

The Excellence in Chronic Disease Management (CDM) Programme seeks to ensure the highest possible quality of care for the maximum number of adults with LTCs whilst making the best use of available resources.

Given the prevalence of chronic disease and long term conditions in our population we have set out to develop a coherent set of programmes, which will build on the progress we have made so far in relation to

- The UK's first large scale care management service for CDM (Birmingham OwnHealth®) and the CARE (Cancer and Recovery Enhancement) service
- The development of Case Management and step down to community nursing and Birmingham Own health

- Initial rollout of Assistive Technology to support high intensity users (HIUs) on case management
- The successful application for Pilot Status for Personal Health Budgets
- Capacity building in primary care with the establishment of a Community Diabetes Team and the up-skilling of primary care in diabetes management supported with a Local Enhanced Service
- Championing self-care approaches, development of disease specific and generic self-care services and testing additional models within the pain management service
- Developing a cadre of LTC clinical leads and local pathway networks for cancer, respiratory conditions-COPD, cardiovascular diseases and neurological conditions.

In commissioning for excellence in chronic disease management we intend to take a systems approach that incorporates

- Population Management Principles
- Personalisation at its best
- Maximises the opportunities for self-management
- Programme budgeting to decide how we use our capacity across the programmes and sub-programmes
- A seamless set of processes through the programmes and their projects

Using our gateway and performance accelerator processes we shall ensure we are able to test and learn from innovation before ensuring 'spread' across the PCT and incorporation into mainstream clinical practice.

7.4.1 High Intensity Users. This activity centres on ensuring a match between case-mix and skill-mix and ensuring the use of technology for LTC care. It supports the redesign of the Assertive Case Management Service and Specialist LTC Nursing alongside the development of Risk Stratification. The Remote Care sub-programme further develops the use of assistive technology (tele-healthcare) alongside Birmingham OwnHealth®.

7.4.2 Self Management: The Self-Management Programme (as distinct from a 'wider' Self-Care Programme) will build on the experience gained as a result of delivering one of the national Personal Health Budget Pilots to embed personalisation within the delivery of long term condition care. This will include exploring the mainstreaming of Care Planning, the use of Health Psychology and the commissioning of condition specific and generic patient self-management courses. Once established these initiatives and approaches can be incorporated into the integrated pathways.

7.4.3 Integrated Pathway Design and Procurement: Integrated pathways describes an approach that allows us to commission (on a co-mission basis) care from coherent sets of service networks. The pathway seeks to support a coherent patient journey from prevention via diagnosis and assessment to treatment and rehabilitation and continuing care. The pathway will also include end of life care as appropriate. A clear governance structure will bind the providers of services along the pathway driven by a set of key performance indicators (KPIs) that help us

collectively to understand the major spend in each pathway, the return on investment for the pathway and each component, and the inequalities between and within each pathway. Such an approach will facilitate quality, safety, innovation, productivity and partnership whilst contributing to our strategic outcomes.

The programme for integrated pathways has already begun and therefore each pathway is at a different stage of maturity exhibiting the features described above to varying extents. The type of governance structure will vary according the type of pathway involved.

7.4.4 Maximum Effectiveness of Primary Care: The fourth programme is designed to ensure we are able to maximise the contribution of primary care to LTC management so that patients are managed at the most cost-effective point of each pathway. This will link relationships and contracting processes to other the other CDM programmes. It will prioritise identification of high risk individuals and assertively invite them into care. Through GP MyPractice we shall target practices with high exclusion rates for QoF, or who under diagnose against expected epidemiology, to find those most at risk of premature mortality and bring them into structured care. We shall monitor variation in prescribing and symptom control, offer preferred investment with long term relationships to those practices most successful in delivering evidence based care.

7.5 Care Closer to Home

Care Closer to home is a well-established strategy within the PCT; with a focus on changing the pattern of care to improve quality at reduced cost. It is based on a commitment to ensure that the home can increasingly become the hub of healthcare; this requires significant disinvestment in institutional forms of delivery. The principles which underline Care Closer to Home are:-

- Solutions which are sustainable
- Solutions which allow for disinvestment
- Solutions which ensure empowerment and self management
- Solutions which deliver 24/7 care (where possible)
- Solutions which demonstrate quality and safety

A basic requirement to support care closer to home is resilient, capable, and responsive primary care. NHSBEN has worked with contractors, particularly in general practice, over the last 7 years to address long-standing capacity issues and build confidence and capability to manage increasingly complex conditions in primary and community services. We have introduced 4 new multi-partner practices (3 between 2008 and 2010, through the equitable access scheme) and supported the integration of 10 practices into 3 through LIFT developments, with another 6 practises coming together to form Midlands Medical Practice as a single partnership covering 70,000.

Our commitment to patients being seen and treated at the most appropriate, least specialised level of the system will continue to drive change across a range of services and providers. Much of the activity in this theme draws on the long-standing collaboration between the PCT and HOEFT known as 'Working Together for Health'.

As members of the Kaiser Permanente beacon programme since 2003, we have championed service re-design across organisational boundaries. Over the years, activity has expanded to include colleagues from mental health and social care, and we have sought to develop a whole health economy approach, which includes Solihull Care Trust. The key principles have been captured in a whole health economy strategy as:

- Integration of activity along patient pathways
- Keeping patients out of hospital on the basis that 'an unplanned admission is a system failure'
- Active management with patients to prevent illness and improve quality of life
- Promotion of self care and shared care
- Clinical leadership for change, in partnership with management
- Maximising the use of information and communications technology to underpin change management and patient care.

This programme contains a significant range of activity including:

- Increasing Capacity in primary care to support excellence in CDU.
- Closure of urgent care, including nurse led centres
- Significant redesign of interface with acute care, including in risk, and range of ACSC to minimise unplanned admissions
- Major new partnership with Healthcare at Home to provide dedicated and skilled nurse support advocacy and self management group and individual interventions in community settings.

It is of particular concern that despite this consistency of approach, the city has been a relative poor performer in relation to **delayed transfers of care** (DTC), continuing to be over 3% across local hospitals and highlighted as a red flag in the city in CAA 2009. Despite a series of system improvements in partnership between social care, the PCT and HoEFT, more than 3.2% of patients in BEN have continued to experience delays, concentrated into some very long waits for working age adults with complex needs. Through the BHWP we shall focus our attention on achieving the pan-city LAA target of 10.2 per 10k by 2012, but in NHSBEN as a key health outcome indicative of local health system

Performance, we are seeking to achieve a maximum of 2% delays for our patients by 2012. In 2009, we have introduced a new step down model of convalescent care, which we expect to make a significant contribution and which we shall track closely as a key activity.

NHSBEN is particularly focused on delivering a better experience at the **End of Life**, as reflected in this being one of our 11 key WCC health outcomes. Further to our Strategy development, we shall implement a managed care pathway for supportive care at the End of Life, integrated with long term conditions, dementia and older people's services, in addition to oncology. Care will be coordinated, using a common risk stratification model, and will support access to Local Authority services. The delivery framework describes a named key worker supported by a core team of patient, carer, GP, district nurse and out of hours services, with access to a

coordinating centre, a hospice at home service, and a dedicated community based, multi-disciplinary team, which has access to beds.

Our legacy home death rate is 17.7% in 2007 (excluding care home deaths). The LAA sets conservative targets of an increase by 1% in 08/09, a significant increase of 3% in 09/10 to 22.32%, and a further 3% in year 10/11, to 25.32%. We believe effective end of life care is essential for credibility with patients and families and is key to demand management in acute hospitals. We have established shadow targets of 10% increases, year on year following the initial foundation year (September 2008 to September 2009). This will result in a potential available home death rate of 70% (including care home deaths), recognising that up to 20% of people will require complex medical care within a hospital setting, and about 10% may choose to die in a hospice. This is one of our most ambitious and challenging programmes.

7.6 Vulnerable Adults

There is a significant burden of disability within the PCT area, and many adults remain dependent on treatment and care services throughout their lives. This makes their experience a crucial determinant of their quality of life, and places significant responsibility on services to ensure they are supported to achieve their full potential, with as much independence as possible. The personalisation agenda in social care is driving new models of care, and rightly raising expectations of individuals and their families of having a greater say over the way they live their lives and the support they receive.

NHSBEN is co-ordinating commissioner across the Birmingham PCTs for both mental health and learning disability. In partnership with Adults and Communities in the City Council, NHSBEN hosts an ambitious programme of joint commissioning, which seeks to integrate our approach in both mental health and learning disability services. This integration, and the advent of a Section 75 agreement in April 2010, provides significant opportunities for both market development and cost management, within the context of clarifying expectations of improvement in both service experience and effectiveness.

After leading the way in developing community-based interventions for adult mental illness during the 1990s, it is now timely to review the role of community mental health teams, and the relative responsibilities of specialist, third sector and primary care providers. The models of home treatment and assertive outreach targeted to those with significant and enduring mental illness continue to need active review and monitoring in achieving the right balance of independence and safety. There will be a significant programme of re-design with BSMHFT to re-profile investment over the next 5 years, making full use of the joint approach with the City Council to realise value across support, care and treatment, and ensure access to increased capacity in socially and culturally inclusive psychological services in primary care, including high intensity interventions. Only those with serious mental health problems who require specialist medical care and the enhanced care programme approach (CPA) will need referral into secondary care, and up to 30% of historic specialist caseload will potentially return to primary care. Conversely, we need to develop greater

understanding of the relationship between local secure and high dependency services and a reduction in use of medium secure facilities.

The video diaries developed within PRIME have revealed a significant burden of mental distress, and have demonstrated how it limits the individual's motivation to access services and reinforces risky behaviours (including drug and alcohol use, sedentary lifestyles and poor diet). We shall increasingly seek to assertively identify and manage mental distress as part of core chronic disease management, and to promote well-being on the 5 step model described in 3.1 above.

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and manage mental distress as part of core chronic disease management, and to promote well-being on the 5 step model described in 7.2 above.

7.7 Collaborative Commissioning

NHSBEN PCT is an active player in the collaborative commissioning of the most appropriate and high quality specialised services, which includes hosting the West Midlands Specialised Commissioning Team (WMSCT). NHSBEN CEO chairs the Pan-Birmingham Local Collaborative Commissioning Board supported by Chief Operating Officer and deputy and is therefore one of the five CEO's on the West Midlands Strategic Commissioning Group and is the West Midlands representative on the National Specialised Commissioning Group (NSCG) of ten PCT CEO's.

The West Midlands Specialised Commissioning Team is responsible for the collaborative commissioning of £900m of services on behalf of our collective 5.4m population to ensure access to a range of typically high cost, low volume services. Whilst the team is currently responsible for a portfolio of some 35 separate services, current key initiatives are highlighted below.

All 17 PCTs rely on West Midlands Ambulance Service to provide emergency response, and a range of legacy transport activity. This organisation has developed from the merger of 3 predecessors, and has not yet fully integrated systems or approach. It has a conservative approach to service delivery and despite several years of support and investment has yet to respond to new patterns of urgent care and demand management activity, or to meet key performance targets. Commissioning is hosted by WMSCT with active PCT participation and leadership from NHSSB, and will focus increasingly on performance in emergency response and application of best practice technologies, e.g. stabilisation for primary angioplasty and in stroke and achieving value for money.

WMSCT has led an award-winning market intervention, improving quality and reducing price with NHS, independent sector providers of medium and low secure and tier 4 Child and Adolescent Mental Health (CAMHS) services. This has delivered significant benefits to NHSBEN, as we have 641 secure and 65 CAMHS patients. Demand for specialised mental health treatment continues to grow, and the team are continuing to support the development of additional NHS capacity, which will be local to BEN.

Cancer is increasingly a significant health issue in NHSBEN, as we are more successful in tackling premature mortality, a greater proportion of the population are living long enough for the prevalence of cancer to rise. Over the last five years, the 5 PCTs in Birmingham, Solihull and Sandwell have made significant investment in a range of new pharmacology through our local collaborative board, and are developing audits to evidence the impact this has had, and its relative return on investment, given the emphasis on 3rd and 4th line treatment, where the patient is typically already in an End of Life phase, though this may not be explicit.

A key component of cancer treatment is radiotherapy, which is known to actively contribute to a cure either on its own or in a combination treatment, and with a

greater impact when available early enough than most chemotherapy. Using the National Radiotherapy Advisory Group as a framework WMSCT has undertaken a regional scoping exercise by PCT, to understand the requirements if all recommendations are to be met and to improve efficiency, reduce waits and develop capacity. In this context, the Pan Birmingham Collaborative Commissioning Board plans to ensure the best use radiotherapy capacity to meet NRAG targets (NHSBEN by 2011 from 23,000 fractions pmp to 30,000 pmp by 2011) and improve specificity of targeting which includes additional linear accelerators within the locality in the long term. This will also require a strategic approach to workforce development which will be led through the regional subgroup of the WMSCT.

The WMSCT have agreed plans for the delivery of improved neonatal intensive care at agreed designated centres, and made an investment to ensure the safe transfer of sick babies between units on a 24 hour basis through the Newborn Network. This intervention is showing early signs of positive impact and will contribute to our strategic commitment to reduce the number of babies transferred outside the West Midlands by 5%. In addition PICU capacity has increased alongside the development of a PIC transport service to improve appropriate utilisation of available capacity. Considering the high fertility in BEN and profile of sick babies this has been an important intervention for newborn and children and forms the basis of further reconfiguration of neonatal intensive care units (NICU) and paediatric intensive care units (PICU) over the next two years, which will be subject to active formal public consultation across the region, and will reinforce the levels of intensity and capacity in Birmingham. Joint work between WMSCT and the NHSBEN complex care team will develop a protocol to support commissioners across the Region in placing babies and children requiring long-term complex support in local settings. We shall also initiate work with the newborn network to develop clinical protocols to govern 'rescue' decisions. These initiatives will both support better outcomes and targeting of intense support to babies and children who will most be able to benefit.

WMSCT convened a regional 3 day event to develop a strategy for paediatric surgery across the Region, in response to ad hoc shifts in specialist and local activity. This has identified 6 key principles as the basis for a strategy: 6 principles

For the West Midlands and its localities to create a whole system pathway for children needing surgery which ensures being assessed and treated at the right time, in the right place.

To establish a single network for children needing surgery which will agree common standards, outcomes, data , IT and consistency of 'brand'.

To create a single consistent approach across the West Midlands to the collaborative PCT Commissioning of services for children needing surgery.

Every child and parent will know exactly how to access the most relevant and effective advice / treatment at the time they need.

Maximise the use of technology to support the pathway for children needing assessment and surgery to ensure treatment by the right people, at the right time, in the right place.

Review workforce requirements for surgeons, anaesthetists, nurses & allied health professionals in the West Midlands to ensure safe & sustainable services for children needing surgery.

This will be a significant process of development, consultation and implementation over the next few years.

Given the profile of heart disease in the West Midlands, the WMSCT has had a strong focus on developing a specialist service infrastructure which would facilitate access to safe services in a high prevalence population. The group made early investment in a fourth cardiac surgery centre, which has now been open three years and has contributed to the region benefiting from the highest rates of access to coronary artery bypass graft (CABG) and cardiac surgery in the country. In parallel, the Birmingham, Sandwell and Solihull Cardiac Network has pioneered the introduction first of interventional cardiology and more recently of primary percutaneous coronary intervention (PCI) during myocardial infarction. The majority of BEN PCT residents now have access to cutting edge cardiac interventions as routine, and have reversed the inverse care law, with our majority disadvantaged population enjoying access to international standards of service. Discussions will continue about the right balance of interventional cardiology and surgery and further work is required to align transition from the specialist activity back into community rehabilitation and secondary prevention.

Genetic Services

As part of the specialised commissioning team a key programme of work in being undertaken in relation to genetic services. The team has begun work on developing a new strategy for genetics services focusing on the family history service. This includes:

- Reviewing the family history service for cancers.
- Developing outline service specification and policies related to those services
- Mapping out the elements of a strategy related to this particular service
- Reviewing the role of genetic counsellors and contribution to the service
- Developing a draft patient pathway for familial hypercholestroanemia service.

7.8 Quality and Safety

Given the focus of our four goals, a concern for quality and safety is implicit throughout our commissioning activity, but this is made explicit in specification, re-design, procurement and contract management. To ensure resilience and capacity we have invested in clinical leadership through a Medical Director and an infrastructure to ensure good governance and the capacity to drive improvement through our Professional Services, Strategy and Re-design and Human Resources teams.

A wide range of PCT activities support, promote and assure clinical quality and patient safety. These activities can be summarized into four themes:

Leadership for clinical quality and patient safety: local investment in senior capacity has driven a quality focus through the WTfH re-design programmes and the development of integrated clinical leadership development between primary and specialist care. We have also invested in non-medical consultant roles to enhance leadership in nursing and allied health professions.

Quality and safety information and intelligence: early experiments with benchmarking and sharing performance data for GPs are now being developed into GP Practice Quality Profiles, (and associated locality profiles for PBC) to support peer challenge and review and demonstrate performance on standards of quality and safety within primary care. These quality profiles bring together a range of existing quality and safety information into a single place, with the intention of reducing inappropriate variability, driving up standards of clinical quality and improving patient safety. Clinical quality indicators are increasingly integrated within standard contracts for acute and community providers and further work is underway through the Investing for Health programme to develop a core indicator set for quality outside hospital. Further work is ongoing to ensure that routine, robust and systematic performance monitoring is focused on these quality indicators.

Improvement in clinical quality and patient safety: redesign work has taken seriously the Kaiser Permanente adage that “an unplanned admission is a system failure” which by its nature puts vulnerable adults at additional risk. More recently we have focused attention on tackling health care acquired infections and a whole health economy approach has overseen the development of a joint overarching plan supported by our own BEN PCT plan for the prevention and control of infection. Work is underway to both fully implement and systematically monitor all elements of the plans.

Our concern to develop an informed and empowered community is reflected at an individual level in a commitment to prioritise dignity and respect as core principles in service provision, ensuring that increasingly our patients feel like partners in care and have a positive experience in all health service contacts.

Learning from NHSWM appreciative enquiry event in November 2009 will be embedded into our Quality and Safety systems for commissioned services.

7.9 Overall impact, by goal

In summary, the PCT is undertaking a range of activity designed to further our core purpose of tackling health inequalities and health improvement and deliver our four strategic goals. The tables in appendix 2 identify particular contributions each activity will make.

Within the QIPP framework:

- Quality includes access and focus our goal of “

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CHAPTER 8 PERFORMANCE AND DELIVERY

8.1 Past delivery performance

NHS BEN has a track record of delivering significant improvements in performance, sustaining these and in reducing costs in order to make investments in innovation and further improvement. Our learning, over the last seven years, will inform our activity going forward.

Key insights include:

- When working across the whole system, it is essential to adopt a formal programme approach, with clearly defined work-streams, multi-agency groups and accountable officers with delegated authority to act. We developed a very effective approach as part of our male life expectancy programme through the BHWP, which was celebrated by the NST Tackling Inequalities and has informed our partnership and WtFH work going forward.
- Doing more of the same, will produce the same results; we have learnt to be more circumspect about the assumptions, health beliefs and preferences of our customers. In our heart failure programme, we initially invited people to participate with a very traditional letter. They didn't. In male life expectancy, focus group work revealed that we needed a non-GP based programme, and one that could be booked over the phone. It worked. We now invest more time upfront in understanding each specific audience, to design appropriate interventions which will be well-received.
- Birmingham OwnHealth® has been a 'blue ocean' intervention, which has designed a new style of service, and opened up a new market in telephone-based delivery of health care. We are currently considering which other traditional face-face interventions may more effectively and efficiently be offered over the phone. We are also exploring how to apply digital technology in our daily work and in particular for direct communication with our public.
- Historically, we have been strong on innovation, partnership and improvement, but we have needed to build our capacity and commitment to process capture and management in order to design prototypes and then scale up and to ensure sustainability of services over time and as they are rolled out universally beyond particular committed or interested clinicians into the mainstream of practice.
- It is essential that we 'make it easy for people to do the right thing'. It is very easy to design systems which are bespoke and which require additional effort and thought on the part of busy front-line staff and which are therefore doomed to failure. We need to pay increasing attention to ensuring that as new interventions are introduced they are fully integrated with existing practice, maximising the chances of large-scale adoption; hence the Map of Medicine approach to pathway redesign.

- We celebrate creative stealing; there seems little point in reinventing the wheel and if there is a service or intervention which has already demonstrated ‘proof of concept’ we need to ensure it is adapted and adopted as quickly and consistently as possible – this is however counter-cultural to the broader NHS, and to clinical cultures in particular where ‘not invented here’ is always a challenge to overcome.
- We will not be seduced by the ‘artisan’ approach, dependent on one dedicated clinician, which delivers a bespoke service for 20 or 200 people, whilst 20,000 experience routine, poor care. We prototype services which are designed to be delivered on an ‘industrial’ scale to ensure that the whole of a client group can benefit where a service has proved its value.
- The full cycle of commissioning from identified need, through target group, prototyping, gateway development, impact assessment to full roll-out takes at least two years to scale.

Specification development, with flexibility to respond to learning as services bed in, takes time and formal procurement rules will extend time periods by three months, even when managed to their tightest legal timescale.

- In introducing others to our programmes, we need to support them through the ‘Alignment to move beyond ‘not interested here’ to an appetite for adoption and understanding of the product.

8.2 Risk management

Our risk analysis against our strategic initiatives reflects a scoring system based on potential severity of impact and likelihood of occurrence. The table below highlights the key risks according to impact on finance, deliverability and stakeholder relations.

Strategic Initiative Risks						
Risk Category	Initiative Area	Risk	Mitigating Actions	Severity	Likelihood	Severity grade
Deliverability	PRIME, care, Closer to home, Maternity and Children, vulnerable adults	Ability of programmes to effect change, engagement with key stakeholders. Ability to deliver services in existing facilities.	Monitoring via Strategic Partnership boards and Performance Accelerator.	Major (4)	Possible (3)	12
Workforce	PRIME, Care closer to home, Chronic Disease Management	Recruitment/Retention of staff to deliver outcomes	Partnership working with specialist teams.	Major (4)	Possible (3)	12
Affordability	PRIME, Maternity & Children services, Chronic Disease Management, Care Closer to Home. Collaborative commissioning.	Impact of new initiatives to deliver outcomes. Ability to deliver shift from secondary care	Ongoing dialogue with secondary care.	Major (4)	Possible (3)	12
Reputation	PRIME, care closer to home, vulnerable adults.	Concept of social marketing alienates NHSBEN from community	Testing of PRIME approaches with Patient groups.	Major (4)	Unlikely (2)	12
GP Support	Promoting Health and Self care, care closer to home, Chronic Disease management, PRIME	Failure to engage to manage primary care workload.	Monitoring of strategic initiatives, continued dialogue with General Practitioners.	Major (4)	Unlikely (2)	8
Patient & Public perceptions	PRIME, Promoting health & self care, collaborative commissioning.	Failure to recognise and engage with at risk individuals.	Monitor feedback via PPI forums, complaints and website. Monitoring of uptake in self care programmes and interventions.	Major (4)	Unlikely (2)	8

8.3 In year monitoring

Each key activity within the initiatives has an identified lead and a sponsor Director. All activities are logged and tracked on performance accelerator, and can be interrogated by any member of the Board at any time. A highlight report identifying performance outcomes and risks is produced on a monthly basis. Performance Accelerator supports the development and monitoring of improvement plans.

8.4 Organisational requirements and enablers

The organisational development plan identifies five key work streams essential to building our organisational competencies in the context of World Class Commissioning. A full learning review of Organisational Development activity was held in early December 2009. This involved a look back of OD activity and look forward to ensure relevant, coherent and aligned OD support to enable delivery of the strategic plan. Subject to maintaining 3 PCTs in the City, the core OD programmes will remain the same with changes made to the programme activities and their priority. The five key workstreams will be:

- Workforce and organisation design
- Planning, Innovation, Process Excellence (PIPE)
- Knowledge management and IT infrastructure
- Programme for Relationships and Intelligence Metrics and Equality (PRIME)
- Community Health Services development

The workstream on CHS will be very active in year, as this will be focused on the transfer of services to a range of alternative providers according to service.

At the December 2009 OD learning review we mapped a “driver” diagraph for the WCC competencies. This confirmed the following 4 competencies as key to leveraging the maximum impact in commissioning development in NHS BEN:

1. PPI
2. Collaborate with clinicians
3. Manage knowledge and assess need
4. Promote innovation and improvement

From January 2010, we should identify a clear direction of travel for the configuration of commissioning organisations in the city. Where this includes structural change, this would drive development of a dedicated integration plan and we would recommend an OD process and plan, building on our learning from the successful 2005-06 integration of predecessors EBPCT and NBPCT into BEN

8.4.1 Workforce development and organisational design activity

The PCT has developed an ambitious programme of service redesign activity which will require access to new skills, personal development for existing staff and opportunities for local people seeking entry to the job market. We have designed a participative approach to developing our new workforce strategy, which will address strategic challenges and respond to our initiatives, and in the process itself be a

development opportunity for a cross-section of staff within the organisation. We are working with other NHS organisations in the local economy to develop a forum which can focus on workforce issues and drive commissioning through the deanery to ensure that training and development reflects employer need.

NHS BEN has established a partnership with Vista Consulting Team, which gives us access to an open process network of OD practitioners over a three year period. The VISTA OD Network will support the PCT in being 'consistently fit for purpose' as an organisation, addressing all five elements of Galbraith's star approach⁵.

Organisational design

Continuing to involve a wide range of internal and external stakeholders in the work of building an organisation which is able to develop and execute strategy in dynamic, comprehensive and effective ways through whole system workshops and active review of goals and strategy.

• Process improvement

To build process improvement capability in the PCT, ensure we have a knowledge management system which can capture and track process improvement initiatives and support a number of priority process improvement activities.

• Performance analysis

Support PRIME to ensure that measures and tools are live within the PCT and assertively applied to improve performance and demonstrate impact in reducing inequalities, including knowledge transfer of specific skills and abilities.

• Board and team development

Support the Board and leaders throughout the PCT to ensure high performance and grow our ability to work across and within teams, with a particular focus on intimate conversations and team development.

• Workforce strategy and organisational development (OD)

Through PRIME we want to improve on our staff satisfaction rating, and ensure that our workforce continues to be actively engaged and motivated by our ambitious goals and passion for improvement.

We shall use the information from staff surveys and our workmat exercise (which involved over 1300 staff), as the basis for a workforce development strategy, involving staff in the development of the Strategy and the plans to implement it successfully. We shall formalise our approach to leadership development and talent management.

• Knowledge management (KM)

Support to knowledge transfer from PRIME and design and facilitation of deliberative events.

⁵ Jay Galbraith (1995) Designing Organisations (Jossey Bass)

8.4.2 Planning, Innovation, Process Excellence (PIPE)

This programme draws together the range of improvement activity which the PCT will undertake to further build our core capability in the commissioning process. It is a core programme within our OD Plan but includes activities dedicated to build commissioning competence.

- Map and develop core commissioning processes and ensure they are LEAN and effective, drawing in multidisciplinary, cross directorate resources as required.
- Changing contractor and provider expectations to improve contract management processes and ensure these are applied consistently and robustly, particularly in primary care.
- Develop stratification and practices to identify strategic partners in primary care Document annual negotiating strategy and clarify Board expectations in the event of failure to reach preferred agreement.
- Review and develop our existing practice based commissioning infrastructure to support increased delegation within a clear framework of accountability and delivery, and a developing model of partnership to support a focus on core primary care delivery.
- Review and enhance our procurement capacity, beyond our initial investment in expanding the capacity of our internal procurement team. Plans in the spec 2 development of West Midlands Commercial Support Unit and explore options for enhanced relationship management capacity for our various commercial partnerships. Deliver planned update training in the basics of procurement for middle managers, with a focus on our Strategy & Redesign and Health Improvement directorates and the partnership and specialised commissioning teams.

8.4.3 Knowledge Management and IT infrastructure

NHSBEN identified in Spring 2007, the need to invest in skills and capacity for process improvement, and we have appointed a substantive Director of Process Improvement during 2008 with a key role in the development of systems to support excellence in knowledge and process management in the PCT. The Board has now considered and approved the paper “knowledge management and process excellence within BEN PCT” and this provides the framework for our emerging work programme to build our capability in this area.

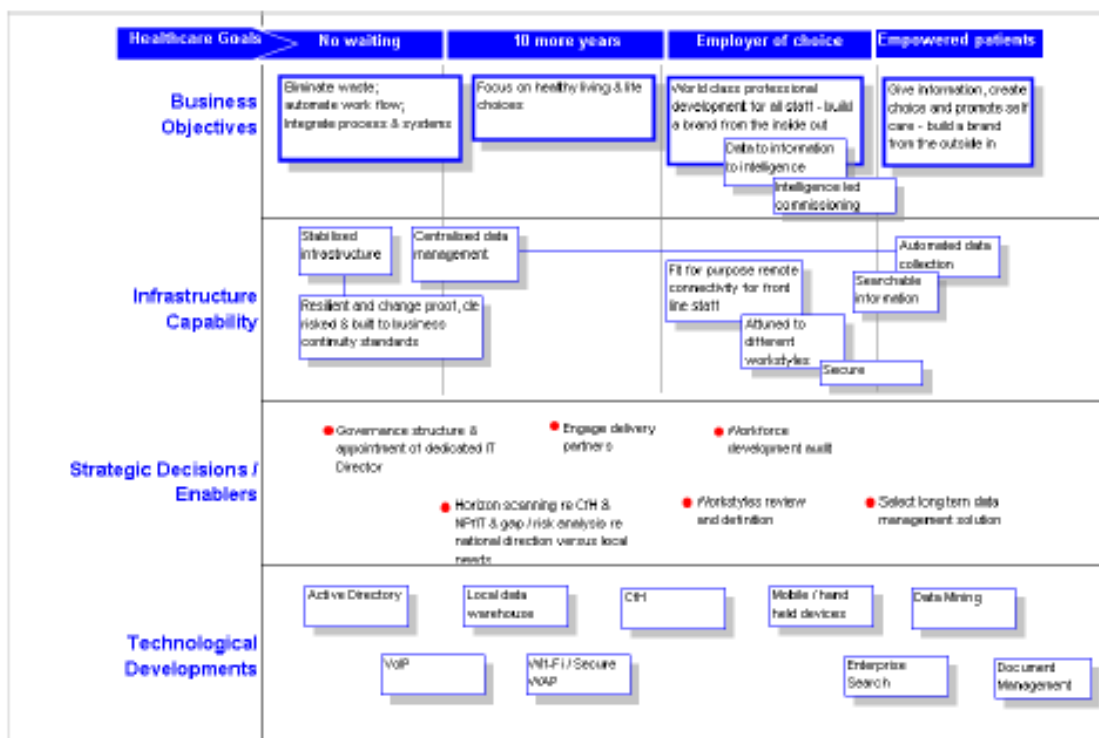
The table below summarises this work programme which is also discussed in our OD plan as a key workstream. We are addressing Knowledge Management and IT infrastructure through a single distinct programme because the PCT recognises the importance of having a fit for purpose IT infrastructure that is both business driven and built on a set of interlinked core technologies. This will be critical to enabling the delivery of other key OD and strategic programmes e.g. PRIME and knowledge management (KM). We have invested in the performance accelerator software to ensure a coherent and retrievable library of evidence of our activity. We are

reviewing our legacy server infrastructure to support improvements in KM processes, and the potential to support enhanced mobile communications for clinical staff. Our technology roadmap illustrates the relationship between business objectives, infrastructure capability, strategic decisions and the technological developments that will support this programme.

Although we have actively pursued the Connecting for Health (CfH) programme, this is proving slow to roll-out, with a patient administration system only becoming available to the PCT in 2008, and that not appropriate to capture much of our innovative practice. We have a sound infrastructure amongst General Practitioners, but wish to fast-track digital information exchange between clinicians in different provider organisations as a support to enhanced quality, safety and patient responsiveness. We shall be increasingly circumspect about adopting CfH products, versus exploring alternatives which may be more fit for purpose, whilst retaining an absolute focus on inter-operability and the efficiencies of scale and consistency.

Initial work is focused on ensuring a sound hardware infrastructure to support core communications and metric feedback at the frontline. More developmental is our experimentation with mobile communications to support remote access to clinical information, and potential identification of a technology partner with whom to develop our approach to tele-health and tele-care. As a board member of Digital Birmingham, we are committed to maximising the opportunities offered by the Birmingham Prospectus commitment to developing a “connected” city. With over 30% penetration of digital and cable, we shall increasingly be using new technologies for core communications and relationship management with our customers, partners and public; not least through the digital technologies work-stream of the PRIME programme.

Figure 10: Knowledge Management and Process Excellence



8.5 Financial plan

The PCT's financial plan for the next five years fulfils the following criteria:

- It delivers a surplus of 0.5% of Trust core allocation to provide a buffer against the statutory financial duty to achieve breakeven
- It provides a consistent level of recurrent investment to support the delivery of the PCT's strategic initiatives
- It makes non recurrent resources available per annum for years 2 and 3 of the plan to support any double running costs associated with the strategic initiatives and for investment in new initiatives that are self financing by 2012/13
- It is based on a set of assumptions that provide an overall budget that has a balanced set of financial risks.

We have modelled our financial plans based on a "flat cash" scenario for the next CSR. In this funding context we are therefore focussing on the entirety of our portfolio to identify areas where we can deliver improved services to patients at a lower cost to the tax payer.

The high level financial plan is shown below. The financial strategy contains the assumptions that support the plan as of December 2009.

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m
Recurrent Resources	639.2	674.2	711.2	711.2	711.2
Non Recurrent Resources	22.4	15.8	18.3	18.9	18.9
Recurrent Growth	35.0	37.0	-	-	-
Total Resources	696.6	727.0	729.5	730.1	730.1
Baseline Expenditure		695.9	718.3	727.6	731.5
Inflation		8.0	(8.2)	(7.3)	(8.7)
Joint Commissioning		2.4	2.3	2.4	2.4
Population Growth		0.5	0.5	0.5	0.5
Strategic Initiatives		12.0	8.0	6.5	3.9
NR Initiatives Fund		3.0	6.0	-	-
PCT Infrastructure		1.5	3.5	3.5	3.5
Contingency		4.1	4.1	4.1	4.1
Total Expenditure	694.2	727.4	734.5	737.3	737.2
Surplus/(deficit) before savings	2.4	(0.4)	(5.0)	(7.2)	(7.1)
Savings from Strategic Initiatives		3.5	8.7	10.8	10.8
Surplus	2.4	3.0	3.6	3.6	3.6

8.6 Provider requirements and plurality of provision

As outlined in Chapter 4, NHS BEN takes an active approach to understanding the local market and developing plurality of provision. The Trust sets out its commissioning intentions in its five year commissioning plan, which is refreshed on an annual basis. These intentions reflect our goals and strategies, and are consistent with the local health economy strategy. They link directly to pathway re-design work through Working Together for Health and NHS West Midlands Investing for Health strategy / NHS Next Stage Review.

We have planned significant changes over the next five years in the local profile of health services. These changes are subject to ongoing dialogue between commissioners and providers through various forums including the WTfH programme board, redesign workshops and tripartite contract performance meetings.

Heart of England Foundation Trust (HoEFT)

Successful intervention in the system will see a reduction in overall activity in HoEFT, particularly in outpatients, A&E attendances and unplanned admissions but with increases in very acute and more specialised care, maternity delivery and radiotherapy.

Chapter 7 and **Appendix 2** sets out a range of activities, all of which have been subject to joint discussion and implementation requires consistent action across commissioner and provider services, with HoEFT scaling beds up and down over the next ten years in its capital development strategy according to the impact and success of proposed transitions in care.

By March 2013 some 70,454 less outpatients will occur in the trust - 16% of all current outpatients.

By March 2013 9,700 accident and emergency attendances will be seen in the second urgent care centre 5% of current attendances

By March 2013 some 7,500 admissions will no longer be required due to the commissioning of increased community capacity for people at the end of their lives, increased community rehabilitation, increased telephone and assistive technology based support. This will be 13% of current emergency admissions and will mean a reduction in hospital beds.

There are significant opportunities for the Trust to develop its capacity and capability in maternity and paediatric surgery.

The PCT is supportive of the Trust developing its specialist capability to ensure appropriate access and rapid implementation of effective new technology.

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)

The commissioning of new capacity in primary care mental health services will impact on the trust. However current modelling with the FT suggests that this will be minimal in financial terms, as BSMHFT will re-use this capacity to expand specialist activity including low and medium secure services with the support of commissioners. The re-design of core adult mental illness services is anticipated to reduce expenditure in the Trust by some £7-14m across Birmingham over the next 5 years through some 30% historic advice centre activity being managed in primary care in future.

Primary care and community services

Our focus on prevention, excellence in chronic disease management and care closer to home, will have the cumulative effect of significantly increasing investment into primary care, domiciliary and community services. The effect of all these strategies will be to increase the range of services available and the choices available to members of the public not only in the number of different providers but also the types of interventions and choice of location. Commissioning an increased range of technology options alongside remote contact will bring into the market an increasingly diverse range of providers not traditionally associated with healthcare. The effect of these changes will mean that present providers may find themselves in a network of care or part of a competitive market for future provision to the public. This will increasingly mean that where providers are not delivering to the standards expected, these services will be decommissioned.

BEN Community Health Services currently provide a range of core community services which are essential to health improvement, rehabilitation, demand management and patient safety. We shall continue to actively review this portfolio in the context of the local market and of partnership work with Birmingham City Council, HOEFT, NHS Direct and others.

The NHS currently dominates the market in Community Health Services. Over the next 5 years it is clear that:

- NHS BEN will not provide CHS from April 2010
- We shall seek to sustain a dedicated NHS provider of CHS in the city
- We shall take a commissioning approach to each service area which is likely to result in specific services having a different range of providers in the future
- Some current NHS services may seek to become commercial or in future be provided in a social enterprise model.
- The 3rd care sector play an increasing role in provision particularly in relation to health improvement, domiciliary support, rehabilitation, convalescence and acute care.

Primary Care

NHSBEN will increasingly expect to understand the nature of local practices, and whether they have the capability and disposition to act as partners, or whether they will continue to have a culture of 'contracting ' for care. Our specification and

contract management will become increasingly robust as we seek to ensure that we realise the true potential of excellent primary care in acute response, chronic disease management and efficient utilisation of more specialist services. Our primary care strategy establishes an expectation that we shall increasingly favour practices serving a minimum of 10,000 patients, with a doctor / patient ratio of 1:1500 and a team approach, able to offer peer support and review, and an extended range of services over an extended stay. Given the current profile of 40% single handed practices, this is likely to drive significant change in providers within this market over the next 5 years.

The NHS has only recently become responsible for commissioning and contract management of dental and pharmacy providers. There is development work to be done to build relationships and understanding, and the scope and scale of activity is likely to change as this happens.

8.7 Board Ratification

This strategic plan has been developed with the full engagement of the PCT Board who have ratified its content.

Appendix 1 – Current

Provider	£000's*
Acute Services	
Heart of England NHS FT	199,940
Sandwell & West B'ham NHST	21,120
University Hospital B'ham NHS FT	12,920
Birmingham Childrens Hosp NHST	9,689
Royal Orthopaedic Hosp NHST	5,977
Birmingham Womens Hosp NHST	1,943
Mid Staffs General Hosp NHST	1,270
Walsall Hospitals NHS Trust	1,328
Univ Hosp Cov & Wark NHST	1,337
George Eliot Hospital NHST	73
Dudley Group of Hospitals NHST	163
Royal Wolverhampton Hosp NHST	217
Worcester Acute NHS Trust	282
Aston Academy of Life Sciences	175
Midland Eye Institute	21
West Midlands Amubulance Trust	10,466
Community Providers	
BEN Provider Arm	46,011
South Birmingham PCT	34,819
Heart of Birmingham PCT	9,525
Walsall PCT	331
Solihull CT	700
St Mary's Hospice	413
Badger City Nights	394
Homestart	154
South Staffordshire PCT	263
Focus on Blindness	121
Stroke Association	108
Sandwell PCT	115
Acorns	160
Birmingham Citizens Advice Bureau	78
BVSC	68
Freshwinds	59
Birmingham Own Health	3,405
Healthcare at Home	751
Primary Care Providers	
GPs	56,001
General Dental Practitioners	16,441
Pharmacists	5,538
Mental Health Providers	
B&SMHT	41,535
Acquarius	439
MIND	259
BITA	243
Turning Point	106
South Staffordshire and Shropshire Healthcare	100
Dudley and Walsall MH Partnership	422
Other Providers	
Birmingham City Council	1,677
BUPA	1,186

*Indicative spend for 2009/10

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APPENDIX 2

Strategic Initiative: Key Activities

PRIME	Quality	Innovation	Prevention	Productivity	Key Partner(s)
Baseline analysis to establish focus of programme, and track impact <ul style="list-style-type: none"> Benchmarking core cities and ONS group Media and brand audits Programme KPIs 	Access, relevance, equity	Systematic approach to segmentation and marketing	Effective communication of key messages	Improved targeting and uptake of services	Dr Foster Intelligence
Profile population and identify groups most at risk of ill health and poor outcomes <ul style="list-style-type: none"> Introduce PHM Develop Typologies Video diaries 	Ability to target + track interventions for health improvement and	Typologies assessment	Understand preferences identify high risk groups	Effective targeting and design to	
Social Marketing programme to respond to priority areas, targeted to highest risk groups in 5 areas: smoking, alcohol, obesity, infant mortality, mental well-being	Population targeted access	Typologies assessment	Understand preferences identify high risk groups	Effective targeting and design to	
Infrastructure to support public participation and engagement <ul style="list-style-type: none"> PPI microsite PPI database Household panel 'Seldom heard' workshops PET trackers 	Systematic Good coverage of different PPI mechanisms	Diverse methods of engagement Personalised and systematic	Enhances ability to feedback messages	Effective targeting and design to	
GP facing Knowledge Management infrastructure: GP MyPractice <ul style="list-style-type: none"> Collate information 	Bespoke tool for GPs	Supports GP segmentation and partnering	Supports practice ability for target prevention	Systematic and personalised GP practice plans	

Design tool OD and re-design to support					
Knowledge Transfer on project by project basis	Link to KSF	Link to KSF and workforce development	Skills for prevention	Supports 'Do' 'Buy' 'Share'	
Digital tracking <ul style="list-style-type: none"> • Re-design of web-presence • Health Inequalities dashboard 	Qualitative data	Tracks inequalities	Identifies and tracks		

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Promoting Health / Self Care	Quality	Innovation	Prevention	Productivity	Key Partner(s)
Assertive screening at risk adults for CVD and stroke <ul style="list-style-type: none"> Model of community based health check programme with assistive technology to engage with resistant population 	Access, relevance, Equity	Assistive technology to improve quality and outcomes.	Early identification and management of disease	Limiting damage and improving outcomes in disease	BHWP Lloyds Primary care
Healthy Incentives schemes to support behaviour change <ul style="list-style-type: none"> Reduction smoking in pregnancy 	Equity, effectiveness, acceptability	Testing impact	Behaviour change to prevent disease	Limiting damage and improving outcomes in disease	Young Foundation
Promoting uptake of cervical, breast and bowel cancer screening to go beyond 80%	Access, relevance, Equity	Assertive identification and invitation to care	Early identification and management of disease	Limiting damage and improving outcomes in disease	
Smoking reduction and cessation <ul style="list-style-type: none"> Targeted marketing campaigns: inc committed smokers, pregnant women Re-design of services Develop reduction programmes for long term heavy smokers Target those with chronic disease through hospital programmes 	Effectiveness, Equity, efficiency	Typology targeting, harm reduction	Prevention of chronic diseases	ROI range of £1:£13 to \$1:\$25,000	DFI
Obesity in adults <ul style="list-style-type: none"> Weight management programmes Access to BeActive Exercise on Prescription 	Evaluative success of programme	Typology Targeting with BCC	Prevention of chronic diseases		BCC Commercial organisations
Support to self care <ul style="list-style-type: none"> Programme fit and healthy Disease specific education Expert patient programme 	Effectiveness, Equity, efficiency	Promoting culture of personnel responsibility	Prevention of chronic diseases	ROI as a result in self care and delay in disease onset	BHWP BCC
Supporting Self Management <ul style="list-style-type: none"> Self care skills Self diagnostic tools and monitoring 	Effectiveness, Equity, efficiency	Promoting culture of personnel responsibility	Better control of disease and reduction in relapse.	ROI as a result in self care and delay in disease onset	BHWP BCC

<p>Health and Work initiatives to retain and return to employment</p> <ul style="list-style-type: none"> • Fit for work Service Pilot • Primary Care Training in Health and Work Issues • “Back to Work” Programme for those on Incapacity Benefit • Healthy Workplace Initiative 	<p>Improves health of working age population, supports local economy</p>	<p>New models of intervention able to target populations not previously accessible</p>	<p>Improved management of LTCs</p>		<p>BCC, JCP</p>
<p>Total Place, Total Community</p> <ul style="list-style-type: none"> • New town centre • 3000 houses • Integrated public service offer through new hub • Test bed for joint approach MH, LD, vulnerable families, alcohol and gangs. 	<p>Improve health and well being of significant section of the population</p>	<p>Shared vision and financial links to increase public sector productivity</p>	<p>Improved mental and social well being</p>		<p>BCC</p>

Maternity and Children's Services

Activity	Quality	Innovation	Prevention	Productivity	Partnership
Maternity redesign across HOEFT <ul style="list-style-type: none"> • Pregnancy outreach workers • Explicit social and clinical risk assessments, audited • Dedicated breastfeeding and stop smoking activity as mainstream • Additional midwifery capacity • Contract management to standards • Increased access to Maternity Scanning • Increased Maternal choice in 'delivery' options 	Access Choice Equity	Personalised Care	Identification Reduction Health Inequalities	Targets for KPI in agreed data set	Birmingham Solihull Maternity- Neonatal Clinical Network Children's Centres
Early booking service and marketing, inc assessment for genetic counselling <ul style="list-style-type: none"> • Recording of ethnicity at booking 	Access, relevance, effectiveness, Equity	Community- development approach	Early identification and management of Foetal Growth restriction	Data Targets For Early booking in targeted wards	BHWP Maternity Birmingham Solihull Maternity- Neonatal Clinical Network
Breastfeeding initiation and sustainability <ul style="list-style-type: none"> • Peer support workers • UNICEF accreditation • Social marketing • Parent craft initiative 	Effectiveness, Equity, Efficiency	Peer support Recruited from local families	Resistance to infection, protective for obesity and chronic disease	Targets for progression through UNICEF accreditation Targets Initiation & sustain inability BF rates	UNICEF Children's Services Maternity Birmingham Solihull Maternity- Neonatal Clinical Network Services BHWP
Early intervention with vulnerable families <ul style="list-style-type: none"> • Family Nurse Partnership • Local Model of Progressive Universalism in Children's Services • Child Population stratification • Pilot Total place activity 	Effectiveness, Equity, Efficiency - 82 -	High intensity Intervention Integrated provision	Targeted intervention Prevention of risks & delays patient pathway	Targets for workforce redesign and development Targets for resource allocation	BCC Children's Centre Sure Start

Excellence in Chronic Disease Management Major Programmes	Quality	Innovation	Prevention	Productivity	Key Partner(s)
<p>Case/Care Management</p> <ul style="list-style-type: none"> • High Intensity Care • Case Management • Risk Stratification • Specialist LTC Nursing • Remote Care • Assistive Technology • Birmingham OwnHealth • Telecare • Benefit 	<p>Improves Quality of life for High Intensity Users of Health Services</p>	<p>Use of intelligence to target type of intervention</p>	<p>Supports self management and social wellbeing</p>	<p>Demand management through secondary care admission avoidance</p>	<p>Improves relationships between providers along the pathways</p>
<p>Self Management</p> <ul style="list-style-type: none"> ○ Care Planning Pilot ○ Personal Health Budget Pilot ○ Disease Specific <ul style="list-style-type: none"> ▪ Xpert ▪ EPP ▪ DESMOND ▪ DAFNE ○ (Year of Care) ○ Health Psychology 	<p>Improved patient experience through involvement in care</p>	<p>Embedding effective Care Planning and access to menu of choices and use of PHB</p>	<p>Supports self –care and slows disease progression</p>	<p>Increases co-production between citizen and healthcare professional</p>	<p>Inclusive of Third Sector</p>

<p>Integrated Pathways</p> <ul style="list-style-type: none"> • Cancer (Screening) (Early Detection) (Cancer Reform Strategy) • CARE • Respiratory • COPD • Asthma • Other Chronic Lung Conditions • CVD • CHD • CKD • PVD • HF • Stroke • Diabetes • Neurological • Epilepsy • Parkinson's • MS • Inherited 	<p>Improved quality of life and improved survival</p>	<p>Development of Pathway KPIs</p>	<p>Proactive management of condition at wherever in pathway</p>	<p>Release of capacity in secondary care</p>	<p>Builds and manages the supply chain</p>
<p>Quality Improvement in Primary Care</p> <ul style="list-style-type: none"> • QoF/QoF+ • Local Enhanced Services (Diabetes) • Registers • Risk Factor Management • Inequalities - Expected Prevalences • MURs in Pharmacy 	<p>Improving clinical outcomes in primary care</p>	<p>Use of intelligence, incentives and expert support to drive improvements in outcomes</p>	<p>Tackles adverse lifestyle factor in those with CDM</p>	<p>Supports the Integration of Pathways</p>	<p>Builds on the Partnering Approach with Primary Care Providers and PbC</p>

Care Closer to Home	Quality	Innovation	Prevention	Productivity	Key Partner(s)
Capacity in General practice - Mergers - LIFT - 1:1500					
Dentistry capacity					
MESH Project (Acute Care at Home) -Family Liaison service -Chronic Disease Management -Enhanced Supported Discharge -Home based Chemotherapy	Access 24/7, Personalisation Universal, Care plan and co-ordinator, covers whole family Access 24/7, personal, preventative, promotes self- management Reduces acute stay, re-ablement at home, 24/7 access, promotes personal control and self- management Access, effectiveness, 24/7 support, Choice of	Looking after the whole family before, during and after death 24/7 24/7 increased range of community interventions not available at present KP model skill nursing facility at home, tariff reductions for ESD, 24/7 for two weeks after discharge	Prevention of unplanned admissions in eol phase of care Increased control and self-management for population served Reducing LOS / supports reduction in HACIs/ DTOCs Reduces hospital interventions	Reduction in unplanned interventions Reduction in unplanned interventions Increased staff capacity acute sector, reduce bed occupancy rates, increase in bed capacity	Strategic partnership with Healthcare at Home Integrated working between Acute Trust, Community Services and Healthcare at Home Integration with ward staff

-Mental Health	place of care	Treatment at home support of consultants		Increase capacity and access to services	Partnership with Hospital Consultants
End of Life Managed Network Procurement	Care co-ordination and navigation, increased access to a range of interventions, 24/7, home based care	All individuals in End of Life phase of care in managed system of care	Increased knowledge and understanding of condition and better decision making about support required less hospital exacerbations	Reductions in unplanned interventions more productive use of resources	Strategic Partnership with Managed Care Network Provider
2 nd Urgent Care Centre Saltley	Access, relevance and acceptability	Nurse led system of care	Reductions in A&E attendances, Education of patients to use services appropriately	Streamlines Accident and Emergency, more effective treatment of residual patients in A&E	Partnership with Community Health Services
Sexual Health services redesign -Chlamydia screening -LARCs uptake -New centre Erdington	Increased access to a range of services in relevant settings, one stop services	Increased social marketing approach to targeting provision of services	Building knowledge about STIs and reduction in STIs Reduction in teenage pregnancy		Partnership with new provider to deliver new model of care
Partners in Health Centre Model -Development of Sutton Cottage as second centre -Enhancement of current centre through move to new premises	Increased range of health and other services, increased across population access to present services	Patients as partners designing services and interventions	Prevents need for mainstream services increasing population who are knowledgeable about their condition	Increase in range of community based services, reductions in hospital capacity required	Partnership with Patients

<p>Full-scale development of Muscular Skeletal Services</p> <ul style="list-style-type: none"> -Orthopaedic triage -Back pain -Knee service 	<p>Access within agreed timeframe, direct access to specialist service in the community, urgent onward referral where required, quick access to diagnostics and physiotherapy</p>	<p>All referrals go through MSK with networked system to pain management, diagnostics</p>	<p>Early Intervention reduces longer term problems, prevention of inappropriate outpatient attendances</p>	<p>Reduces need for first outpatients, follow ups and consultant to consultant referrals</p>	<p>Opportunity for Community Health Services to develop integrated partnership with acute hospital</p>
<p>Enhanced re-ablement / convalescent care to promote independence and minimise DTOCs</p> <ul style="list-style-type: none"> -Community Units 	<p>Reduced LOS in acute bed, model of re-ablement opportunity to return home</p>	<p>Model of care (convalescence) on acute site, financial arrangements, staff development, increased numbers of patients return home</p>	<p>Prevention of readmission, prevention of admissions to residential or nursing home</p>	<p>Reduces LOS in Acute Setting, increases opportunities for bed reduction</p>	<p>Partnership with HoEFT and Adults and Communities</p>
<p>Development of Social Enterprises in the community</p>	<p>Access to services for hard to reach groups, opportunity to gain self-management skills, increasing aspiration</p>	<p>PCT supporting development of social enterprise for local benefit but national sustainable developments, creation of employment opportunities</p>	<p>Economic degeneration</p>	<p>More individuals accessing preventative services. Less reliance on acute care</p>	<p>Strategic partnership with the Young Foundation and developing Social Enterprises</p>
<p>Expansion capacity in primary care</p> <ul style="list-style-type: none"> • Practice mergers • Additional dental capacity • 1 GP: 1500 patients • Extended hours <p>Pharmacy?</p>	<p>Access, equity, acceptability, effectiveness</p>				

Vulnerable Adults					
Activity	Quality	Innovation	Prevention	Productivity	Partnership
Integration of health and social care investment in adult mental health and learning disability services	Relevance, equity and effectiveness		Shift institutional to domiciliary focus	Improved return on investment	BCC A&C
Re-design primary and community capacity for mental illness	Access, Relevance, equity and acceptability		Minimising long-term impact of acute episode	40% reduction in referrals to specialists 30% historic caseload back to primary care	BSMHFT
Market stimulation and management of services for people with Learning Disability					BCC A&C
Re-specification and procurement of provision of complex care <ul style="list-style-type: none"> Expand capacity for working age adults with complex needs Improve vfm of contracts 					
Development of information, support and advice to carers <ul style="list-style-type: none"> Active promotion of carer assessments Potential to integrate approach with BCC 					BCC A&C
Development of self-directed care including piloting of personal budgets in NHS					BHWP
Investment in alcohol harm reduction <ul style="list-style-type: none"> Expand capacity Develop services responsive to women Ensure A&E and police liaison 					
Model impact of investment in capacity for low secure MH on activity and cost of medium secure					

Collaborative Commissioning					
Activity	Quality	Innovation	Prevention	Productivity	Partnership
Specification and contract management of WMAS	Access Efficiency	Redesign of urgent care system.	Urgent care system to prevent inappropriate transfers.	Evidence of relative ROI	PCT / WMAS Task Group
Audit of ROI for cancer drugs				Evidence of relative ROI	
Radiotherapy investment / efficiency	Access Effectiveness Acceptability	Region wide oversight of productivity plans.	Early intervention drives improved outcomes	Process improvement for efficiency More cost-effective than chemo	West Mids PCTs / providers. Member of NRAG.
Introduction and development Neonatal intensive care and retrieval	Access Effectiveness Equity	Region wide workforce plant new training programme for nurses.	Rapid specialist response drives improved outcomes	More efficient use of capacity across system.	Neonatal network.
Regional Strategy for Paediatric surgery	Access, effectiveness, acceptability	Interdependencies framework for services.	Workforce resilience and patient safety	More efficient use of capacity	West Mids PCTs
Expanded Paediatric Intensive Care capacity	Access Efficiency		Patient safety	More efficient use of capacity	PIC Forum West Midlands
Expanded Secure/CAMHS Tier 4 capacity	Access Efficiency/consistency	New specification and contract and procurement framework	Early intervention to minimise admissions / improve discharges	Improved LOS use of capacity	West Mids PCT, DH Commercial Directorate
Interventional Cardiology	Access, effectiveness	Primary PCI 24/7	Improved specialist intervention presenting further procedure.	More efficient use of capacity.	Cardiac and Stroke Network.

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